2011 BENEFITS

FIELD GUIDE

THE EVOLUTION OF HEALTH CARE

YOUR 2011 HEALTH PLAN

OPEN ENROLLMENT
NOVEMBER 5-16, 2010

BENEFITS
OUTLOOK
Health. Wellness. Life.

ALDINE SCHOOL DISTRICT
HOUSTON TEXAS
EXCELLENCE

IF FOUND, PLEASE RETURN THIS BENEFITS GUIDE TO:

WHAT I LEARNED IN THIS GUIDE:

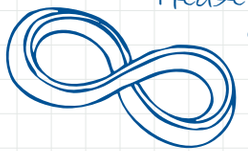
- ☐ CHANGES FOR 2011
  - Including:
    - ☐ Medical plan options
    - ☐ New hospital and specialist networks
    - ☐ Pharmacy
- ☐ VOLUNTARY OPTIONS
- ☐ HOW TO ENROLL
- ☐ HOW TO GET FIT AND HEALTHY
- ☐ HOW TO GET ANSWERS TO MY QUESTIONS

NOTATIONS:

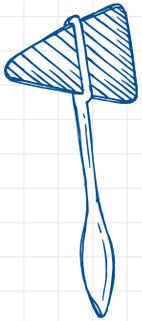
aldinebenefits.org

THE EVOLUTION of HEALTH CARE

Welcome to your 2011 benefits program. As you go through this guide, you'll notice significant changes in the way the plans work and the decisions you'll need to make. These changes are all part of a very concerted effort to provide options that deliver the highest quality care at the most reasonable rates.



Please take the time to go through the information carefully so you can make the best choices for you and your family. For help based on your unique situation, check out the Coverage Advisor on Benefits Outlook, powered by WebMD.



All health care is not created equal. Paying greater attention to the providers we choose puts us all in a better position to enjoy the best medical care and the best outcomes, along with the peace of mind they bring.

WHAT'S NEW FOR 2011

New networks for Consumer option participants

If you enroll in Consumer Plus in 2011, you will have a choice of two specialist and hospital networks, and your per-paycheck premiums depend on the selection you make. The Limited network is composed exclusively of Memorial Hermann specialists in 12 designated categories, as well as Memorial Hermann hospitals. The Choice network provides greater options, with specialists in 12 categories and hospitals divided into two tiers, and the amount you pay in coinsurance and deductibles depends on which tier the provider is in. See page 8 for more details.

Open Access options discontinued

Beginning in 2011, the Open Access options will no longer be offered. If you are currently enrolled in one of the Open Access options and do not make a new selection during Open Enrollment, you will be moved to the Consumer Plus Choice option, and your per-paycheck premiums will decrease. You are still free to choose any of the other plan options available for 2011.

Rate increase for the POS II High and Select Low options

Rates for the POS II High plan are increasing substantially in 2011 to make this plan self-supporting. However, there are no changes to the plan design. Rates for the Select Low option (formerly the POS II Low option) are increasing by 5% and out-of-network care will no longer be covered, except in the case of an emergency.

Modest premium increases, changes in plan design for Consumer Plus and Basic

There will be a 5% increase in premiums for Consumer Plus and Basic for 2011, as well as adjustments to deductibles, coinsurance, out-of-pocket maximums, HealthFund deposits and prescription drug copays. In addition, out-of-network care will no longer be covered, except in the case of an emergency.

Preventive care covered at 100%

For all medical plan options, preventive care is now covered at 100%, with no annual maximum.

New Accident Plan

The Accident Plan is a new voluntary benefit for employees that provides a cash benefit to assist with deductibles and out-of-pocket expenses associated with accidental injuries. The Accident Plan covers emergency treatment, hospital admissions, confinements and diagnostic exams, as well as other expenses, such as transportation and lodging.

New prescription drug deductibles, adjustments to copays

Beginning in 2011, there will be a $50 per-person annual deductible for prescription drugs that is separate from your medical plan deductible, along with adjustments to copay amounts.

New Limited FSA for dental and vision expenses

This new option allows you to save pre-tax dollars in a separate FSA earmarked specifically for dental and vision expenses. Be aware that if you enroll in this Limited FSA, you cannot also participate in the Health Care FSA, which allows you to use pre-tax dollars for medical, dental and vision expenses.

