FBISD LiveWell

A world of healthy living.

2011 **Benefits Guide**

Welcome to Fort Bend ISD

Fort Bend ISD is pleased to offer a comprehensive benefit program to our faculty and staff. This benefit enrollment guide provides summary information about the benefits offered. Review your options and choose the plans that best fit the needs of you and your family.

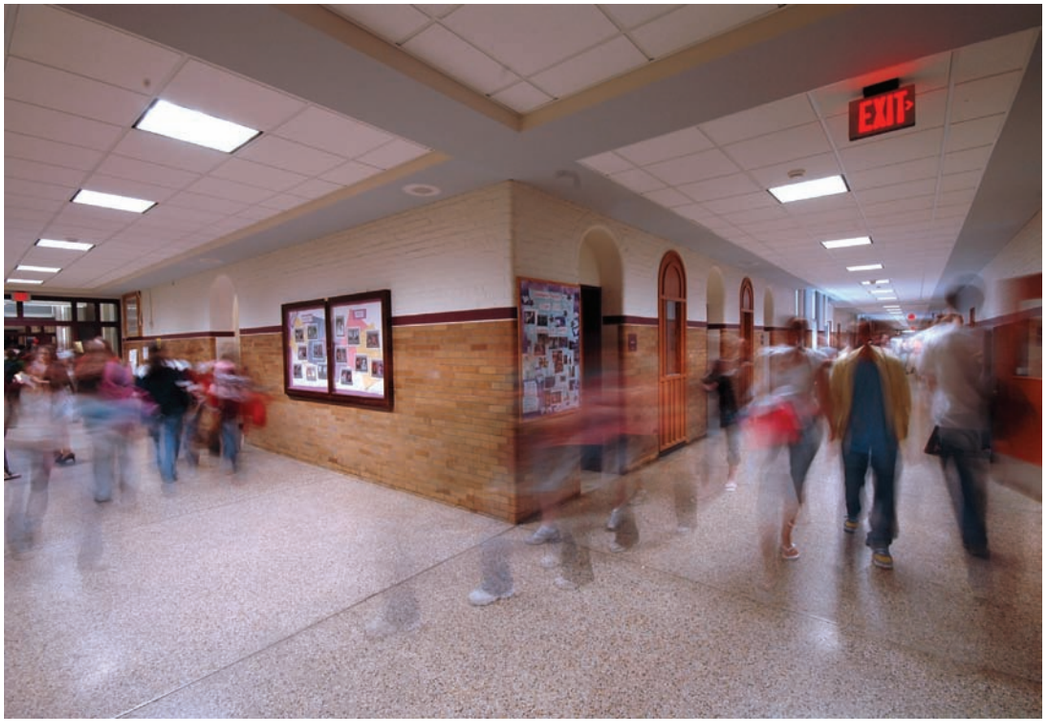
Should you have any questions, contact the Benefits Department at **281.634.1418** or by e-mail at **benefits@fortbendisd.com**.

Important

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a new Federal Law gives you more choices about your prescription drug coverage. Please see the notice on page 28 of this guide for more details.

Remember

The choices you make during Annual Enrollment will remain in effect until the next Annual Enrollment period unless you have a change in status. Additional information on status changes is enclosed.



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What's New for January 1, 2011

What's New

Effective January 1, 2011, we will be making changes to the Medical Choice Plus PPO and the iPlan, as well as the voluntary life and disability plans. Details of these changes are outlined in the document.

Eligibility

- Dependent children married or unmarried, to age 26 (student status does not apply), are eligible for the benefit plans.
- A spouse who is eligible for medical coverage where he or she works is not eligible for the FBISD medical plan and should obtain coverage through his or her employer's medical plan.

Choice Plus PPO Plan – UnitedHealthcare

- The annual in-network deductible will increase to $600 per individual and $1,200 per family.
- The annual in-network out-of-pocket maximum will increase to $3,000 per individual and $6,000 per family.
- The emergency room copay of $250 will now be subject to calendar year deductible and out-of-pocket maximum. The copay will be waived if admitted to the hospital.
- Outpatient diagnostic x-ray and lab will be subject to the calendar year deductible and out-of-pocket maximum.

iPlan – UnitedHealthcare

- FBISD will no longer contribute towards the Personal Benefit Account (PBA).
- The in-network coinsurance paid by you will increase to 30% from 20%.

Prescription Drug – Express Scripts

- Retail Prescription Drug copays will be changing to 30% generic, 40% preferred brand, and 50% non-preferred brand.
- Mail Order Prescription Drug copays will be changing to 25% generic, 35% preferred brand, and 45% non-preferred brand. The maximum cost per prescription per 90-day supply is $150.
- Specialty Medications copays will be 45% up to a maximum per prescription of $50 per 30-day supply. All specialty medications must be received through CuraScript.

Voluntary Disability Plan – Sun Life Financial

- FBISD is simplifying the voluntary disability plan options.
- You will have two elimination periods to choose from. The elimination period is the period of time that must elapse from the onset of a disability, before you are eligible to receive monthly benefits. Currently, employees have many elimination periods to choose from (0/7, 14, 30, 60, 90 or 180-day).
- The benefit employees will receive is 66.7% of their income.

Voluntary Life and Accidental Death and Dismemberment (AD&D) Insurance Plan – Sun Life Financial

- FBISD is simplifying the voluntary life and AD&D plan options.
- When you elect voluntary employee life, you will receive an AD&D benefit in the same amount as your life election.
- You may elect spouse life in $10,000 increments up to 100% of your employee life election. When you elect spouse life you will receive an AD&D benefit in the same amount as your spouse life election.
- You may elect $10,000 child life and AD&D.

Health Care Flexible Spending Account – UnitedHealthcare

- The definition of qualified medical expense for purposes of Flexible Spending Accounts and Health Reimbursement Accounts is now limited to prescribed medications and insulin. Over the counter medications and supplies are only eligible for FSA reimbursement when purchased with a doctor's prescription.

FBISD is pleased to announce a new wellness program for our employees! The program will provide support, education, and motivation to empower you and your family to reach all of your health and wellness goals and, ultimately, lead happy, healthy lives! This year, you'll see:

- Health screenings
- Activity and weight loss challenges
- Online wellness resources
- Monthly wellness tips
- Partnerships with local health and fitness organizations
- Newsletters
- Wellness presentations
- **Incentives!**

What Benefits Are Available January 1, 2011?

Eligible employees have the option of participating in any of the following plans:

- UHC Medical Choice Plus Plan & iPlan
- Alternate Plan
- Catastrophic Plan
- UHC Dental PPO & HMO
- Vision Plan
- Flexible Spending Accounts
- Optional Life/AD&D
- Long-Term Disability
- Prepaid Legal
- AFLAC Supplemental Plans

These benefits are available to you at NO COST:

- Basic Life and AD&D

Eligible Dependents* include

- Legal spouse;
- Dependent children, married or unmarried, to age 26 (student status does not apply). For the group health plan, tax dependent status does not apply;
- Child of any age who becomes physically or mentally disabled while covered under the benefits plan, the child's coverage may be continued as long as the child remains disabled and depends on you for support.

Child means

- Natural child; or
- Legally adopted child; or
- Child who has been placed in your legal guardianship* and is less than 26 years of age.

*Proof of dependent eligibility is required; see the list of necessary documents on the next page.

Membership Guidelines

Who Is Eligible for Coverage?

All active, full-time employees contributing to the Teacher Retirement System (TRS) are eligible for benefits through Fort Bend ISD.

When Can You Enroll?

- Enrollment forms must be returned to the Benefits Department within 30 days of your start date.
- For **all employees**, benefits will be effective on the first of the month following your start date.
- If you do not complete enrollment within this time period, you will be eligible to enroll for benefits during the Annual Enrollment period held in the fall of every year. Most benefits elected during the Annual Enrollment period will be effective the first day of the following year. Coverage that requires Evidence of Insurability will not be effective until and unless approved by Sun Life.

Making Enrollment Changes During the Year

In most cases, your pre-tax benefit elections are irrevocable and remain the same for the entire plan year (January 1 – December 31). During each Annual Enrollment period, you will have the opportunity to review your benefit elections and make changes for the coming year.

Certain coverages allow limited changes to elections during the year. Under these benefits, you may make changes to your elections only during the year if you have a status change. Status changes include:

- Marriage or divorce;
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, marriage, or reaching the dependent child age limit;
- Changes in your spouse's employment affecting benefit eligibility;
- Changes in your spouse's benefit coverage with another employer that affects benefit eligibility.

Please note: Newborns must be added to the FBISD plan within 30 days of birth in order to be covered.

