Flexible Benefits Wrap-Around Plan Document and Summary Plan Description

Employee Welfare Benefits Program
For the Employees of the
Killeen Independent School District

Wrap-Around
Plan Document
and
Summary Plan Description

Effective January 1, 2021

This document, together with the certificates of insurance, benefit description booklets, and summary plan description issued by Killeen Independent School District, or an insurance carrier, and attached hereto, constitutes the Wrap-Around Plan Document and Summary Plan Description for each of the Component Benefit Programs offered by Killeen Independent School District. If the certificates, booklets, or summaries are not attached, then this Wrap-Around Plan Document and Summary Plan Description is not complete and you should contact Human Resources or the Killeen Independent School District for a complete copy.

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Section One
Introduction

1.1 Introduction

The Killeen Independent School District (the "Employer") maintains the following Killeen Independent School District Employee Welfare Benefits Plan (the "Plan") for the exclusive benefit of its Eligible Employees and their eligible Spouses and Dependents.

Each of these Component Benefit Programs is summarized in a certificate, booklet or summary issued by an insurance company, a summary plan description, the summary of benefits and coverage, enrollment documentation, or another governing document prepared by the Employer, and are incorporated as part of this Wrap-Around Plan Document. A copy of each certificate, booklet, summary, or other governing document, is attached hereto as Component Documents 1 through 13, as noted below.

1.2 Purpose of this Wrap Document

The Employer is providing this Wrap-Around Plan Document and Summary Plan Description ("Wrap Document") to give you an overview of the Plan and to address certain information that may not be addressed in the Component Documents. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in the Glossary of this Wrap Document.

1.3 Component Benefit Programs

The Plan provides the following Component Benefit Programs:

Health/Prescription Program Options: (Fully Insured Programs)

- Plan A - BSW Preferred HMO (Custom HMO Plan) (Component Document 1)
- Plan B - NationCare Custom PPO (Component Document 2)
- Plan C - BSW Preferred HMO (Custom HDHP HMO Plan) (Component Document 3)
- Plan D - BSW Preferred HMO (Custom HDHP HMO Plan) (Component Document 4)

Dental Program Options: (Fully Insured Programs)

- United Concordia Dental Base Plan (Component Document 5)
- United Concordia Buy-Up Plan (Component Document 6)

Vision Program Option: (Fully Insured Program)

- Avesis Advantage Vision Care (Component Document 7)

Flexible Benefits Plan Program Options:

- KISD Flexible Benefits Plan (Component Document 8)
  - Premium Payment Plan ("POP")
  - Health Flexible Spending Account ("Health FSA")
  - Health Savings Account Contribution Benefit ("HSA Contribution Benefit")
  - Dependent Care Flexible Spending Account ("Dependent Care FSA")

Life/AD&D Program Option: (Fully Insured Program)

- Unum Group Life and Accidental Death and Dismemberment Plan (Component Document 9)

Short Term Disability Program Option: (Fully Insured Program)

- Unum Short Term Disability Insurance (Component Document 10)

Long Term Disability Program Option: (Fully Insured Program)

- Unum Long Term Disability Insurance (Component Document 11)

Voluntary Accident Program Option: (Fully Insured Program)

- Unum Group Voluntary Accident Insurance (Component Document 12)

Voluntary Critical Illness Program Option: (Fully Insured Program)

- Unum Voluntary Group Critical Illness (Component Document 13)

Read All Documents. You must read this Wrap-Around Plan Document, Summary Plan Description, the Summary of Benefits and Coverage, and any enrollment documentation, along with the respective Component Document for each Component Benefit Program to understand your Benefits!

You must enroll to receive benefits. Enrollment requirements are explained in Section Three on Eligibility. Some of these Component Benefit Programs require you to make an annual election to enroll for coverage. The details of such annual election are described in the Component Benefit Documents.

This document and the Component Documents constitute the Plan Document and SPD for the Component Benefit Programs.

Even though included in this document, the Life and AD&D, Short Term Disability, and Long-Term Disability Component Benefit Programs are not subject to the requirements of HIPAA. Inclusion of Component Benefit Programs that are not subject to HIPAA as part of this Plan is not intended to subject the Component Benefit Programs to HIPAA.

Component Benefit Programs hereunder are provided pursuant to an insurance contract or pursuant to a governing plan document adopted by the Employer. If the terms of this Wrap-Around Plan Document and SPD conflict with the terms of the Component Documents, then the terms of the Component Documents will control, rather than the terms of this Wrap-Around Plan Document and SPD, unless otherwise required by law.