New Best Doctors benefit offers free second-opinion service

If you or a covered dependent faces a difficult medical decision, a new second-opinion service called Best Doctors can help you get your questions answered and provide certainty that you have the right diagnosis and treatment plan. Best Doctors offers you access to the best doctors in the nation to review your case and offer a second opinion. The service is free for individuals enrolled in the medical plan. See page 5 for additional information.

Medical coverage for dependents to age 26

One impact of health care reform is the ability to cover adult children up to age 26 under your medical plan option. You may now add children to your district medical coverage effective January 1, 2011, whether or not they are full-time students. Plus, there will no longer be an additional after-tax premium for medical coverage for non-student dependents over age 19.

Changes to eligible Health Care Flexible Spending Account (FSA) expenses

Beginning January 1, 2011, over-the-counter (OTC) drugs such as pain relievers, sinus medicine and acid controllers will not be eligible for reimbursement through your FSA unless you have a prescription from your doctor. Other OTC medical supplies and products will continue to be eligible without a prescription.

MEDICAL PLAN OPTIONS

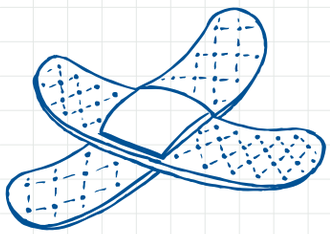
Everyone's health needs are different. That's why the district offers a choice of health plan options that vary by premium, deductible and coinsurance so that you can decide which option is the best fit for you and your family.

You can choose from two different types of plans in 2011:

CONSUMER (PLUS AND BASIC)

CHOICE POS II (HIGH AND SELECT LOW)

See medical plan comparisons on pages 12 - 13 and coverage costs on page 28.



TIP

Use Coverage Advisor to help you select the best medical plan option for you and your family. You can access it on *Benefits Outlook*, powered by WebMD.

All medical plan options feature:

- Prescription drug coverage through CVS Caremark, with money-saving mail service
- Direct access to specialists. You do not need a referral from a primary care physician to receive specialist care
- A wealth of health and wellness tools provided free-of-charge on the *Benefits Outlook* website, including the Carewise personal health management program, which offers a Personal Health Assessment, 24/7 Nurse Line, disease management, health notes and best-practice reviews of potential treatments
- A very large group of local, in-network primary care physicians
- A large national network of providers, which is especially important if you travel often or have a dependent child attending school outside the local area

Benefits claims advocates help you navigate the system

Benefits Claims Advocacy is a free service through Carewise Health for you and your dependents. If you are a benefits-eligible employee, the advocates can help you understand how your benefits work and can help resolve problems with your claims. For assistance, call the *Benefits Outlook* toll-free number at 1-866-284-AISD (2473), select option 2 for Carewise Health and then option 4 to speak to an advocate.

NEW IN 2011

BEST DOCTORS
GIVE YOUR DIAGNOSIS A CHECK-UP

Founded in 1989 by Harvard Medical School physicians, Best Doctors is an expert medical consultation service that works with you to help improve your health care quality. Best Doctors provides you—and your covered family members—with access to world-class medical expertise to help you make better informed health care choices and ensure you are getting the right diagnosis and treatment when faced with an important medical decision. On average, more than 20% of cases reviewed by Best Doctors result in a change of diagnosis, and more than 60% in a change of treatment.

HOW IT WORKS

1

When you—or another covered family member—have questions about a medical diagnosis or treatment plan, contact Best Doctors at 1-866-904-0910 and ask them to complete a thorough examination of your case. An intake nurse will triage your call and determine if your situation warrants further investigation. The service is free-of-charge to all Aldine ISD medical plan members.

2

The Best Doctors medical team completes a comprehensive case analysis and compiles all necessary medical information, including records and tests—and then selects the nationally recognized medical expert best qualified for the case. The expert doctor then conducts an analysis of the patient's condition and treatment.

3

The patient and/or his or her doctor receive an easy-to-understand report summarizing the expert's findings, letting them know if the diagnosis and treatment plan are on target. Best Doctors works with you and your treating physician and is always available for follow-up questions.

CONSUMER PLUS & BASIC

For individuals who like maximum control over the health care dollars they spend, Aldine ISD offers two Consumer options. This type of coverage is meant to offer you maximum flexibility and put more decisions in your hands as a health care consumer—but you have to take responsibility for the choices you make. You can choose from two Consumer options: Plus and Basic. Each has varying coverage levels and premiums, but both options work the same way.