You have 30 days from the date of a status change to submit documentation of dependent eligibility and a completed enrollment change form to the Benefits Department. Requests for changes in benefit elections must be consistent with the status change. Otherwise, you must wait until the next Annual Enrollment period to make a change to your elections.

Coverage Levels

The "levels of coverage" under each plan vary and the selections you make affect your per-pay-period cost. You may choose a different level of coverage for each benefit. For example, you may choose Employee + Family coverage for medical, Employee + 1 for dental and Employee Only coverage for vision. However, you cannot select coverage for a dependent when you have not chosen coverage for yourself for that benefit selection.

Dependent Eligibility

Requirements to Add a Dependent to the FBISD Benefit Plans

To enroll your dependents in the benefit plans, you must submit proof of eligibility with your benefit enrollment forms. Make sure the official seal is clear and visible. You should NOT submit an original document or a certified copy (which would have a raised seal). Make copies of each document you submit, and keep them for your records. Original documents cannot be returned.

Proof Documents Required

- **Legal Marriage Documents**

  If you are legally married, you must submit a COPY of:

  - Marriage Certificate; **AND**
  - Most Recent Federal Tax Return

- **Common Law Marriage Documents**

  If you are in a common law marriage, you must submit a COPY of:

  - County Certificate from the County where the marriage was recognized or recorded; **OR**
  - If the County does not issue certificates, you can submit a Common Law Marriage Affidavit, plus the supporting documents listed on the affidavit; **AND**
  - Most Recent Federal Tax Return

- **Biological Child Documents**

  To verify the eligibility of a biological child, you must submit a COPY of:

  - Birth Certificate of Biological Child; **OR**
  - Documentation on hospital letterhead indicating the birth date of the child or children under 6 months old.

- **Adopted Child Documents**

  To verify the eligibility of an adopted child or a child placed with you for adoption, you must submit a COPY of the following documents. The documents you submit will depend on the current stage of the adoption.

  - Official court or agency placement/guardianship papers for a child placed with you for adoption (initial stage); **OR**
  - Official Court Adoption Agreement for an Adopted Child (mid-stage); **OR**
  - Birth Certificate (final stage)

- **Stepchild Documents**

  To verify the eligibility of your stepchild, you must submit a COPY of:

  - Child's Birth Certificate showing the child's parent is the employee's spouse; AND
  - Marriage Certificate showing legal marriage between the employee and the child's parent; AND
  - Most Recent Federal Tax Return

- **Grandchild Documents**

  To verify the eligibility of a grandchild you must submit a COPY of:

  - Most Recent Federal Tax Return

- **Other Child Documents (Niece/Nephew, Brother/Sister, Other)**

  To verify the eligibility of any other type of child for whom you are the legal guardian, you must submit a COPY of:

  - Court papers demonstrating legal guardianship, including the person named as the legal guardian; AND
  - Most Recent Federal Tax Return

- **Disabled Child Age 19 or Older Documents**

  To verify the eligibility of a disabled child, you must submit a COPY of:

  - A certified Handicapped Child/Disabled Student Attending Physician Statement signed by the employee and the child's attending physician.

About Submitting Tax Returns

Make sure to submit the pages that display all tax dependents, your tax filing status, your address, your signature (and your spouse's, if appropriate), and the filing date. Submit either one joint return or the returns of both spouses, if you filed as "Married, Filing Separately." This is required even if you filed electronically.

Make sure to **black out your financial information**. For audit verification, your personal income data is not required. If you have not filed your most recent tax return, submit your prior year's return.

PLEASE NOTE: Tax returns will not be used to verify dependent eligibility for the group health plan.

About Your UnitedHealthcare (UHC) Medical Coverage

Fort Bend ISD's Medical Plan options offer a broad range of benefits coverage to fit your individual needs. You may choose from two medical plan options: the Choice Plus Plan or the iPlan.

Medical Benefits

Administered by UnitedHealthcare (UHC)

How Does My Choice Plus Medical Plan Work?

You pay less out-of-pocket if you use the physicians, hospitals, and other health care providers that participate in the PPO network with UHC. While you do not need referrals to visit specialists, you receive the highest level of benefits when you use **Preferred Providers.** In some instances, such as hospital admissions and home health care services, UHC may require prior approval. In other words, UHC must approve the need for care before you seek it, or they may choose not to pay for such care.

To Find Preferred Providers (In-Network)

- Visit the **www.myuhc.com** web site and click on "Find a Physician, Laboratory or Facility."
- Call **800.842.5658** to find out if the provider you select is Preferred.

The medical summary of benefits in this guide shows a comparison between benefits when you use In-Network Providers and benefits when you use Out-of-Network Providers. Also, keep in mind that your health plan pays the Allowed Price for services and supplies. In-Network Providers agree to accept the Allowed Price as payment in full. When you use Out-of-Network Providers, you must pay the difference between the Allowed Price and the provider's charge.

Benefits for most services require that you pay a **deductible** each year for In-Network Providers' services and Out-of-Network Providers' services. Once you have met your deductible, you share the cost of your care through **coinsurance**. Deductible and out-of-pocket amounts do not cross apply.

Once again, your coinsurance percentage for Out-of-Network Providers is higher than the one for In-Network Providers. You need only pay the deductible and coinsurance until you meet your out-of-pocket maximum for the year. You receive **first-dollar coverage for office visits** on the Choice Plus Plan. You do not have to pay a deductible or coinsurance for these services, but you do have to pay a **copay** for each visit.

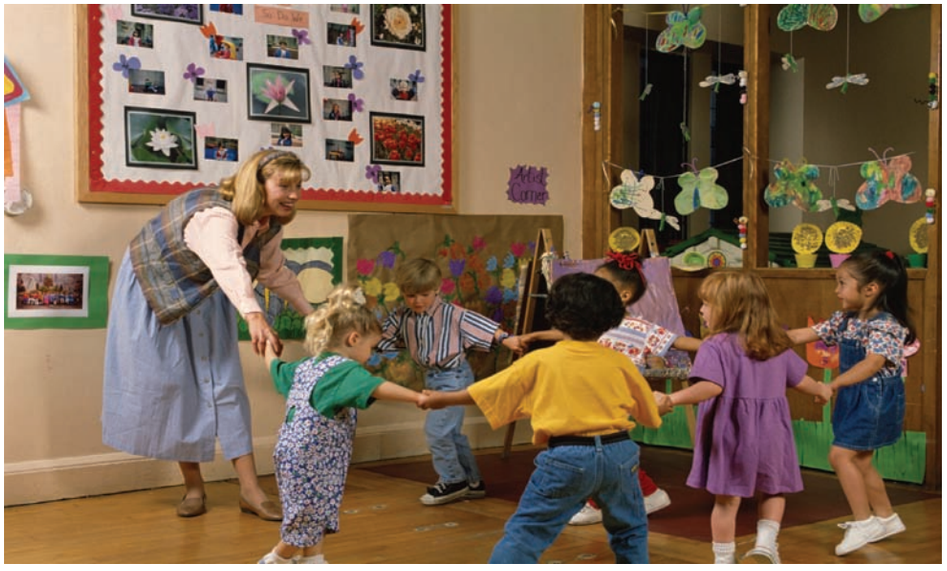
UHC Online – myuhc.com

Myuhc.com is a self-service health and well-being web site for UHC members that provides personalized support for you and your family. After you register through **www.myuhc.com**, you will be able to:

- Verify your Explanation of Benefits (EOBs)
- Check the status of your claims online
- Search for in-network providers
- Print a temporary ID card or order a replacement card
- Look up health and wellness information

Catastrophic Illness Supplement (CIS)

The CIS provides paid leave identical to the employee's base salary to those employees who have exhausted all accumulated paid leave due to a catastrophic illness or injury for which they are currently seeking medical treatment.



Disease Management

UHC Personal Health Support

If you're dealing with complex healthcare needs or living with a chronic condition such as **asthma, coronary artery disease, congestive heart failure or diabetes**, it can be difficult to sort through all the available information to make informed decisions. UnitedHealthcare Personal Health Support with Disease Management can provide you with access to specialized nurses as well as other resources that can help you better manage your healthcare needs and improve your quality of life.

If you are contacted by a UHC Personal Health Support Nurse, we encourage you to participate in this new program offering.

You Do Not Need to Do Anything to Enroll

Your eligibility for this program is determined by UHC when you experience certain health events that require medical attention or if you receive a high-risk score when you complete a personal health assessment. If you are eligible for the program, a Personal Health Support Nurse assigned to you will contact you by phone. A Personal Health Support Nurse will explain the program details to you and help you to enroll in the program. If you need help with managing a specific chronic condition, a Personal Health Support Nurse assigned to you will put you in touch with a specialized Disease Management Nurse who can provide you with the tools and support you need to better manage your condition.