The terms of this Wrap-Around Plan Document and SPD are designed to incorporate important differences between the Fully Insured Component Benefit Programs and the Self-Funded Component Benefit Program. Nothing in this document or any of the Component Documents shall be construed as to change the funding nature of any Component Benefit Program, such as transferring a Fully Insured Component Benefit Program into a Self-Funded Component Benefit Program, or vice versa. For example, the use of Fully Insured language and terminology in a Self-Funded Component Document would not change the funding structure of that Component Benefit.

Section Two
General Plan Identifying Information

Name of the Plan	Killeen Independent School District Employee Welfare Benefits Plan
Type of Plan	Employee Welfare Benefits Plan
Address of Plan	Killeen Independent School District P.O. Box 967 2301 Atkinson Killeen, TX 76540-0967 Tel: (254) 336-0067
Plan Administrator	Killeen Independent School District Attn: Jessica Neyman, Chief Human Resources Officer P.O. Box 967 Killeen, TX 76540 Tel: (254) 336-0067
Agent for Service of Legal Process	Killeen Independent School District Chief Human Resources Officer Attn: Jessica Neyman P.O. Box 967 Killeen, TX 76540
Named Fiduciary	Killeen Independent School District P.O. Box 967 Killeen, TX 76540 Tel: (254) 336-0067
Plan Number	502 - Welfare Benefit Plan 501 - Flexible Benefits Plan
Plan Sponsor and its IRS Employer Identification Number	Killeen Independent School District P.O. Box 967 Killeen, TX 76540 Tel: (254) 336-0067 EIN: 74-6001505
Effective Date	January 1, 2021
Plan Year End	December 31, 2021

Health/Prescription Component Benefit Programs – Fully Insured (Component Documents 1,3,4)	
Health/Prescription Plan Administrator	Scott & White Care Plans 1206 West Campus Drive Temple, TX 76502 Customer Service: (800) 321-7947 (TTY 711) Website: swhp.org/kisd
Health Program Claims Fiduciary	Scott & White Care Plans 1206 West Campus Drive Temple, TX 76502 Customer Service: (800) 321-7947 (TTY 711)

Health/Prescription Component Benefit Program – Fully Insured (Component Document 2)	
Health/Prescription Plan Administrator	National Health Insurance Company (by Meritain) 300 Corporate Parkway Amherst, NY 14226 Tel: (888) 324-5789
Health Program Claims Fiduciary	National Health Insurance Company (by Meritain) 300 Corporate Parkway Amherst, NY 14226 Tel: (888) 324-5789 Website: www.meritain.com

Dental Component Benefit Programs – Fully Insured (Component Documents 5-6)	
Plan Administrator/Fiduciary	United Concordia Dental 4401 Deer Path Road Harrisburg, PA 17110 Tel: (888) 320-3316, option 4
Claims Fiduciary	United Concordia Claims P.O. Box 69421 Harrisburg, PA 17106-9421 Tel: (866) 357-3304

Vision Component Benefit Program – Fully Insured (Component Document 7)	
Plan Administrator/Fiduciary	Avesis Third Party Administrators, Inc. Corporate Headquarters 10400 N 25th Avenue, Suite 200 Phoenix, AZ 85021 Tel: (800) 522-0258 Customer Service: (800) 828-9341 Website: www.avesis.com
Claims Fiduciary	Avesis Third Party Administrators, Inc. Attn: Vision Claims Department P.O. Box 38300 Phoenix, AZ 85069-8300 Tel: (800) 828-9341

Flexible Benefits Plan Component Benefit Program (Component Document 8)	
Plan Administrator/Fiduciary	Killeen Independent School District P.O. Box 967 Killeen, TX 76540 Tel: (254) 336-0070
Claims Fiduciary	Kazdon, Inc. P.O. Box 29927 Austin, TX 78755-9927 Tel: (512) 345-0404

Life/AD&D Component Benefit Program – Fully Insured (Component Document 9)	
Plan Administrator/Fiduciary	Unum Life Insurance Company of America 1 Fountain Square Chattanooga, TN 37402 Tel: (866) 679-3054
Claims Fiduciary	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 Tel: (800) 635-5597

Short Term Disability Component Benefit Program – Fully Insured (Component Document 10)	
Plan Administrator/Fiduciary	Unum Life Insurance Company of America 1 Fountain Square Chattanooga, TN 37402 Tel: (866) 679-3054
Claims Fiduciary	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 Tel: (800) 858-6843