HOW IT WORKS

NEW IN 2011
Preventive care is covered at 100% with no annual limit.

HEALTHFUND

- Every year, the district contributes money into your HealthFund account.
- These dollars are used to pay for your covered medical expenses, like office visits, lab work and tests. (Be aware that if you are enrolled in a Health Care FSA, those funds will be used first to pay for your eligible medical expenses. HealthFund dollars may only be accessed after all FSA funds have been exhausted. It's an IRS rule. For more information, see page 16.)

  Tip: Use the Treatment Cost Advisor on *Benefits Outlook* to help you estimate the cost of different medical procedures, tests and visits.
- Unused funds roll over from year to year, as long as you stay enrolled in a Consumer option.

ANNUAL DEDUCTIBLE

- You are responsible for paying an annual deductible before the plan begins to pay a percentage of covered expenses.
- The money in your HealthFund account will help you meet your deductible.
- If you have been enrolled in a Consumer option for more than two years, you may have saved enough money in your HealthFund to meet a larger portion of your deductible.

MAJOR MEDICAL COVERAGE (COINSURANCE)

- After you meet your annual deductible, you pay a percentage of the cost of covered expenses, called coinsurance.
- If you still have money in your HealthFund after the deductible is met, it will be used to help pay your coinsurance expenses.
- Once you reach your annual coinsurance maximum, the plan pays 100% of any of your remaining covered expenses for the rest of the year (not including emergency room, hospital and prescription drug copays).

CONSUMER PLUS & BASIC

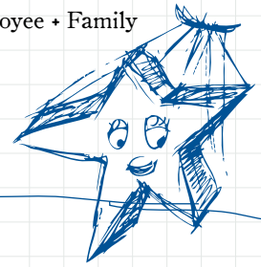
The district's 2011 HealthFund contributions

Enrolled in Consumer Plus or Basic as of October 1, 2010:

- $700 for Employee-Only coverage
- $950 for Employee + Spouse, Employee + Child or Employee + Children
- $1,200 for Employee + Family

New to the plan in 2011:

- $500 for Employee-Only coverage
- $750 for Employee + Spouse, Employee + Child or Employee + Children
- $1,000 for Employee + Family



PROS

- These options have some of the lowest premiums.
- Any unused balance in the district-provided HealthFund account rolls over to the next year, providing a health care nest egg for future medical expenses.

CONS

- If you become seriously ill or need a costly medical procedure and have spent all your HealthFund dollars, you will be responsible for paying the balance of your deductible and coinsurance, up to the out-of-pocket maximum. This doesn't necessarily mean that you will pay more overall, however, because the premiums for these options are significantly lower.

NEW PROVIDER NETWORKS:
HIGH PERFORMANCE, LOWER COST

Beginning in 2011, we're introducing new provider networks designed to increase access to high-performing and cost-effective hospitals and specialists.

If you choose the Consumer Plus plan, you will also have two network options, called Limited and Choice, and your per-paycheck premiums depend on the decision you make. If you select the Consumer Basic plan, you are automatically enrolled in the Choice network.

LIMITED NETWORK	CHOICE NETWORK	
When you need to use a hospital or doctor in 12 designated specialties, you must choose from a list of Memorial Hermann providers for your care.	You have the option to choose from a wider range of hospitals and specialists who are divided into two categories, called tiers. The price you pay for your care (in deductibles and coinsurance) depends on which tier the provider you choose is in. You have the flexibility to use providers in both tiers whenever you need care. The choice is up to you.	
You still have access to any primary care physician in the larger Aetna network.	You still have access to any primary care physician in the larger Aetna network. All primary care physicians are considered Tier I providers.	
MEMORIAL HERMANN **YOU MUST USE MEMORIAL HERMANN HOSPITALS EXCLUSIVELY FOR YOUR CARE.** For specialists in 12 designated categories, you must choose from a list of providers who have admitting privileges at Memorial Hermann facilities. (Outside the 12 designated categories, you may see any specialist in the larger Aetna network.)	TIER I $ To pay the lowest out-of-pocket, use one of these hospitals for your care: **MEMORIAL HERMANN** **ST. LUKE'S** **CHRISTUS** **ST. JOSEPH'S** **TENET** **TEXAS CHILDREN'S** In this tier, specialists in 12 designated categories have received Aetna's highest ranking for performance and cost effectiveness. So you pay less to choose a provider from this list. (Outside the 12 designated categories, you may see any specialist in the larger Aetna network. These specialists are all considered Tier I providers.)	TIER II $$ You pay more when you choose one of these hospitals: **METHODIST** **MD ANDERSON** **HCA** Your out-of-pocket costs are greater if you see a specialist in 12 designated categories in this tier. (Outside the 12 designated categories, you may see any specialist in the larger Aetna network. These specialists are all considered Tier I providers.)
There is no out-of-network care, except in the case of an emergency.	There is no out-of-network care, except in the case of an emergency.	