In addition, a Personal Health Support Nurse will:

- Provide you with **one-on-one** healthcare information, guidance and support.
- Help **coordinate your care** with physicians and health care professionals.
- Support you in understanding and following your doctor's **treatment plan**.

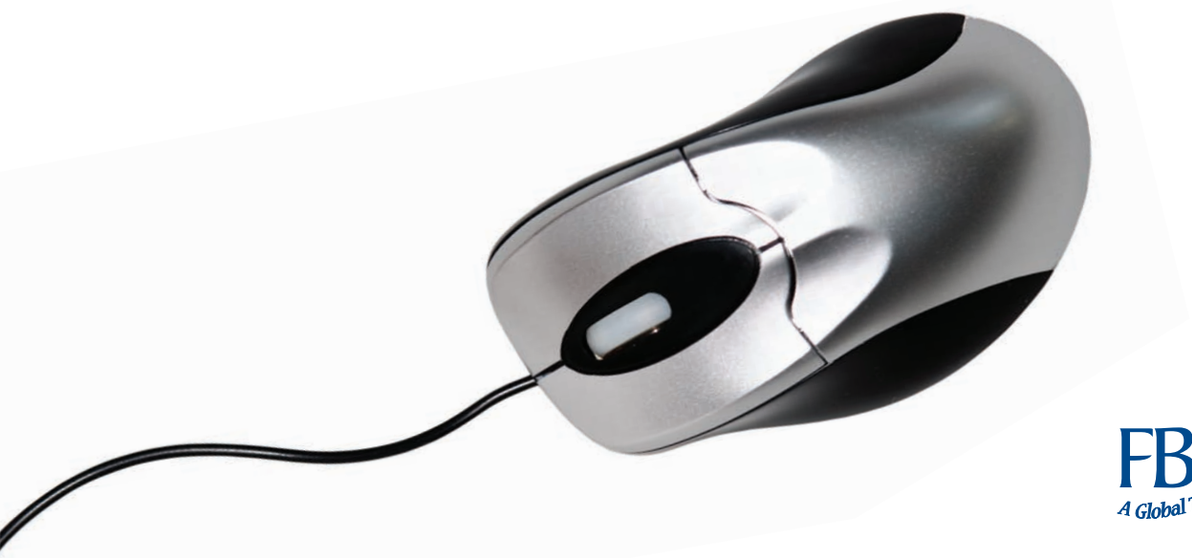
If you are considering treatment decisions for a specific condition, Personal Health Support with Disease Management includes a service called **Treatment Decision Support** designed to help you make informed decisions. A specialized Treatment Decision Support Nurse will provide you with access to the information you need to:

- Help you select the treatment option that best meets your needs.
- Choose a physician and hospital for your treatment.
- Prepare for your upcoming treatment and for a successful recovery.

All of your personal health information is treated with the highest level of confidentiality.

A Number of Healthcare Programs Are Available to You

If you do not need this support right now, know that UHC Personal Health Support with Disease Management is there if you do. Your UHC benefit also includes a number of health improvement programs and resources on **myuhc.com**. Programs that range from weight loss to fitness to smoking cessation are available to all members. Simply login to **myuhc.com** today and click "Health&Wellness."



Choice Plus Summary of Medical Benefits

Medical Provider	UnitedHealthcare
Policy Number	706484
Customer Service	800.842.5658
Website	www.myuhc.com

	24 PAY	19 PAY
Employee Only	$55.50	$70.11
Employee + Spouse	$182.00	$229.90
Employee + Child(ren)	$162.00	$204.63
Employee + Family	$244.00	$308.21

	CHOICE PLUS PPO	
	In-Network	Out-of-Network
	You Pay	You Pay
DEDUCTIBLE (CALENDAR YEAR)		
Individual	$600	$1,000
Family	$1,200	$2,000
OUT-OF-POCKET MAXIMUM (EXCLUDING DEDUCTIBLE AND COPAYS)		
Individual	$3,000	$5,000 per covered person, per calendar year
Family	$6,000	
ANNUAL MAXIMUM BENEFIT	$2 million per covered person	
LIFETIME BENEFIT MAXIMUM	Unlimited	
INPATIENT HOSPITAL SERVICES	20% after deductible	40% after deductible
Per Admission Deductible	$250	$250
Penalty for Failure to Pre-Authorize	None	$500
OUTPATIENT SURGERY	20% after deductible	40% after deductible
PHYSICIAN OFFICE VISIT Including injections received in the Physician's office	$25 copy	40% after deductible
SPECIALIST OFFICE VISIT	$35 copay	40% after deductible
PREVENTIVE CARE	Covered at 100% deductible and copays do not apply	40% after deductible
URGENT CARE FACILITY	$75 copay	40% after deductible
EMERGENCY ROOM (True Emergencies)	$250 copay (waived if admitted); deductible and coinsurance apply; $250 inpatient admission deductible applies if admitted	
LABS AND X-RAYS Outpatient basis	20% after deductible	40% after deductible
CT SCANS, MRIs, PET SCANS, AND NUCLEAR MEDICINE	20% after deductible	40% after deductible
MENTAL HEALTH/SUBSTANCE ABUSE	20% after deductible	40% after deductible

iPlan Summary of Medical Benefits

Medical Provider	UnitedHealthcare
Policy Number	706484
Customer Service	866.734.7670
Website	www.myuhc.com

	24 PAY	19 PAY
Employee Only	$31.00	$39.16
Employee + Spouse	$108.50	$137.05
Employee + Child(ren)	$94.00	$118.73
Employee + Family	$146.00	$184.42

	iPLAN	
	In-Network	Out-of-Network
	You Pay	You Pay
DEDUCTIBLE (CALENDAR YEAR)		
Individual	$2,000	$4,000
Family	$4,000	$8,000
OUT-OF-POCKET MAXIMUM (EXCLUDING DEDUCTIBLE AND COPAYS)		
Individual	$3,500	$7,000
Family	$7,000	$14,000
ANNUAL MAXIMUM BENEFIT	$2 million per covered person	
LIFETIME BENEFIT MAXIMUM	Unlimited	
INPATIENT HOSPITAL SERVICES	30% after deductible	50% after deductible
Penalty for Failure to Pre-Authorize	None	$500
OUTPATIENT SURGERY	30% after deductible	50% after deductible
PHYSICIAN OFFICE VISIT	30% after deductible	50% after deductible
PREVENTIVE CARE	Covered at 100% deductible and copays do not apply	50% after deductible
URGENT CARE FACILITY	30% after deductible	50% after deductible
EMERGENCY ROOM (True Emergencies)	30% after deductible	
LABS AND X-RAYS	30% after deductible	50% after deductible
CT SCANS, MRIs, PET SCANS, AND NUCLEAR MEDICINE	30% after deductible	50% after deductible
MENTAL HEALTH/SUBSTANCE ABUSE	30% after deductible	50% after deductible

Prescription Drug Benefits

Prescription Drug Provider	Express
Customer Service	888.778.8896
Website	www.express-scripts.com


cripts

About Your Express Scripts Prescription Drug Coverage

You are automatically enrolled in the prescription drug program, administered by Express Scripts, when you enroll in one of the Fort Bend ISD medical plans administered by UHC. The prescription drug program provides both retail and mail order pharmacy services.

Retail

With retail benefits, you can obtain up to a 34-day supply at any in-network pharmacy.

Mail Order

You also can order routine medications through the mail order service. With this feature, you can receive up to a 90-day supply. This is an easy way to pay less for prescriptions you use on a routine basis, such as allergy or blood pressure medications. Sign up for the mail order program online, by phone or by mailing in a mail order claim form.

What You Pay for Prescription Drugs

For both retail and mail order prescriptions, you pay different copayments for generic and brand-name prescriptions. Talk to your physician about taking generic prescriptions to save money.

PRESCRIPTION DRUGS	RETAIL (UP TO A 34-DAY SUPPLY)	MAIL ORDER (90-DAY SUPPLY)
Generic	30% of drug cost	25% of drug cost
Preferred Brand	40% of drug cost	35% of drug cost
Non-Preferred Brand	50% of drug cost	45% of drug cost
Specialty Medications	45% of drug cost to a maximum of $50 per 30-day supply	

If you choose a brand-name prescription when a generic prescription is available, you will pay the cost difference between the brand-name prescription and the generic prescription plus the applicable coinsurance.

Mail Order Prescriptions have a maximum per 90-day supply of $150.
Specialty Medications have a maximum per 30-day supply of $50.