Long Term Disability Component Benefit Program – Fully Insured (Component Document 11)	
Plan Administrator/Fiduciary	Unum Life Insurance Company of America 1 Fountain Square Chattanooga, TN 37402 Tel: (866) 679-3054
Claims Fiduciary	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 Tel: (800) 858-6843

Voluntary Accident Component Benefit Program – Fully Insured (Component Document 12)	
Plan Administrator/Fiduciary	Unum Life Insurance Company of America 1 Fountain Square Chattanooga, TN 37402 Tel: (866) 679-3054
Claims Fiduciary	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 Tel: (800) 635-5597

Voluntary Critical Illness Component Benefit Program – Fully Insured (Component Document 13)	
Plan Administrator/Fiduciary	Unum Life Insurance Company of America 1 Fountain Square Chattanooga, TN 37402 Tel: (866) 679-3054
Claims Fiduciary	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 Tel: (800) 635-5597

Benefit Program Effective Dates	The original effective date of the Fully Insured Health/Prescription program was January 1, 2019.
	The original effective date of the Fully Insured Dental program was January 1, 2020.
	The original effective date of the Fully Insured Vision program was January 1, 2020.
	The original effective date of the Flexible Benefits Plan program was December 15, 1989.
	The original effective date of the Fully Insured Life/AD&D program was June 1, 2014
	The original effective date of the Fully Insured Short Term Disability program was January 1, 2003.
	The original effective date of the Fully Insured Long Term Disability program was January 1, 1991.
	The original effective date of the Fully Insured Voluntary Accident program was January 1, 2014.
	The original effective date of the Fully Insured Voluntary Critical Illness program was January 1, 2014

Funding Medium and Type of Plan Administration	Some Benefit Programs under the Plan may be Self-Funded by the Employer and some may be Fully Insured under applicable insurance contracts. Insurance premiums for the Fully Insured Benefit Programs are paid in whole or in part by Killeen Independent School District contributions and by participants' payroll deductions (which may be pre-tax or post-tax). Contributions for the Self-Funded Benefit Programs are paid in whole or in part by Killeen Independent School District contributions and by participants' payroll deductions (which may be pre-tax or post-tax). The Plan Administrators for the various Benefit Programs will provide a schedule of the applicable contributions during the initial and subsequent open enrollment periods and upon request for each of the Benefits Programs, as applicable. The Fully Insured Plan A - BSW Preferred HMO (Custom HMO Plan), Plan C - BSW Preferred HMO (Custom HDHP HMO Plan), and Plan D - BSW Preferred HMO (Custom HDHP HMO Plan) programs is insured by Scott & White Care Plans, which is responsible for paying claims and administering the Health/Prescription benefit option. The Fully Insured Plan B - Nation Care Custom PPO Health/Prescription program is insured by National Health Insurance Company (by Meritain), which is responsible for paying claims and administering the Health/Prescription benefit option. The United Concordia Dental Plans are Fully Insured by United Concordia Dental, which is responsible for paying claims and administering the United Concordia Dental Plan benefit options. The Vision Program Option is Fully Insured by Avesis Third Party Administrators, Inc., which is responsible for paying claims and administering the Avesis Advantage Vision Care benefit option.

Funding Medium and Type of Plan Administration *(continued…)*	The Flexible Benefits Plan is adopted by Killeen Independent School District, which is responsible for administering the POP, Health FSA, HSA Contribution Benefit, and Dependent Care Flexible Spending Account benefit options. The Life/AD&D Program Option is Fully Insured by Unum Life Insurance Company of America, which is responsible for paying claims and administering the Unum Group Life and Accidental Death and Dismemberment Plan benefit option. The Short-Term Disability Program Option is Fully Insured by Unum Life Insurance Company of America, which is responsible for paying claims and administering the Unum Short Term Disability Insurance benefit option. The Long-Term Disability Program Option is Fully Insured by Unum Life Insurance Company of America, which is responsible for paying claims and administering the Unum Long Term Disability Insurance benefit option. The Voluntary Accident Program Option is Fully Insured by Unum Life Insurance Company of America, which is responsible for paying claims and administering the Unum Group Voluntary Accident Insurance benefit option. The Voluntary Critical Illness Program Option is Fully Insured by Unum Life Insurance Company of America, which is responsible for paying claims and administering the Unum Voluntary Group Critical Illness benefit option.

Section Three
Eligibility and Participation Requirements

3.1 Eligibility and Participation

An individual is eligible to be a Participant in the Plan if such individual meets the definition of an Eligible Employee as set forth in the Glossary.