While this may limit your choices a little, your per-paycheck premiums will be lower if you select this option.

This option offers greater flexibility but you'll pay more per-paycheck in premiums.

For the most current and complete list of providers in both networks, use the Aetna DocFind tool.
The Limited and Choice networks have been custom-designed for Aldine ISD.

12 DESIGNATED SPECIALTIES

1. CARDIOLOGY
2. CARDIOTHORACIC SURGERY
3. GASTROENTEROLOGY
4. GENERAL SURGERY
5. NEUROLOGY
6. NEUROSURGERY
7. OBSTETRICS & GYNECOLOGY
8. ORTHOPEDICS
9. OTOLARYNGOLOGY/ ENT
10. PLASTIC SURGERY
11. UROLOGY
12. VASCULAR SURGERY

If you enroll in Consumer Basic in 2011, you are automatically enrolled in the Choice network.

CHOICE NETWORK
THE DECISION IS UP TO YOU.

The new Choice network groups specialists in 12 designated categories, as well as hospitals, into two categories, called tiers. At the time you need care, you decide which hospital or specialist you want to use. You will have lower out-of-pocket costs when you select a Tier I provider.

If you want to use a Tier II specialist or hospital, that's fine too. But you'll have to pay higher out-of-pocket costs when you do. The choice is up to you.

(Hint: Don't wait until you have an emergency to determine which tier your favorite provider is in. You can look up that information now using Aetna's DocFind tool at www.aetna.com/docfind/custom/aldinebenefits.)

AVOID SURPRISES.
Estimate your costs before you get care.

To help you decide the right hospital for you, take advantage of Aetna's online cost estimator before you make a decision.

1. Log in to www.aldinebenefits.org and click the link to Aetna.
2. Go to *Take Action* on *Your Health* and select *Cost of Care.*
3. Select *Get your estimate now.*

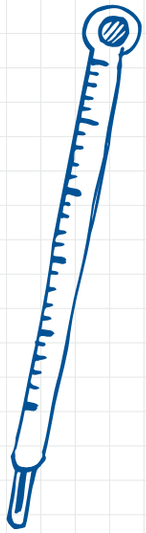
The Limited and Choice networks have been custom-designed for Aldine ISD.

IS THE CONSUMER PLAN YOUR PLAN FOR 2011?

Health insurance costs are a major expense for all of us. And it's not easy deciphering all your options. Still, to decide which medical option is right for your family, you have to consider everything—not just the cost of your per-paycheck premiums, but how much you're likely to spend over the course of a year when you take premiums and all your other expenses into account.

Predictability might just be overrated

In the past, many Aldine employees chose an Open Access option simply because it seemed more predictable, which felt comfortable, even though the premiums were higher. But all things considered, and in real-world situations, you may actually spend less monthly overall with one of the Consumer options.



Creative thinking can pay off

Many Consumer option participants seem to have found the best of all worlds—they pay the Consumer option's lower premiums and then just set aside the difference in premiums they'd be paying if they'd chosen another option. That way, if they need that piggy bank to handle out-of-pocket expenses, it's there for them. And if they don't need it, they can use that saved-up stash any way they'd like at the end of the year. Win. Win.

For them, it's more practical than paying higher premiums just in case they have a costly medical event that exceeds their HealthFund dollars.

Thinking of using out-of-network facilities? You might want to think twice.

QUALITY AND EFFICIENCY

Out-of-network services can increase your health care cost—and the district's—since these facilities set their own fees. Out-of-network hospital emergency-room care should be used *only* when you are faced with a life-threatening emergency. Out-of-network emergency room care for non-emergency medical attention can result in excessive charges that increase health care costs for everyone. The POS II High plan includes a limited-fee schedule for out-of-network facilities. When you use an out-of-network facility for non-emergency services, you will be directly responsible for paying the difference between the scheduled fee for the care you receive (which is based on the market rate for our geographic area) and the amount the facility charges. This fee schedule is meant to protect everyone from excessive out-of-network facility charges, which, over time, increase plan costs.