Specialty Prescription Drugs – CuraScript

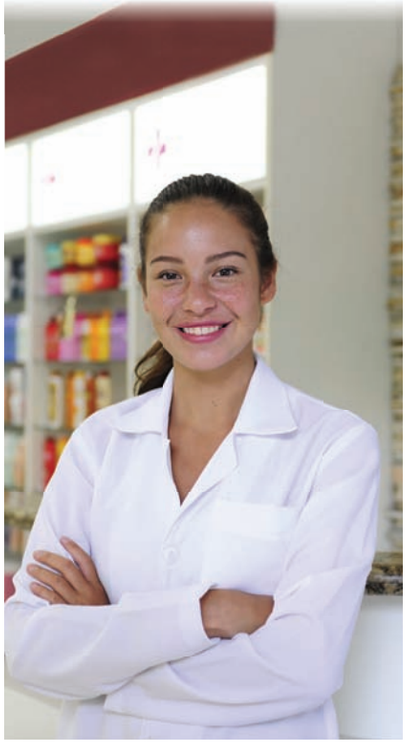
You MUST order your specialty medications directly through Express Scripts' specialty pharmacy, CuraScript. If you choose CuraScript, your specialty medications will continue to be delivered to your home, your doctor's office or any approved location. You'll also have access to other services available exclusively through CuraScript, including:

- Access to experienced specialty healthcare experts
- Guidance in how to take specialty medications correctly
- Support in managing your medical condition
- Personal care and health advocacy through a patient care coordinator
- Complimentary medication supplies — such as syringes, needles and alcohol swabs

To receive your next supply of specialty medication(s) through CuraScript, call toll-free, 866.848.9870 (Monday through Friday, 8 a.m. to 9 p.m. EST and Saturday, 9 a.m. to 1 p.m. EST).

What Is Step Therapy?

Step Therapy is a program designed especially for people who take prescription drugs regularly to treat ongoing medical conditions. The program makes prescription drugs more affordable for most members and helps FBISD control the rising cost of medications. It allows you and your family to receive the affordable treatment you need and helps FBISD continue to provide you with prescription drug coverage. **If you have taken a medication in the past 130 days that is affected by step therapy, you are "grandfathered" into this program and these step therapies do not apply to you in regards to that medication.**



Prescription Step Therapy Program

Prescription Drug Provider	Express Scripts
Customer Service	888.778.8896
Website	www.express-scripts.com

In Step Therapy, drugs are grouped in categories, based on cost:

Front-line drugs – the first step – are generic drugs that are proven safe, effective and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

Backup drugs – Step 2 and Step 3 drugs – are brand-name drugs such as those you see advertised on TV. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Backup drugs always cost more.

Step Therapy is developed under the guidance and direction of independent doctors, pharmacists and other medical experts. Together with Express Scripts – which manages our pharmacy benefit plan – this professional panel reviews the most current research on thousands of drugs that have been clinically tested and approved by the FDA for safety and effectiveness. Then, these medical experts recommend appropriate prescription drugs for a Step Therapy program, and FBISD's pharmacy benefit plan chooses the drugs that will be covered.

For more information on how Step Therapy works and how it benefits you, watch this short video at: www.express-scripts.com/members/steptherapy.

What Happens at the Pharmacy?

The first time you submit a prescription that isn't for a front-line drug, your pharmacist should inform you that our plan uses Step Therapy. This simply means that, if you'd rather not pay full price for your prescription drug, you need to first try a front-line drug. To receive a front-line drug:

- **Ask your pharmacist to call your doctor** to request a new prescription; OR
- **Contact your doctor** to get a new prescription. Only your doctor can change your current prescription to a front-line drug covered by the step therapy program.

How do I know which front-line drug my doctor should prescribe?

Only your doctor can make that decision. Contact Express Scripts for a list of your plan's front-line drugs. Just give this list to your doctor so he or she will know which drugs are covered and can write your prescription accordingly.

What can I do when I need a prescription filled immediately?

If you've just started taking a prescription drug regularly or if you're a new plan member, you may be informed at your pharmacy that your drug isn't covered. If this should happen and you need your medication right away, you can:

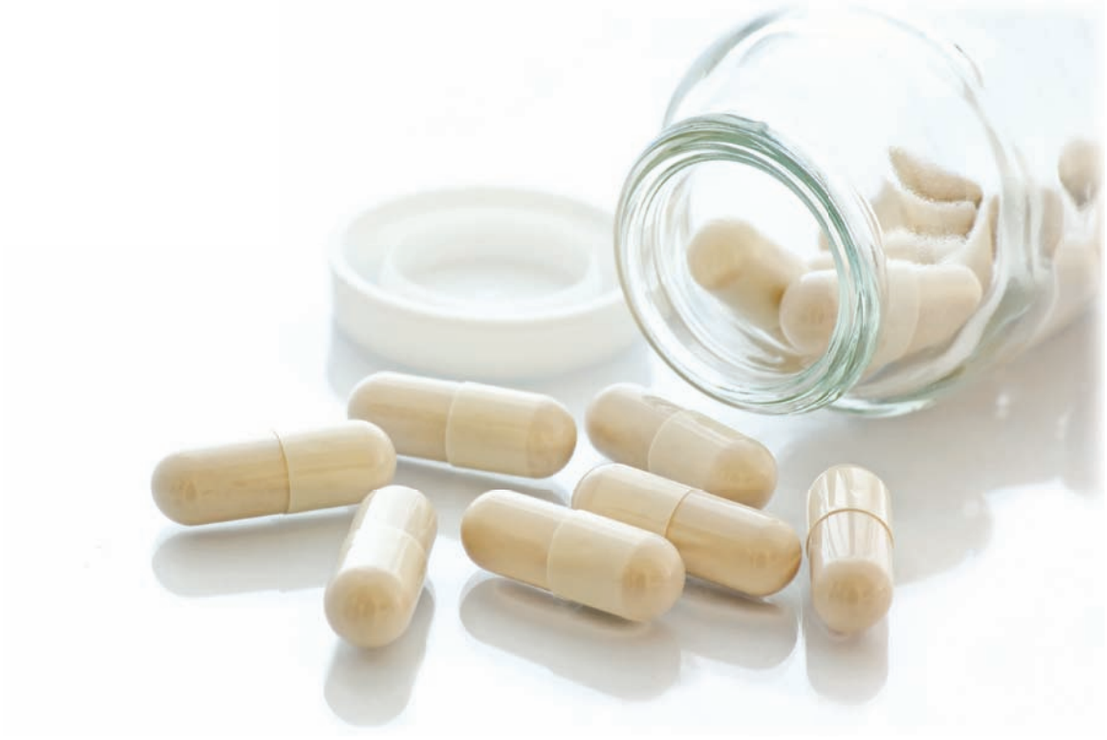
Talk with your pharmacist about filling a small supply of your prescription right away. (You may have to pay full price for this quantity of the drug.) Then ask your doctor to write you a new prescription for a front-line drug. Remember: only your doctor can change your prescription to a front-line drug.

What can I do if I've already tried the front-line drugs on the list?

With Step Therapy, more expensive brand-name drugs are usually covered as a backup in the program if:

- You've already tried the generic drugs covered in your Step Therapy program.
- You cannot take a generic drug (for example, because of an allergy).
- Your doctor decides, for medical reasons, that you need a brand-name drug.

If one of these situations applies to you, your doctor can request an override for you, allowing you to take a backup prescription drug. Once the override is approved, you'll pay the appropriate copayment for this drug. If the override isn't approved, you may have to pay full price for the drug.



Alternate Plan

Alternate Plan Administrator	R.H. Administrators
Customer Service	800.680.0892
Claims Fax	806.783.0895

Alternate Plan – R.H. Administrators

The Alternate Plan is available to all active, full-time employees contributing to TRS who are **not** enrolled in one of Fort Bend ISD's Medical Plans. The annual reimbursement benefit allows employees to receive reimbursement of up to $500 per year for eligible health care out-of-pocket expenses.

Examples of eligible expenses include, but are not limited to:

- Charges for deductibles, coinsurance and copays
- Dental treatment
- Eyewear
- Wellness exams

Only expenses incurred by the employee are eligible for reimbursement. **Dependents are not eligible under this plan**.

Any portion of the Annual Reimbursement Benefit ($500) will be forfeited back to Fort Bend ISD if it is not used within the plan year (January 1 – December 31).

Please note that this benefit is NOT medical insurance.