The eligibility and participation requirements may vary depending on the particular Component Benefit Program. You must satisfy the eligibility requirements under a particular Component Benefit Program in order to receive benefits under that program. Certain individuals related to you, such as a spouse or your dependents, may be eligible for coverage under certain Component Benefit Programs. To determine whether you or your family members are eligible to participate in a Component Benefit Program, please read the eligibility information contained in the attached Component Documents for the applicable Component Benefit Programs.

Certain Component Benefit Programs require enrollment (either once or annually) for coverage. Information about enrollment procedures, including when coverage begins and ends for the various Component Benefit Programs, is found in the Component Documents. Once eligible, you may begin participating in the Plan upon your election to participate in a Component Benefit Program in accordance with the terms and conditions established for that program or, if earlier, upon meeting the eligibility criteria and becoming covered under a Component Benefit Program that does not require enrollment or an election.

3.2 Need for Enrollment: Time Limits

While some of the Component Benefit Programs may be provided automatically to Eligible Employees, other Component Benefit Programs require the completion of application forms, annual elections, or other administrative forms, as described in the Component Documents. For Component Benefits requiring enrollment, new employees must generally enroll within certain time periods after being hired or after first becoming eligible as described herein and in the Component Documents. Thereafter, enrollment for each Component Benefit Program is generally limited to the annual enrollment period that occurs before the beginning of each Plan Year, unless circumstances give rise to special enrollment rights as described immediately below, or unless other enrollment opportunities are available for a particular Component Benefit Program, as described in the Component Documents.

- New employees must complete enrollment forms within the first thirty (30) calendar days of employment.
- All current employees must complete benefits selections for the following plan year during the annual open enrollment period (October 1st- October 30th).

- If an employee does not complete his or her benefits selections during this period, the employee will only be eligible for the Flexible Spending Account.

3.3 Special Enrollment Rights

In certain circumstances, enrollment may occur outside the open enrollment period, as explained in the Component Documents. The Plan's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which has been furnished to you. Contact Human Resources if you need another copy.

3.4 When Coverage Begins

An employee may commence participation in the Plan upon satisfaction of the eligibility requirements. The plan entry date is the later of the date the employee files a salary reduction agreement or the 1st of the month after the eligibility requirements are met.

As determined by the Employer, coverage may begin at different times for each of the Component Benefit Programs.

For additional information about when coverage begins, please read the eligibility information contained in the Component Documents.

3.5 Termination of Participation

Coverage under a particular Component Benefit Program will terminate as set forth in the Component Documents. Depending upon which Component Benefit Programs you are participating in, other circumstances will also result in the termination of your benefits as specified in the Component Documents. Note that termination of coverage under a particular Component Benefit Program may not necessarily mean that all Plan coverage terminates. You (or your covered family member) may still have coverage under another Component Benefit Program.

Coverage for your spouse and dependents stops when your coverage stops and for other reasons specified in the Component Documents (for example, divorce, dependent's attaining age limit, and other reasons). Benefits will also cease for you, your spouse and dependents upon termination of the Plan.

3.6 COBRA Continuation Coverage

If health, prescription, vision or dental coverage for you, your eligible spouse, or your eligible dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the Plan's definition of dependent) specified in a federal law called COBRA, then you, your eligible spouse, or your eligible dependents may have the right to purchase continuing coverage under the Plan for a limited

period of time. For more information, see the "COBRA" summary, a copy of which has been previously furnished to you. Please contact Human Resources if you need another copy.

If you or your eligible family members qualify for such continuation coverage, then the Health Flexible Spending Account will be treated as a separate plan from the KISD Flexible Benefits Plan, and its Dependent Care, Health Savings Account and Insurance Premium Payment Plan Component Benefit Programs, according to the provisions of the applicable Component Documents.

3.7 USERRA Continuation Coverage

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available pursuant to USERRA is included in the Component Documents.

For some Component Benefit Programs, You May Have Rights Under COBRA and USERRA. For Component Benefit Programs to which COBRA and USERRA apply, your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA. COBRA and USERRA may both apply with respect to the continuation coverage elected. If COBRA or USERRA give you or your covered dependents different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstance.

3.8 Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Employee's non-custodial child as required by any qualified medical child support order (QMCSO) under ERISA §609(a), including a National Medical Support Notice. The Plan has procedures for determining whether an order qualifies as a QMCSO. You can obtain, without charge, a copy of such procedures from Human Resources.