CHOICE POS II HIGH & SELECT LOW

You can choose from two Choice POS II options: High—a TRS 3 look-alike plan—and Select Low—a low-cost, catastrophic plan (formerly called the POS II Low option).

CHOICE POS II HIGH

HOW IT WORKS

- Preventive care is covered at 100%, with no annual maximum.
- There is no annual deductible for in-network expenses.
- You pay a copay for in-network office visits and a percentage of the cost for all other care, until you reach the annual coinsurance maximum.
- You must meet a deductible before the plan pays for any out-of-network care. Once you meet your annual out-of-network deductible, you are responsible for paying a set percentage of covered expenses (coinsurance) until you reach the annual coinsurance maximum. (Please note: If you use an out-of-network facility, the difference you pay out-of-pocket between the limited fee schedule and what the facility actually charges does not apply to your annual coinsurance maximum.)

PROS

- This is the only option that offers you access to both in- and out-of-network providers, but your in-network costs are lower with office visit copays and no deductible.

CONS

- Annual premiums are the highest of all the medical plan options.

SELECT LOW

HOW IT WORKS

- Preventive care is covered at 100%, with no annual maximum.
- The plan pays for the first $225 of your covered office visits.
- After you meet your deductible, you pay a percentage of any additional medical expenses (coinsurance), up to an annual maximum.
- New in 2011: There are no out-of-network benefits.

PROS

- The plan is designed as "safety net" coverage for people who rarely use medical services but want catastrophic coverage.

CONS

- The plan requires a high deductible that must be met before the plan starts paying benefits for its share of covered expenses.

TIP

Just because your doctor is in-network, the facility in which you are treated or are referred to might not be. Go to aldinebenefits.org and click on Find a Medical Provider or call Aetna to confirm that the treatment facility is in-network.

PLAN FEATURES		CONSUMER PLUS - LIMITED	CONSUMER PLUS - CHOICE		CONSUMER BASIC - CHOICE		CHOICE POS II - HIGH (TRS-3)		SELECT LOW (CATASTROPHIC)
Receive Care		MEMORIAL HERMANN NETWORK ONLY	TIER I	TIER II	TIER I	TIER II	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK ONLY
Lifetime Maximum Benefit		Unlimited					Unlimited	Unlimited	Unlimited
HealthFund	New to the Consumer plan	$500 per Employee Only, per year $750 per Employee + Spouse and Employee + Child(ren), per year $1,000 per Employee + Family, per year					N/A		
	Currently in the Consumer plan as of Oct. 2010	$700 per Employee Only, per year $950 per Employee + Spouse and Employee + Child(ren), per year $1,200 per Employee + Family, in 2011							
YOU PAY:									
Annual Deductible[2] (will be reduced by HealthFund balance)		$2,000 Individual $3,750 Family	$2,000 Individual $3,750 Family	$2,500 Individual $4,750 Family	$2,750 Individual $5,000 Family	$3,250 Individual $6,000 Family	None	$500 Individual $1,500 Family	$4,000 Individual $8,000 Family
Annual Coinsurance Maximum (plus deductible, copays and other costs not covered by the plan)		$3,000 Individual $5,750 Family	$3,000 Individual $5,750 Family	$3,500 Individual $6,750 Family	$3,750 Individual $8,500 Family	$4,250 Individual $9,500 Family	$1,000 Individual None Family	$3,000 Individual None Family	$4,000 Individual $8,000 Family
Office Visit/ Physician Services	Primary Care	20%	20%	See Tier I	25%	See Tier I	Copay: $20	40%	0% for the first $225, then 30%
	Specialist[3]	20%	20%	See Tier I	25%	See Tier I	Copay: $30	40%	
	12 designated specialties	20%[4]	20%	35%	25%	45%	Copay: $30	40%	
Preventive Care[5]		Free-of-charge with no annual limit							
Inpatient – Hospital (pre-certification required)		20%[6]	20%	35% plus $500 copay per admission[7]	25%	45% plus $500 copay per admission[7]	20% plus $100 copay per day[8]	40% plus $100 copay per day[8]	30%
Outpatient – Hospital (pre-certification required)		20%[6]	20%	35%	25%	45%	20% after $100 copay	40% after $100 copay	30%
Outpatient – Free Standing and Surgical Center (pre-certification required)		20%	20%	20%	25%	25%	20% after $100 copay	40% after $100 copay	30%
Emergency Care		20% plus $150 copay (waived if admitted)	20% plus $150 copay (waived if admitted)		25% plus $150 copay (waived if admitted)		20% plus $100 copay (waived if admitted)		30%
Non-Emergency Care in an Emergency Room		40%	40%		45%		40%	50%	50%
Urgent Care Facility		20%	20%		25%		20% after $50 copay		30%
Lab, X-ray, Diagnostic Mammogram, Diagnostic Scans (MRI, MRA, CAT, PET) – Outpatient Hospital		20%[6]	20%	35%	25%	45%	20%	40%	30%
Lab, X-ray, Diagnostic Mammogram, Diagnostic Scans (MRI, MRA, CAT, PET) – Freestanding Facility, Independent Lab		20%	20%	20%	25%	25%	Copays: $20 or 20% if in a facility	40%	See office visit or 30% if in a facility
Maternity – Prenatal		20%	20%	35%	25%	45%	20%	40%	30%
Mental Health – Inpatient & Outpatient[9]		20%	20%	See Tier I	25%	See Tier I	20%	40%	30%
Substance Abuse – Inpatient & Outpatient[10]		20%	20%	See Tier I	25%	See Tier I	20%	40%	30%
PRESCRIPTION DRUG BENEFITS — THROUGH CVS CAREMARK									
Prescription Deductible[11]		$50	$50		$50		N/A	N/A	$250 Individual / $500 Family
Generic/ Formulary Brand/ Non-Formulary Brand/ Specialty[12]	Retail 30-day supply	$15/$30/$50/$50	$15/$30/$50/$50		$15/$35/$60/$60		$15/$35/$50/$130	N/A	30%
	Mail order 90-day supply	$37.50/$75/$125/$50	$37.50/$75/$125/$50		$37.50/$87.50/$150/$60		$30/$70/$125/$130	N/A	30%