R.H. ADMINISTRATORS	ALTERNATE PLAN
ANNUAL REIMBURSEMENT BENEFIT	$500 per plan year
BASIC LIFE / AD&D COVERAGE	$45,000 per Covered Employee Enrolled in the Alternate Plan
CATASTROPHIC ILLNESS SUPPLEMENT (CIS)*	
Catastrophic Illness Supplement (CIS)*	6 Weeks per Plan Year
CIS Lifetime Maximum	12 Weeks

*** Fort Bend ISD Catastrophic Illness Supplement (CIS) Benefit is provided to all Alternate Plan participants. The CIS Benefit provides paid leave identical to the employee's base salary to those employees who have exhausted all accumulated paid leave due to a catastrophic illness or injury for which they are currently seeking medical treatment.**

Dental

Dental PPO

Dental Provider	UnitedHealthcare
Policy Number	GA-706484
Customer Service	877.816.3596
Website	www.myuhcdental.com

Fort Bend ISD offers all eligible employees the opportunity to participate in one of two dental plans: a Dental PPO or Dental HMO.

Dental PPO – UnitedHealthcare

With the Dental PPO, you may see any dentist that you choose. However, in-network dentists have agreed to accept reduced fees for the services they provide. They have also agreed not to charge you any amount that exceeds the allowable amount, aside from deductibles, coinsurance and services that are limited or not covered under the Plan. This will reduce your out-of-pocket expenses. If your dentist is an out-of-network provider, dental benefits will be based on reasonable and customary charges.

How to Find a Dental Provider

Visit **www.myuhcdental.com** or call **877.816.3596**.

	DENTAL PPO BENEFITS
	You Pay:
DEDUCTIBLE (CALENDAR YEAR)	
Individual	$50
Family Maximum	$150
ANNUAL BENEFIT MAXIMUM (per Covered Person)	$2,000
PREVENTIVE SERVICES	
Cleanings, Oral Exams, Fluoride Treatments, Sealants, X-Rays	0% No Deductible Applies
BASIC SERVICES	
Minor Restorative Services, Fillings, Space Maintainers, Endodontics, Periodontics	20%
MAJOR SERVICES	
Major Restorative Services, Stainless Steel Crowns, Prosthetics	50%
ORTHODONTIA (Children under age 19)	50%
Orthodontia Lifetime Maximum	$2,000

Dental (Continued)

Dental HMO

Dental Provider	UnitedHealthcare
Policy Number	GA-706484
Customer Service	800.232.0990
Website	www.myuhcdental.com

Dental HMO (DHMO) – UnitedHealthcare

The UnitedHealthcare Dental HMO plan provides benefits for eligible care you receive from providers in the UHC network. To find an in-network provider, visit **www.myuhcdental.com**. **You must select a General Dentist who will provide you with general dental care through UHC's network. Services performed by out-of-network providers are not covered under the DHMO plan**. Should your treatment plan require the services of a specialist, you will be referred to one.

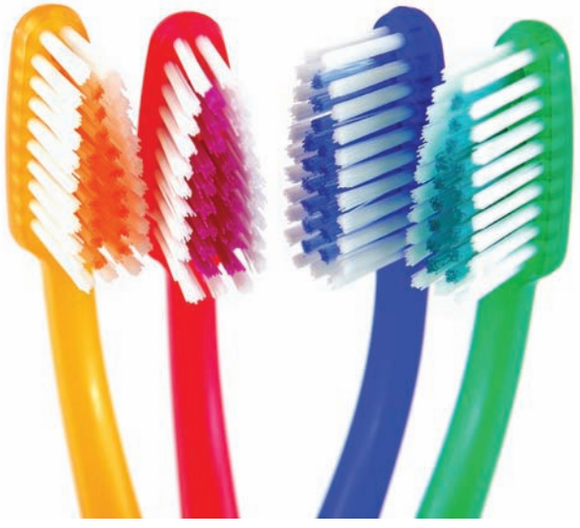
When you receive care, you will pay the applicable copayment listed on the Benefit & Copayment Schedule in the FBISD plan document. All benefits and copays apply to specialty services, as long as the referral has been approved by UHC.

Highlights of the UHC DHMO plan

- Unlimited maximum annual benefits allowed per person.
- No deductibles.
- Your exact "out-of-pocket" costs (if any) are listed in the Benefit & Copayment Schedule.
- Adults and Children are eligible for orthodontia.
- Access to the UHC web site describing plan benefits and in-network providers.

How To Find A Dental Provider

Visit **www.myuhcdental.com** or call **800.232.0990**.



Vision

Vision Provider	Vision Service Plan (VSP)
Policy Number	12017151
Customer Service	800.877.7195
Website	www.vsp.com

Locate a provider and check the status of your claims at **www.vsp.com** or call **800.877.7195**.

Vision – VSP

VSP provides benefits for primary vision care through a national network of optometrists, ophthalmologists, independent opticians and national and regional optical chains. You may receive care and services from providers outside the VSP network, but at a reduced level of benefit.

VISION BENEFITS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
VISION EXAM (1 every 12 months)	$20 copay	Up to $45*
VISION MATERIALS	$20 copay	Reimbursement Amounts (below)
LENSES (1 every 12 months)		
Single Vision	Covered in full*	Up to $45*
Lined Bifocal	Covered in full*	Up to $65*
Lined Trifocal	Covered in full*	Up to $85*
Tints	Covered in full*	Up to $5
FRAMES (1 every 12 months)	Covered up to $130*	Up to $47*
CONTACT LENSES (in lieu of lenses and frames)		
Visually Necessary		
Professional Fees and Materials	Covered in full*	Up to $210*
Elective		
Professional Fees and Materials	Up to $130	Up to $105*

***Subject to copay, if any.**

Flexible Spending Account (FSA)

FSA Administrator	UnitedHealthcare
Phone Number	877.311.7849
Website	www.myuhc.com

Flexible Spending Account (FSA) – UnitedHealthcare

A Flexible Spending Account allows you to set aside part of your salary (before taxes) to pay yourself back for eligible medical or dependent care expenses. Here's how it works:

- Choose a specific amount of money to contribute each pay period (tax-free, up to the maximums allowed), to one or both accounts during the plan year (January 1 – December 31).
- The amount is automatically deducted from your pay at the same level each pay period.
- As eligible medical and dental expenses are incurred, you are automatically reimbursed with your tax-free contributions through UHC's auto-rollover feature. Dependent Care FSA expenses are reimbursed by submitting a paper claim form to UHC.

FSA Rules

In return for the tax advantages, the IRS has strict rules:

- You cannot change the amount that you contribute to either account until the next plan year, unless you experience a change in status (see Membership Guidelines).
- Transfers of money from one account to the other are not allowed.
- **Any amount left in either account at the end of the plan year (January 1 – December 31) will be forfeited**.

Auto-Rollover

If you have medical and/or dental coverage and a healthcare FSA through UHC, you will be automatically enrolled in auto-rollover and have the ability to manage it online at www.myuhc.com. With auto-rollover, claims are automatically submitted for reimbursement, practically eliminating the need to submit manual claims. Please keep your receipts as you may be asked to verify a charge.

If you do not want to be enrolled in auto-rollover, you must notify UHC via phone or online at www.myuhc.com and submit your claims manually.

Consumer Accounts Debit Card

The Consumer Accounts MasterCard is a debit card that allows you to quickly and conveniently access funds in your FSA. You may use it to pay for eligible expenses at the time of service and at locations that accept it. Payments are made directly to the doctor or the vendor initiating the transaction.

ACTUAL SAVINGS WILL VARY, BASED ON YOUR INDIVIDUAL TAX SITUATION.	WITH FSA	WITHOUT FSA
GROSS SALARY	$35,000	$35,000
HEALTH / DAY CARE EXPENSES (BEFORE-TAX)	$4,000	N/A
TAXABLE INCOME	$31,000	$35,000
TAX (30%)	$9,300	$10,500
HEALTH / DAY CARE (AFTER-TAX)	N/A	$4,000
TAKE-HOME PAY	$21,700	$20,500
YOUR TAX SAVINGS	$1,200	$0

Flexible Spending Account (Continued)

Health Care FSA – Maximum Contribution of $3,500 Per Plan Year

When you enroll in the Health Care FSA, you may be reimbursed for out-of-pocket medical, dental and vision expenses incurred by you and your dependents with your pre-tax contributions. IRS regulations do not allow you to use the Health Care FSA to pay for health insurance premiums and cosmetic treatments. Services must be intended to treat or prevent a specific medical condition.

Examples of eligible Health Care FSA expenses:

- Deductibles, coinsurance and copays under the medical, dental and vision plans;
- Dental and orthodontic care, excluding those services for cosmetic reasons;
- Vision care (exams, glasses, contacts, laser eye surgery);
- Other eligible health costs that are not covered by any health care plan in which you participate (for example, dental costs if you do not have dental coverage).