3.9 Family and Medical Leave

As explained in the Component Documents issued by the Employer, if a Participant is on a Family or Medical Leave of Absence, the Participant may continue coverage in accordance with the Family and Medical Leave Act, and the Plan will continue coverage, as if the Participant was Actively at Work if the following conditions are met:

- The required Contribution is paid; and
- The Participant has written approval of leave from the Employer.

Coverage will be continued for up to the greater of:

- The leave period required by the Family and Medical Leave Act of 1993 and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the Participant returns to Actively at Work status no new Waiting Period will apply.

Section Four
Plan Benefits Summary

4.1 Benefits

The Plan provides you and your eligible dependents with benefits under the Component Benefit Programs as set forth in Section One of this Wrap-Around Plan Document. A summary of each Component Benefit Program, describing the benefits provided under the program is set forth in the Component Documents.

4.2 Premiums and Contributions

The cost of the benefits provided through the Component Benefit Programs will be funded in part by Employer payments called premiums (for Fully Insured plans) and contributions (for Self-Funded plans) and in part by employee premiums and contributions (which may be pre-tax or after-tax, subject to the terms of the KISD Flexible Benefits Plan and applicable Component Benefit Program 8). The Employer will determine and periodically communicate your share of the cost of the benefits provided through each Component Benefit Program, and it may change that determination at any time.

The Employer will make payment of its premiums or contributions in an amount that (in the Employer's sole discretion) is sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee premiums or contributions. With respect to Fully Insured Component Benefit Programs, the Employer will pay its own premiums and employee premiums to the insurance carrier specified above. With respect to benefits that are Self-Funded, the Employer will use its own contributions and employee contributions to pay benefits directly to or on behalf of you and your eligible family members from the Employer's general assets or from those assets held in trust (where applicable) for that purpose.

Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of benefit.

4.3 Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be allocated consistent with applicable federal law.

The following three notices in Sections 4.4 through 4.6 apply to the Group Health Plan Component Benefit Programs (but only to the extent they provide applicable benefits).

4.4 Newborns and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., your Physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits for out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

4.5 Reconstructive Surgery Following Mastectomy

On January 1, 1999, a new federal law, the Women's Health and Cancer Rights Act of 1998, became effective for the Plan. The law requires group health plans to provide coverage for breast reconstruction, prostheses and complications following a mastectomy. The law mandates that a Participant or Dependent who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the attending Physician and the patient, and will be subject to the same annual Deductible, Coinsurance and/or Copayment provisions otherwise applicable under the Plan. If you have any questions about coverages for mastectomies and post-operative reconstructive surgery, please contact the applicable Plan Administrator.

4.6 Michelle's Law

A Dependent will not lose status as a Dependent while on a Medically Necessary Leave of Absence. A "Medically Necessary Leave of Absence" is a leave of absence from a post-secondary educational institution that:

- Commences while the Dependent is suffering from a severe illness or injury;

- Is medically necessary (as certified by the Dependent's physician);
- Causes the dependent to lose full time student status under the Plan.

Coverage may not terminate due to the Medically Necessary Leave of Absence until the earlier of:

- One year after the first day of the Medically Necessary Leave of Absence; or
- The date the coverage would otherwise terminate under the Plan.

(Section 4.6 may not be applicable due to ACA's age 26 dependent coverage mandate).

Section Five
Plan Administration

5.1 Plan Administrators

The Plan Administrators for the various Component Benefit Programs of the Plan are identified above in Section Two.

5.2 Power of Plan Administrators

Subject to the limitations of the Plan and any Component Document, the Plan Administrators will from time to time establish rules for the administration of the various Component Programs of the Plan and transaction of its business. The Plan Administrators will rely on the records of the Employer with respect to any and all factual matters dealing with the employment and eligibility of an employee. The Plan Administrators will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrators shall have such powers and duties as may be necessary to discharge its functions hereunder, including but not limited to, the sole and absolute discretion to:

- Construe and interpret the various Component Benefit Programs of the Plan;
- Decide questions of eligibility to participate in the various Component Benefit Programs of the Plan; and
- Determine the amount, manner and time of payment of any benefit to any covered person.

The Plan Administrators will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and legally binding.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and further, constitutes agreement to the limited standard and scope of review described in this Section.

5.3 Outside Assistance

The Plan Administrators may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Plan Administrators shall deem advisable. The various Component Benefit Programs of the Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses

incurred by the Plan Administrators in the administration of the various Component Benefit Programs of the Plan.