1. Out-of-network facility charges exceeding the limited fee schedule amount are not covered and will not be applied to the deductible or coinsurance maximum. Employee is responsible for paying the difference between the covered amount and the amount the facility charges.
2. Medical copays and prescription drug deductible and copays, plus limited fee schedule or reasonable and customary cutback penalties, do not apply to the annual deductible or coinsurance maximum. Deductible does not apply to the annual coinsurance maximum.
3. If you are enrolled in a Consumer option, you pay this amount when you see an in-network specialist outside of the 12 designated specialty areas. See page 9.
4. Specialist must be within the Memorial Hermann network in 12 designated specialties. See page 9.
5. Some preventive care includes PSA and pap tests, annual mammogram (age 35+), osteoporosis screenings (age 65+) and colonoscopies (age 50+).
6. Must use a Memorial Hermann facility.
7. Limited to two $500 copays per plan year.
8. $500 maximum copay per admission; $1,500 maximum copay per plan year; pre-certification required.
9. Inpatient maximum stay: 30 days/year combined with chemical dependency. Outpatient maximum visits: 30 visits/year combined with chemical dependency (individual & group combined).
10. Inpatient maximum stay: 30 days/year combined with mental health; lifetime limit of 3 series or $50,000. Outpatient maximum 30 visits/year combined with mental health (lifetime limit of 3 series).
11. The deductible only applies once per year per person and a copay may also be requested.
12. Specialty drugs limited to a 30-day supply and distribution amount; copay is per 30-day supply and only through CVS Caremark's specialty program.

PRESCRIPTION DRUG BENEFITS

All medical plan options include prescription drug benefits through CVS Caremark, available at participating pharmacies and through a mail service.

RETAIL

How it works

For short-term prescriptions or the first month of a newly prescribed maintenance medication, take your prescription and your Aetna ID card to a participating pharmacy. You pay the lesser of the actual drug cost or a copay for each prescription, up to a 30-day supply, after you meet your annual $50 per person prescription drug deductible. (If you enroll in the Select Low option, you pay 30% after you have met your prescription deductible.) You do not need to fill out a claim form. Specialty drugs may be filled only through the CVS Caremark specialty mail program.