Effective January 1, 2011, the definition of qualified medical expense for purposes of Flexible Spending Accounts and Health Reimbursement Accounts is now limited to prescribed medications and insulin. Over-the-counter medications and supplies are only eligible for FSA reimbursement when purchased with a doctor's prescription.

Dependent Care FSA – Maximum Contribution of $5,000 Per Plan Year

The Dependent Care FSA allows you to pay for work-related dependent care expenses with pre-tax dollars. Per IRS guidelines, an eligible expense is "incurred" at the time the service is provided – not when you are billed or when you actually pay for the service.

- You must receive and pay for dependent care services before filing a claim for reimbursement.
- All dependent care claims require that you complete a claim form and fax (or mail) it with your itemized receipt to UHC.
- Dependent Care FSAs reimburse only up to the account balance on the date your claim is received. Claims exceeding the balance are reimbursed when there is enough in the account to cover them.

For a dependent care expense to qualify as eligible, the IRS requires:

For dependents ages 12 and younger:

- You must be able to claim an exemption on your federal income tax return for the child, or you must be a parent who has custody for a longer time during the year than the other parent, even if you cannot claim a dependent exemption.
- A relative may provide the care, unless the relative is your spouse, child or stepchild under the age of 19, or a relative that you can claim as a dependent on your federal income tax return.
- If the care is given by a day care center, that center must comply with all applicable state and local day care regulations.

For dependents ages 13 or older:

- The individuals must be your dependent for federal income tax purposes and must be physically or mentally incapable of self-care.
- The dependent must live with you.
- The care may be given outside the home if the dependent regularly spends at least eight hours per day in your home. If the care is given by a day care center, that center must comply with all applicable state and local day care regulations.

FSA Eligible Expenses

For a complete list of eligible expenses, go to:

- **www.myuhc.com**; or
- **www.irs.gov;** or
  - IRS Publication 502 for Health Care FSA
  - IRS Publication 503 for Dependent Care FSA
  - Call **800.TAX.FORM (800.829.3676**)


THE UNITED STATES OF AMERICA
ONE DOLLAR
WASHINGTON, D.C.
B 86047065 G

Life/AD&D

Life/AD&D Provider	Sun Life
Policy Number	213992
Customer Service	800.247.6875
Website	www.sunlife-usa.com

Basic Life and Accidental Death & Dismemberment (AD&D) – Sun Life

Life Insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Fort Bend ISD. Accidental Death and Dismemberment (AD&D) provides additional security in the case of death due to accidental causes.

As an eligible employee of Fort Bend ISD, you will be covered for Basic Life and Accidental Death and Dismemberment (AD&D) Insurance at **no cost** to you.

SUN LIFE	BASIC LIFE / AD&D
LIFE BENEFIT AMOUNT	
Employees Not Enrolled in the Alternate Plan	$25,000
Employees Enrolled in the Alternate Plan	$45,000
AGE REDUCTION SCHEDULE	50% at age 70

Optional Life and Accidental Death & Dismemberment (AD&D) – Sun Life

In addition to the Basic Life and AD&D insurance provided by Fort Bend ISD, you also have the option to purchase optional life insurance and AD&D coverage for yourself and your eligible dependents. You may make changes to your coverage amount during the Annual Enrollment period. **Any amount over the Guarantee Issue amount will require the submission of an Evidence of Insurability form. If you are a late entrant, all amounts will require the submission of an Evidence of Insurability form. Coverage will not become effective until and unless approved by Sun Life.**

You may also choose Optional Life Insurance and AD&D Insurance coverage for your spouse and children. This coverage would pay a benefit to you in the event that your covered spouse or children passes away or suffers a covered injury. You pay the full cost of this coverage from your paycheck. You must select Optional Life and AD&D for yourself in order to elect coverage for your spouse and/or children.

If you are not actively at work on the optional coverage effective date, your coverage will be delayed until you return to active employment. Similarly, if you request optional coverage for an eligible dependent and that dependent is confined to a hospital on the effective date, coverage may be delayed. Exception: Infants are insured from live birth.

Age Reduction(s)

When you or your dependents attain age 70, the amount of optional life insurance will be reduced by 50%.

Life/AD&D (Continued)

SUN LIFE	OPTIONAL LIFE / AD&D
EMPLOYEE COVERAGE	
Benefit Amount	Increments of $10,000
Maximum Benefit	Lesser of 5x annual earnings or $500,000
Guarantee Issue	$250,000
DEPENDENT COVERAGE	
Spouse Benefit Amount	Increments of $10,000
Spouse Maximum Benefit	100% of employee's approved amount, not to exceed $250,000
Spouse Guarantee Issue	$30,000
Child(ren) Benefit Amount	$10,000

Disability

Disability Provider	Sun Life
Policy Number	213992
Customer Service	800.247.6875
Website	www.sunlife-usa.com

FBISD wants to ensure that every employee is empowered to take care of their family if they become ill or injured. What happens if you have an unexpected injury or illness that leaves you unable to work or earn a paycheck? Few people believe it will happen to them, but the truth is, your risk of becoming disabled is far greater than you may think.

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

You are responsible for the cost of this coverage.

Voluntary Disability – SUN LIFE

Disability plans are designed to replace a portion of your salary in the event you become disabled according to your policy's definition of disability. To prevent overinsurance, benefit payments are reduced by deductible sources of income. Full-time, active employees who are participating in TRS on the date of their enrollment and their effective date of insurance are eligible to purchase this additional coverage. There are two plans available: Option 1 or Option 2.

SUN LIFE	PLANS
BENEFIT	66.7%
MAXIMUM MONTHLY BENEFIT	$7,500
ELIMINATION PERIODS AVAILABLE	Option 1: 14 days injury or sickness Option 2: 90 days injury or sickness
MENTAL ILLNESS, SUBSTANCE ABUSE, AND SELF-REPORTED LIMITATIONS	24 Months
PRE-EXISTING CONDITION LIMITATION	Neither plan will cover any disability that begins in the first 12 months **after** your effective date for which you received medical treatment, consultation or took prescribed medications for in the 3 months **prior** to being covered on the plan.

AGE AT DISABILITY	MAXIMUM BENEFIT DURATION
LESS THAN AGE 60	To age 65, but not less than 60 months
AGE 60	60 months
AGE 61	48 months
AGE 62	42 months
AGE 63	36 months
AGE 64	30 months
AGE 65	24 months
AGE 66	21 months
AGE 67	18 months
AGE 68	15 months
AGE 69 AND OVER	12 months

Legal Services

Legal Provider	Prepaid Legal
Law Firm	Ross & Matthews
Customer Service	800.458.6982
Website	www.prepaidlegal.com

	24-PAY	19-PAY
EMPLOYEE ONLY	$8.50	$10.74

Voluntary Legal – Prepaid Legal

To receive benefits through the Prepaid Legal Services Plan, you must use an attorney from the Prepaid Legal Services Plan Network. Through the plan, you have access to a wide range of legal services, including:

- **Unlimited Toll-free Phone Consultations**

  With a Provider Law Firm for personal and business questions.

- **Phone Calls and Letters**

  If Provider Law Firm recommends writing a letter or making a phone call for you as the best step.

- **Personal Contract and Document Review**
- **Will Preparation and Updates**

  For you and your covered family members.

- **Motor Vehicle Legal Service Expense Benefits**

  Representation for moving traffic violations, as well as defense of criminal charges resulting from the operation of a moving vehicle.

  Eligibility begins 15 days after effective date.

- **Trial Defense Benefit**

  Up to sixty (60) hours the first year and increasing up to 300 hours based on length of time on the plan.

- **IRS Audit Protection Service**

  Up to 50 hours of professional services from a Provider Law Firm to help with the cost of audit representation.

- **Discounted Legal Services**

  Other legal services that are not covered by the plan are available at a 25% discount off the Provider Law Firm's standard hourly rate for representation.

AFLAC Supplemental Plans

Supplemental Provider	AFLAC
Customer Service	281.355.7684
Website	www.aflacclients.com/fortbendk12/Welcome.aspx
E-mail	henry_roth@us.aflac.com

Accident

While Aflac cannot prevent accidents from happening, we can help prepare for those unexpected expenses associated with an accident. Our promise is that when the unexpected happens, Aflac is there. And in today's world, it's comforting to know Aflac will be there to help provide peace of mind that's backed by a brand that people know and trust.

Sickness and Hospital Indemnity

Whether a person is hospitalized for a few days or a few weeks, major medical health insurance typically has a deductible that must be met before benefits begin. Aflac provides cash benefits that can help policyholders recoup their deductibles faster, therefore reducing out-of-pocket expenses.