5.4 Delegation of Powers

In accordance with the provisions hereof, the Plan Administrators have been delegated certain administrative functions relating to the various Component Benefit Programs of the Plan with all powers necessary to enable the Plan Administrators properly to carry out such duties. The Plan Administrators as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the various Component Benefit Programs of the Plan other than expressly provided in this Wrap-Around Plan Document and SPD or the Component Documents.

The Plan Administrator may delegate any of these administrative functions among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

5.5 Power and Authority of Insurance Companies

The following list of benefits programs are Fully Insured and provided under group insurance contracts entered into by the Employer and the applicable insurance companies:

Benefit Program	Insurance Company
Health/Prescription	Scott & White Care Plans and National Health Insurance Company (by Meritain)
Dental	United Concordia Claims
Vision	Avesis Third Party Administrators, Inc.
Life/AD&D	Unum Life Insurance Company of America
Short Term Disability	Unum Life Insurance Company of America
Long Term Disability	Unum Life Insurance Company of America
Voluntary Accident	Unum Life Insurance Company of America
Voluntary Critical Illness	Unum Life Insurance Company of America

You should send claims for benefits under these Component Benefit Programs to the insurance companies. The insurance companies are responsible for (a) determining eligibility for and the amount of any benefits under the applicable Component Benefit Program; (b) prescribing claims procedures to be followed and the claim forms you should use pursuant to the applicable

Component Benefit Program; and (c) payment of all benefits under the applicable Component Benefit Program. The Employer does not assume any responsibility for paying claims under these Component Benefit Programs. However, the insurance companies and the Employer share responsibility for administering the Plan.

5.6 Your Questions

If you have any general questions regarding the Plan or regarding your eligibility for, or the amount of, any benefit payable under the Self-Funded Component Benefit Programs, please contact Human Resources.

If you have questions regarding eligibility for, or the amount of, any benefits payable under a Fully Insured Component Benefit Program, please contact the applicable insurance company as provided in the Component Document.

Section Six
Circumstances That May Affect Benefits

6.1 Denial, Recovery or Loss of Benefits

Your benefits (and, except in some cases in the event of your death, the benefits of your eligible spouse and eligible dependents) will cease when your participation in the Plan terminates. See Section Three. Your benefits will also cease upon termination of the Plan. Your benefits under any individual Component Benefit Program will cease upon termination of any such individual Component Benefit Program.

6.2 Rescission of Coverage

The Plan Administrator reserves the right to rescind coverage under the Plan if an employee, spouse or child becomes covered under this Plan or receives Plan benefits as a result of an act, practice or omission that constitute fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the employee, spouse or child became covered or received a Plan benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30 days advance notice to an employee, spouse or child of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage only has a prospective effect; or
- The cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay Premiums (including COBRA Premiums) toward the cost of coverage. A rescission is subject to the claims payment and appeal procedures described in Article 9.

6.3 Reimbursement and Subrogation

In certain circumstances, the Plan may recover overpaid benefits through its rights to subrogation and reimbursement. These Plan rights are described in detail in the Component Documents.

Section Seven
Amendment or Termination of the Plan

7.1 Right to Amend, Modify, Merge Consolidate, or Replace

The Employer reserves the right to merge, consolidate, or replace the Plan or any individual Component Benefit Program, and to make any amendment, modification, or restatement to the Plan or any individual Component Benefit Program from time to time, including those which are retroactive in effect. Such amendments may be applicable to any covered person. Terminating a Component Benefit Program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

Any amendment, modification, or restatement shall be deemed to be duly executed by the Employer when adopted as part of the Employee Welfare Benefits Plan for the Employees of Killeen Independent School District Wrap-Around Plan Document and Summary Plan Description.

7.2 Right to Terminate

The Plan and its individual Component Benefit Programs are intended to be permanent, but the Employer may at any time and without notice terminate the Plan or any individual Component Benefit Program in whole or in part.

7.3 Effect on Benefits

Except as may otherwise be provided by applicable law or the Component Documents, if the Plan or any individual Component Benefit Program is amended or terminated, covered persons may not receive benefits described in the Plan or in any individual Component Benefit Program after the effective date of such amendment or termination. Any such amendment or termination shall not affect a covered person's right to benefits for claims incurred prior to such amendment or termination. If the Plan or any individual Component Benefit Program is amended, covered persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen at any time. If the Plan is terminated, covered persons will not be entitled to any vested rights under the Plan.

Section Eight
No Contract of Employment

Nothing contained in the Plan or the Component Benefit Programs shall be construed as a contract of employment with the Employer, or as a right to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of the participants, with or without cause.