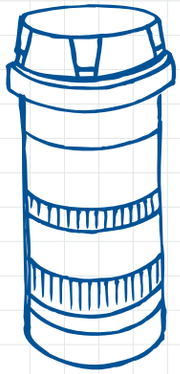
Note: Prescriptions filled at non-participating pharmacies are not covered.

MAIL SERVICE

How it works

For long-term and maintenance medications, you can save money while enjoying the convenience of receiving up to a 90-day supply for the cost of two-and-a-half times the retail copay for generic, formulary and non-formulary brand-name drugs. (If you are enrolled in the Choice POS II - High option, the cost is two times the retail copay for these same classes of drugs.) To fill a prescription using the mail service, complete a Prescription Drug order form (available through the CVS Caremark link at aldinebenefits.org) and mail to the address on the form. Refills may be ordered online, by phone or by mail.

Specialty drugs are only available in a 30-day supply and only through the CVS Caremark Specialty Mail program.



QUESTIONS ABOUT YOUR PRESCRIPTION DRUG BENEFITS? CALL CVS CAREMARK AT 1-800-378-8651 OR LOG ON TO ALDINEBENEFITS.ORG AND CLICK CVS CAREMARK.

Keep forgetting to refill or renew your prescriptions?

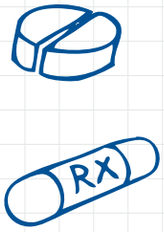
With the Automatic Prescription Refill program, CVS Caremark's mail service pharmacy will automatically send you refill prescriptions for your maintenance medications and will proactively request a new prescription from your doctor when a maintenance prescription is about to expire or when the last refill has been used. All you have to do is visit aldinebenefits.org and go to the CVS Caremark link. Click on *Refill a Prescription*, choose the medications you would like to enroll in the program and sign up for the Refill program or the Renewal program or both. The cost will be billed automatically to your credit card. You can also enroll by calling CVS Caremark customer service at 1-800-378-8651.

Living with high blood pressure, high cholesterol or diabetes?

The prescription drug copay and deductible for generic drugs for hypertension and hyperlipidemia (high cholesterol) are still waived for 2011. Waiving these copays makes it easier for you to follow your doctor's directions by taking prescribed medications and renewing them on time to manage your conditions. In addition, copays for generic diabetic drugs and injectable insulin are waived when you are compliant with your DiabetesAmerica treatment plan.

NEW IN 2011

Effective January 1, 2011, there is a $50 annual deductible for prescription drugs that is separate from your medical plan deductible. The deductible only applies once per year, per person, and a copay may also be requested.



VOLUNTARY PLAN OPTIONS

If you would like supplemental or additional coverage not provided by your medical insurance—as well as added financial protection—consider adding a selection of voluntary plans to your 2010 benefits package. Rates are available on pages 28-31.

For more detailed information about your 2011 benefit options, log on to *Benefits Outlook*, powered by WebMD at aldinebenefits.org.

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you to set aside pre-tax dollars to pay for eligible health and dependent care expenses. With an FSA, you decide ahead of time how much money you anticipate spending on health care or dependent care for the entire year and that amount is deducted from your paycheck and available when you need it, tax-free. It's important to estimate carefully the amount you expect to spend since you will lose any unused funds at the end of the year. Visit the IRS website, irs.gov/publications, for the full list of eligible expenses.

Health Care FSA

- You can set aside a minimum of $600 and a maximum of $5,000 per year, pre-tax, to pay yourself back for eligible health care expenses that are not reimbursable from any other source.
- The full amount you allocate is available to you when the plan year begins on January 1, 2011.
- The FSA may be used for all eligible health care costs for you and your dependents, including vision and dental.
- If you participate in one of the Consumer options, be aware that your medical claims will be paid from your FSA first. Only after all FSA funds have been exhausted will claims be paid through your HealthFund.

Dependent Care FSA

- You can set aside pre-tax dollars for expenses to care for your child or other qualifying person so that you and your spouse can work or look for work. The account cannot be used to pay for dependent medical expenses. Eligible expenses include day care, nursery school or summer day camp.
- You and your spouse may contribute up to a combined total of $5,000 per calendar year.