Cancer

Aflac is a pioneer in the cancer insurance industry – we sold our first cancer policy back in 1958. Since then, we've paid billions in cancer claims. And when you pay billions in cancer claims, you learn a thing or two about the disease, such as about how patients are treated and the cost of care. More than 50 years of experience gives Aflac an advantage over many of our competitors. In addition, we stay informed about advances in cancer treatment so that our policyholders continue to have the most up-to-date policy benefits.

Critical Illness

There has never been a better time to offer critical illness coverage. People are living longer and the likelihood of experiencing a critical illness, such as heart attacks, strokes, comas, paralysis, end-stage renal failure, coronary artery bypass surgery, major human organ transplants, and more, has increased. Helping employees protect themselves against income loss is vital to helping them recover from the medical and non-medical impact of a critical illness.

For illustrative purposes only. Aflac policies have limitations and exclusions that may affect eligibility for coverage and benefits payable. See the policy and outline of coverage for complete details, definitions, limitations, and exclusions.

Think you are completely covered by your major medical plan?

You don't have all the **Aflacts.**

Aflac is different from health insurance; it's insurance for daily living. Major medical pays for doctors, hospitals, and prescriptions. Aflac is insurance for daily living. It pays cash benefits directly to you, unless otherwise assigned, to help with daily expenses due to an illness or accident.

Aflac is an extra measure of financial protection. When you're sick or hurt, Aflac pays cash benefits directly to you to help you and your family with unexpected expenses. The benefits are predetermined and paid regardless of any other insurance you have.

Aflac pays you cash benefits to use as you see fit. You can use your Aflac benefits check to help pay for groceries, child care, rent...it's totally up to you.

Aflac benefits help with unexpected expenses. Your Aflac benefits check helps you pay for the many out-of-pocket expenses you incur when you are sick or hurt – like the cost of transportation to and from medical facilities, parking, and additional child care expenses.

Aflac belongs to you, not your company. When you have an Aflac policy – it's yours. You own it. Even if you change jobs or retire, you can take your Aflac policy with you, with no increase in premiums.

Aflac is affordable. We have a range of products that can fit most budgets. Aflac can help provide you and your family with coverage and security to help maintain your everyday life in case of illness or injury. And, Aflac rates don't go up, even when you file a claim.

Aflac processes claims quickly – usually within four days.* Aflac provides prompt service and fast payment of approved claims to help you pay your bills. While you're focusing on your health, we focus on getting you cash as quickly as possible.

Aflac claims are easy to file. When you're sick or hurt, the last thing you need is a complicated form to fill out. Aflac benefits are easy to understand, and our forms are easy to complete.

Aflac pays you benefits even when you're healthy. We want you to be healthy – that's why we promote preventative care. Get a routine physical, a mammogram, or an eye exam, and we'll pay you.** It's that simple.

We have a spokesduck. Ducks make a variety of unique sounds. However, our spokesduck only makes one sound in many different ways. Also, most company spokespersons don't have wings. Ours does. And we've got you under them.

* For Continental American Insurance Company, the average is five days.

** Benefits may not be available in all states.

Teachers Retirement System of TX

Provider	Teachers Retirement System (TRS)
Customer Service	800.223.8778
Website	www.trs.state.tx.us

Teachers Retirement System of Texas (TRS)

The TRS retirement plan serves a vital role to nearly 1.2 million active and retired state educators and their families by providing service and disability retirement benefits, and death benefits. TRS is one of the largest retirement systems in the nation. The system's core mission is to deliver retirement and related member benefits authorized by the Texas Legislature and to manage the trust fund that finances those benefits. As an employee of FBISD you are automatically enrolled into this Retirement Plan. As a member you will contribute 6.4% of eligible wages to your account each pay period and the State will contribute 6% for retirement benefits. The member's contribution is made on a pre-tax basis. Please visit the TRS web site for additional information at **www.trs.state.tx.us** or contact them at **800.223.8778.**

Optional Retirement Savings Plans:

403(b) Tax-Deferred Annuities

A 403(b) tax-deferred annuity (TDA) is a deferred tax arrangement, which is specifically allowed by Section 403(b) of the Internal Revenue Code. Contribution amounts are not taxable income to the employees until the amounts are withdrawn by or distributed to them.

Employee Savings Plan 457

As an employee of Fort Bend ISD you are immediately eligible to participate in this plan. The Fort Bend ISD Employee Savings Plan is an effective and flexible method of saving, and is available to help you meet your personal retirement planning objectives.

Advantages of 403(b) and 457 Plans

- Contributions through salary reduction agreements are made on a tax-deferred basis. These amounts are not subject to federal income taxation until distributed.
- Any interest earnings and/or gains are also tax-deferred.
- Saving for future needs is easier when your contribution is made directly from your paycheck.
- This is income in addition to your TRS retirement plan income.

Medicare Part D Notice

Important Notice from Fort Bend 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 Fort Bend 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 your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Fort Bend ISD has determined that the prescription drug coverage offered by Fort Bend ISD Medical Plan 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 November 15 through December 31. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Fort Bend ISD coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you drop your current coverage and enroll in Medicare prescription drug coverage, you may enroll back into Fort Bend ISD Medical benefit plan during the Annual Enrollment period under Fort Bend ISD Medical Plan.

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

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

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

Medicare Part D Notice

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

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

For more information about Medicare prescription drug coverage:

Visit **www.medicare.gov**

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call **1.800.MEDICARE (1.800.633.4227).** TTY users should call **1.877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov,** or call them at **1.800.772.1213 (TTY 1.800.325.0778)**.

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

Date:	January 1, 2011
Name of Entity/Sender:	Fort Bend ISD
Contact/Office:	Benefits Department
Address:	16431 Lexington Boulevard Suite 214 Sugar Land, Texas 77479
Phone Number:	**281.634.1418**

Legal Update

HIPAA Special Enrollment Rights

Loss of Other Coverage – If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption – If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after the marriage, birth, adoption or placement for adoption.

Effective April 1, 2009

Fort Bend ISD group health plan will allow an employee or dependent who is eligible, but not enrolled, for coverage to enroll for coverage if either of the following events occur:

1. TERMINATION OF MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE If the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP If the employee or dependent becomes eligible for premium assistance under Medicaid or a State child health plan, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan **within 60 days** after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date your or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the Benefits Department at **281.634.1418**.

Pre-Existing Condition Exclusions (No Pre-Existing Under Age 19)

Fort Bend ISD's plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 12-month period. Generally, this 12-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the twelve month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

For additional information, please contact UnitedHealthcare at **800.842.5658**.

Legal Update (Continued)

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the health care provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and copays consistent with other coverage provided by the Plan.

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

Continuation Required by Federal Law for You and Your Dependents

Federal law enables you or your dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your dependent(s) to continue health insurance if their coverage ceases due to your death, divorce, legal separation, or with respect to dependent children, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your employer's group health plan(s) and is subject to federal law, regulations and interpretations. For additional information, contact the Benefits Department.

Health Insurance Portability and Accountability Act (HIPAA)

Fort Bend ISD in accordance with HIPAA, protects your Protected Health Information (PHI). Fort Bend ISD will only discuss your PHI with medical providers and third party administrators when necessary to administer the plan that provides your medical and dental benefits or as mandated by law.

HIPAA Privacy Notice Update

HIPAA requires Fort Bend ISD to notify you that a Privacy Notice is available from the Benefits Department. To request a copy of Fort Bend ISD Privacy Notice or for additional information, please contact the Benefits Department at **281.634.1418** or locate it online at: **www.fortbendisd.com --> Employee Services --> Employee Benefits & Risk Management --> HIPAA Privacy Notice**

Legal Update (Continued)

Eligibility for Continued Coverage for Dependent Students on Medically Necessary Leave of Absence

A new law referred to as "Michelle's Law" now applies to the Fort Bend ISD group health plan beginning on January 1, 2010. Michelle's Law requires group health plans to provide continued coverage for dependent children who are covered under Fort Bend ISD's group health plan as a student if they lose their student status because they take a medically necessary leave of absence from school.

If your child is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. begins while the child is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed under the plan during this one-year period, the plan will provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination with COBRA Continuation Coverage

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the plan at the end of the continued coverage period, continuation coverage under COBRA may be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Notice of Opportunity to Enroll in Connection With Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in FBISD Group Health Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the Benefits Department at **281.634.1418.**

Legal Update (Continued)

Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under FBISD Group Health Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Benefits Department at **281.634.1418.**

COBRA General Rights Notice

COBRA General Rights Notice

General Notice of Your Rights
Group Health Continuation Coverage Under COBRA

This notice contains important information about your employee benefits plan(s). Please read the entire letter.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the Fort Bend ISD group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's "Summary Plan Description" or contact the Fort Bend ISD Plan Administrator at (281) 634.1418. Also, you may visit the Department of Labor web site (**www.dol.gov**) for more information on COBRA.