Section Nine
Claims and Appeals Procedures

9.1 Claims and Appeals for Fully Insured Component Benefit Programs

For purposes of determining the amount of, and entitlement to, benefits of the Fully Insured Component Benefit Programs, the respective insurer is the Claims Fiduciary (as specified in Section Two) under the Plan. The Claims Fiduciary has the full power to interpret and apply the terms of the Plan to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a Component Benefit Program, you must follow the respective insurer's claims procedures. (See the Component Documents for more information).

The insurance company will decide your claim in accordance with its reasonable claim's procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company denies a claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claim's procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. If you do not appeal on time, then you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). To the extent the Component Benefit Program is subject to provisions of ACA requiring external review, procedures to that effect will be available.

The applicable insurance contract (including the certificate, booklet or summary) provides more information about how to file a claim and details regarding the insurance company's claims procedures.

9.2 Claims and Appeals for Self-Funded Component Benefit Programs

For purposes of determining the amount of, and entitlement to, benefits under the Self-Funded Component Benefit Programs provided through the Employer's general assets, the Plan Administrator is the Named Fiduciary (as specified in Section Two) under the applicable Component Benefit Program. The Named Fiduciary has the full power to make factual determinations and to interpret and apply the terms of the applicable Component Benefit Program to the benefits provided through a Self-Funded Component Benefit Program.

To obtain benefits from a Self-Funded Component Benefit Program, you must submit to the Plan Administrator (or, if applicable to the Claims Administrator for that benefit) in accordance with the claim's procedure for that Component Benefit Program, set forth in the Component

Document. The Plan Administrator or Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim.

The Plan Administrator (or, if applicable to the Claims Administrator) will decide your claim in accordance with the Component Benefit Program's reasonable claims procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. If a claim is denied in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the Plan Administrator (or, if applicable to the Claims Administrator) for a review of the denied claim. The Plan Administrator (or, if applicable to the Claims Administrator) will decide the appeal in accordance with reasonable claims procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. If you do not appeal on time, then you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

See the certificate, booklet, summary or other governing document among the applicable Component Documents for more information about how to file a claim and for details regarding the claim's procedures applicable to a claim.

9.3 Claims Deadline

Unless specifically provided otherwise in a Component Benefit Program or pursuant to applicable law, a claim for benefits under this Plan (including the Component Benefit Programs) must be made within 12 months after the date of service, except in the absence of legal capacity. It is your responsibility, or the responsibility of your designee to make sure this requirement is met.

9.4 Administrative Exhaustion Requirement

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty.

9.5 Limitation on Actions

To the extent not otherwise specified in the applicable Component Document, any legal action for the recovery of any benefits or breach of fiduciary duty must be commenced within one year after the Plan's claim review procedures have been exhausted.

9.6 Failure to File a Request

If you fail to file a request for review in accordance with the claim's procedures outlined herein and in the Component Documents, you shall have no right of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

Section Ten
Plan Information

10.1 Fully Insured Component Benefit Contracts Control

Benefits under the Fully Insured Component Benefit Programs are provided solely pursuant to insurance contracts between the Plan Sponsor and the applicable insurance companies, as set forth in the Component Document for such Component Benefit Program. If the terms of this Wrap-Around Plan Document conflict with the terms of the Component Document, the terms of the Component Document will control, unless superseded by applicable law. For this purpose, silence in an insurance contract (including the certificate of insurance) or HMO booklet, plan document, or other governing document is not necessarily a conflict or inconsistency.

10.2 Self-Funded Component Benefit Plan Documents Control

Benefits under the Self-Funded Component Benefit Programs are provided solely pursuant to the Plan Document, SPD, or other governing document. If the terms of this Wrap-Around Plan Document and SPD conflict with the terms of the Plan Document, SPD or other governing document of any Self-Funded Component Benefit Program, the terms of the Plan Document, SPD or other governing document will control, unless superseded by applicable law. For this purpose, silence in a Plan Document, SPD, or other governing document is not necessarily a conflict or inconsistency.

10.3 Compliance with Federal Mandates

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the certificate, booklet or summary, including the following:

- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
- Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
- Women's Health and Cancer Rights Act of 1998 (WHCRA);
- Genetic Information Nondiscrimination Act of 2008 (GINA):
- The Health Information Technology for Economic and Clinical Health Act (HITECH);
- Mental Health Parity and Addiction Equity Act (MHPAEA); and
- The Affordable Care Act (ACA).

10.4 Verification

The Plan Administrators for the various Component Benefit Programs shall be entitled to require reasonable information to verify any claim or the status of any person as an eligible employee or dependent. If the employee or dependent does not supply the requested information within the applicable time limits or provide a release for such information, such employee or dependent shall not be entitled to benefits under the Plan.

10.5 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Employer, any of its employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provide herein or as provided by law.

10.6 Governing Law

The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Texas, except to the extent such laws are preempted by federal law.

10.7 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

10.8 Caption

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

10.9 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the Internal Revenue Service, we inform you that to the extent this communication (including any of the Component Documents) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (a) avoiding any penalties that may be imposed on you or any other person or entity under the Internal Revenue Code or (b) promoting, marketing or recommending to another party any transaction or matter addressed herein. If you are not the original addressee of this communication, you should seek advice from an independent advisor based on your particular circumstances.

Glossary

Capitalized terms used in the Plan have the following meanings:

Code means the Internal Revenue Code of 1986, as amended.

Component Benefit means the specific benefit(s) contained within a certificate, booklet, summary or other governing document in which an Eligible Employee participates.

Component Benefit Program means the program under which the specific Component Benefit(s) are held.

Component Benefit Program Effective Date means the individual dates listed in Section 2.

Component Document means the certificate, booklet or summary issued by an insurance company, a summary plan description, or another governing document prepared by the Employer summarizing the Component Benefit Programs.

Plan Effective Date means January 1, 2021.

Eligible Employee means an Employee who becomes an Eligible Employee on the first day of the month following 30 days of employment with the Employer.

Employee means an individual who is a common-law employee of the Employer, regularly scheduled to work 17.5 hours or more per week with the Employer.

The following classes of employees are eligible to participate in the Killeen Independent School District Welfare Benefits Plan:

- Union members.

The following classes of employees cannot participate in the Killeen Independent School District Welfare Benefits Plan:

- Leased employees (as defined by §414 (n) of the Code);
- Contract workers and independent contractors;
- Temporary employees, casual employees, and employees hired short-term to meet specific needs of the Employer whether or not such persons are on the Employer's W-2 payroll; and
- Individuals paid by a temporary or other employment or staffing agency.

Employer means Killeen Independent School District, and any wholly owned subsidiary specifically identified in Section 1, and any successor thereto.

KISD Flexible Benefits Plan means the Cafeteria Plan established by the Employer under the Plan. It allows you to use pre-tax dollars to pay for qualifying medical expenses, for the care of your eligible Dependents while you are at work, and for certain insurance premiums.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Section 3.

Plan means this Killeen Independent School District Employee Welfare Benefits Plan.

Plan Administrator means, with respect to the Killeen Independent School District Employee Welfare Benefits Plan for the Employees of Killeen Independent School District, the Employer. With respect to Component Benefit Programs, Plan Administrator means the entity identified as the Plan Administrator in Section 2.

Component Documents

The Plan provides the following Component Benefit Programs:

Health/Prescription Program Options: (Fully Insured Programs)

- Plan A - BSW Preferred HMO (Custom HMO Plan) (Component Document 1)
- Plan B - NationCare Custom PPO (Component Document 2)
- Plan C - BSW Preferred HMO (Custom HDHP HMO Plan) (Component Document 3)
- Plan D - BSW Preferred HMO (Custom HDHP HMO Plan) (Component Document 4)

Dental Program Options: (Fully Insured Programs)

- United Concordia Dental Base Plan (Component Document 5)
- United Concordia Buy-Up Plan (Component Document 6)

Vision Program Option: (Fully Insured Program)

- Avesis Advantage Vision Care (Component Document 7)

Flexible Benefits Plan Program Options:

- KISD Flexible Benefits Plan (Component Document 8)
  - Premium Payment Plan ("POP")
  - Health Flexible Spending Account ("Health FSA")
  - Health Savings Account Contribution Benefit ("HSA Contribution Benefit")
  - Dependent Care Flexible Spending Account ("Dependent Care FSA")

Life/AD&D Program Option: (Fully Insured Program)

- Unum Group Life and Accidental Death and Dismemberment Plan (Component Document 9)

Short Term Disability Program Option: (Fully Insured Program)

- Unum Short Term Disability Insurance (Component Document 10)

Long Term Disability Program Option: (Fully Insured Program)

- Unum Long Term Disability Insurance (Component Document 11)

Voluntary Accident Program Option: (Fully Insured Program)

- Unum Group Voluntary Accident Insurance (Component Document 12)

Voluntary Critical Illness Program Option: (Fully Insured Program)

- Unum Voluntary Group Critical Illness (Component Document 13)