Qualifying Events

If you are an employee of Fort Bend ISD covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the covered spouse of an employee covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

The death of the employee; 2) A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with Fort Bend ISD; 3) Divorce or legal separation from the employee; or 4) The employee becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

The death of the employee; 2) A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with Fort Bend ISD; 3) The parents' divorce or legal separation; 4) The employee becomes entitled to Medicare; or 5) The dependent child ceases to be a dependent child under the Group Health Plan.

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

Coverage Provided

Under COBRA, the employee or a family member has the responsibility to inform the Fort Bend ISD Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. Written Notice must be sent to:

Discovery Benefits
COBRA Business Unit
P.O. Box 869
Fargo, North Dakota 58107

COBRA General Rights Notice

When Discovery Benefits COBRA Business Unit is notified that one of these events has happened, they will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to elect to continue coverage under COBRA. If and when you make this election, coverage will become effective on the day after coverage would otherwise be terminated. If you elect COBRA, Fort Bend ISD is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

Period of Coverage

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment or within 60 days thereafter.* To benefit from this extension, a qualified beneficiary must notify the Fort Bend ISD Benefits Department of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the Fort Bend ISD Benefits Department within 30 days of any final determination that the individual is no longer disabled. If the coverage is extended to a total of 29 months, extended coverage will cease upon a final determination that the Qualified Beneficiary is no longer disabled.

* Note: A qualified Beneficiary who is determined under Title II or XVI of the Social Security Act, to have been disabled as of the date of termination of employment or reduction in hours, or within 60 days of COBRA coverage, may be eligible to continue coverage for an additional 11 months (29 months total). You must notify Fort Bend ISD within 60 days of the determination of disability by the Social Security Administration and prior to the end of the 18-months continuation period. Fort Bend ISD can charge up to 150% of the applicable premium during the 11 month extension.

If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events: 1) Divorce or legal separation; 2) Death; 3) Medicare entitlement; 4) Dependent child ceasing to be a dependent. If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the Discovery Benefits COBRA Business Unit within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA.

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium plus a 2% administration fee for your continuation coverage.

If you have any questions about your COBRA rights, please contact Discovery Benefits COBRA Business Unit at **866.451.3399**. If you have changed marital status or you, your spouse, or any eligible covered dependents have changed addresses, please notify Discovery Benefits in writing so that a separate notice may be sent.

Discovery Benefits
COBRA Business Unit
P.O. Box 869
Fargo, North Dakota 58107

2011 Employee Contributions

	EMPLOYEE CONTRIBUTIONS*	EMPLOYEE CONTRIBUTIONS*
	24-Pay-Periods	19-Pay-Periods
Medical – Choice Plus		
Employee Only	$55.50	$70.11
Employee + Spouse	$182.00	$229.90
Employee + Child(ren)	$162.00	$204.63
Employee + Family	$244.00	$308.21
Medical – iPlan		
Employee Only	$31.00	$39.16
Employee + Spouse	$108.50	$137.05
Employee + Child(ren)	$94.00	$118.73
Employee + Family	$146.00	$184.42
Alternate Plan		
Employee Only	$10.00	$12.63
Dental PPO		
Employee Only	$19.08	$24.11
Employee + 1	$38.17	$48.21
Employee + Family	$57.25	$72.31
Dental HMO		
Employee Only	$4.94	$6.23
Employee + 1	$8.14	$10.28
Employee + Family	$12.10	$15.28
Vision		
Employee Only	$5.70	$7.20
Employee + 1	$9.10	$11.50
Employee + Children	$9.83	$12.41
Employee + Family	$14.98	$18.92
Prepaid Legal		
Employee Only	$8.50	$10.74

*** Actual cost may vary slightly due to rounding. Premium amounts are subject to change.**

Pre-Tax Payroll Deductions: Medical, Dental and Vision

To help offset your contributions for the medical, dental and vision plans, we offer these benefits on a pre-tax basis through the Section 125 (or “cafeteria”) plan. By making your contributions for these benefits on a pre-tax basis, premium is withheld from your pay before federal, state (if applicable), and FICA taxes are calculated. This can reduce the amount of taxes you pay per paycheck.

2011 Employee Contributions

OPTIONAL LIFE / AD&D	MONTHLY RATES*		
Optional Life Insurance Age Band	Employee Rate (per $1,000)	Spouse Rate* (per $1,000)	Child Rate** (per $1,000)
<24	$0.035	$0.090	$0.270
25-29	$0.038	$0.077	
30-34	$0.043	$0.079	
35-39	$0.064	$0.099	
40-44	$0.093	$0.143	
45-49	$0.150	$0.227	
50-54	$0.230	$0.357	
55-59	$0.350	$0.551	
60-64	$0.496	$0.973	
65-69	$0.839	$1.651	
70-74	$1.490	$3.039	
75+	$3.030	$5.898	
AD&D COVERAGE (per $1,000)	$0.028	$0.030	$0.035

* Please note: Spouse premiums are based on the employee's age.

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

Voluntary Life Insurance Calculation

	Coverage Amount		Rate		Monthly Cost
Employee Life/AD&D	$_____	/ $1,000 x	$_____	=	$_____
Spouse Life	$_____	/ $1,000 x	$_____	=	$_____
Child Life	$_____	/ $1,000 x	$_____	=	$_____

Actual cost may vary slightly due to rounding. Your rate will increase as you age and move to the next age band. Premiums are subject to change.

Voluntary Disability Plan

COVERAGE LEVEL	MONTHLY RATE
Option 1 - 14-day Elimination Period	$0.947
Option 2 - 90-Day Elimination Period	$0.885

*Per $100 of Monthly Payroll

Voluntary Disability Insurance Calculation

Annual Salary		Monthly Salary		Monthly Rate		Monthly Premium
_____	/ 12 =	_____	/ 100 x	_____	=	_____

Provider Reference Guide

BENEFIT	CARRIER	TELEPHONE	WEB SITE
Medical **Choice Plus** **iPlan** **Spanish Line** **Health Pregnancy Program**	UnitedHealthcare	 800.842.5658 866.734.7670 866.209.9325 800.411.7984	www.myuhc.com Mental Health Providers: www.ubhprovider.com
Pharmacy	Express Scripts	888.778.8896 TDD: 800.899.2114	www.express-scripts.com
Flexible Spending Account	UnitedHealthcare	877.311.7849	www.myuhc.com
Alternate Plan	R.H. Administrators	800.680.0892 Fax: 806.783.0895	
Dental DHMO	UnitedHealthcare	800.232.0990	www.myuhcdental.com
Dental PPO	UnitedHealthcare	877.816.3596	www.myuhcdental.com
Vision	VSP	800.877.7195	www.vsp.com
Basic Life/AD&D, Optional Life/ AD&D, Disability	SUN LIFE	800.247.6875	www.sunlife-usa.com
Legal Services	Prepaid Legal	General Info: 800.654.7757 Legal Services: 800.458.6982	www.prepaidlegal.com
Supplemental Plans	AFLAC	281.355.7684	www.aflacclients.com/fort-bendk12/Welcome.aspx henry_roth@us.aflac.com
Benefits Department Insurance Specialists	Your last name begins with: A-D E-G H-N O-Z Workers Comp Specialist	 281.634.1214 281.634.2810 281.634.1208 281.634.1241 281.634.1209	Email: benefits@fortbendisd.com Web site: www.fortbendisd.com/departments/benefits
On-Site Representative	UHC Service Consultant UHC Wellness Coordinator	281.634.1429 281.634.1210	www.fortbendisd.com/departments/benefits
Retirement Savings Plans 403(b)	JEM Resource Partners	800.943.9179	www.region10rams.org Email: 403b@jemtpa.com
457 Employee Savings Plan **457 FICA Alternative &** **457 Deferred Compensation**	JEM Resource Partners	800.943.9179	www.region10rams.org info@region10rams.org
COBRA	Discovery Benefits	866.451.3399	www.discoverybenefits.com
Teacher Retirement System (TRS)	TRS	800.223.8778	www.trs.state.tx.us

Notes

Notes

Gallagher Benefit Services, Inc.

thinking ahead

October 15, 2010

The information contained in this guide should in no way be construed as a promise or guarantee of employment. The District reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this guide and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents available from your Benefits Department.

All information in this guide is intended for your general use only and is not a substitute for medical advice or treatment for specific medical conditions. You should seek prompt medical care for any specific health issues and consult your physician before taking any action on your health conditions.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.