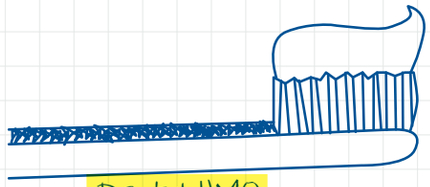
Limited Dental and Vision–only FSA

- You can set aside dollars pre-tax to pay for your vision and dental expenses.
- If you enroll in this option, you cannot participate in the Health Care FSA, which allows you to use pre-tax dollars for medical, dental and vision expenses.

NEW FOR 2011

Beginning January 1, 2011, over-the-counter (OTC) drugs such as pain relievers, sinus medicine and acid controllers will not be eligible for reimbursement through your FSA unless you have a prescription from your doctor.

If you have a balance remaining in your 2010 Health Care FSA, consider using a portion of those funds to take advantage of the pre-tax reimbursement for OTC medications before the end of the calendar year.



Dental HMO

- You choose a primary care dentist (PCD) who directs your care.
- Failure to select a PCD prior to care may result in delay or denial of coverage for services.
- You pay the specified copay when you receive services.
- You may only use in-network providers.
- Specialty care benefits are offered at a discount at participating providers.

Dental PPO

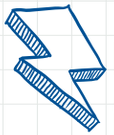
- You pay a deductible before the plan begins to pay its share of covered dental expenses.
- The PPO plan offers a nationwide network of providers.
- When you use a network provider, your out-of-pocket expense is lower.
- You may use any provider you choose and are responsible for costs that exceed the usual, reasonable and customary guidelines.
- You pay the full cost when you receive treatment. If you use an in-network dentist, the provider will submit your claim for reimbursement on your behalf. If you use an out-of-network dentist, submit your receipts and claim form to receive reimbursement for the covered amount.

Managed Cost Dental

- This option is provided free of charge for employee-only coverage and is available for a per-paycheck premium for all other coverage levels.
- You must use a network provider for your care.
- You pay set copays for selected services based on a schedule of fees or receive a 20% discount for other services.

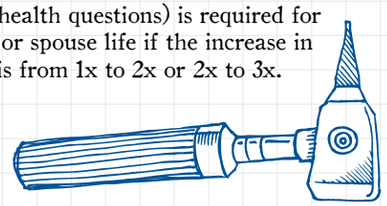
Vision

- You may choose between High and Low options.
- Both offer in- and out-of-network benefits.
- Both cover an annual in-network eye exam for a $20 copay.
- Both cover contact and spectacle lenses every 12 months after a set materials copay.
- The High option covers new frames every 12 months; the Low option covers new frames every 24 months.



Life and Accidental Death and Dismemberment (AD&D)

- Employee coverage is available for up to three times your annual base salary, up to a maximum of $400,000. (Please note: Base salary does not include overtime, stipends, car allowance or other supplemental pay.)
- Spouse life and AD&D coverage is also available, equal to your coverage amount or $100,000, whichever is less.
- Child life and AD&D coverage is available of either $5,000 or $10,000 per child.
- You must designate or update your beneficiary online.
- If your spouse also works for the district, each of you can be covered by either (1) employee coverage or (2) spouse coverage. You cannot have both. A child may not be insured by more than one member.
- No EOI (health questions) is required for employee or spouse life if the increase in coverage is from 1x to 2x or 2x to 3x.



Cancer and Specified Diseases Plan

- This plan provides a cash benefit for procedures and other care related to diagnosis and treatment of cancer and 36 specified diseases, including a wellness benefit.
- The Cancer and Specified Diseases plan offers three coverage options—High, Medium and Low.

Critical Illness

- This plan pays you a lump-sum cash benefit upon first diagnosis of a covered critical illness.
- If elected, spouse coverage is 50% of the employee's coverage amount. Dependent children are covered automatically for 25% of the employee's coverage amount at no additional cost if you elect Employee + Child(ren) or Employee + Family coverage.

Hospital Indemnity

- The plan provides a cash payment to help you pay your portion of hospital expenses, such as deductibles and coinsurance amounts.
- Benefits are paid for hospital admission and hospital stays, including ICU, of up to 365 days.
- Benefits will not be paid for any sickness or loss related to a pre-existing condition (an injury or illness for which medical advice or treatment was received or recommended within 12 months prior to the effective date of coverage).

Accident

- New for 2011: This plan covers emergency treatment, hospital admissions, confinements and diagnostic exams, as well as other expenses, such as transportation and lodging needs.
- If you have a covered accident, you receive cash benefits for expenses that may not be fully covered by your medical option.

Disability

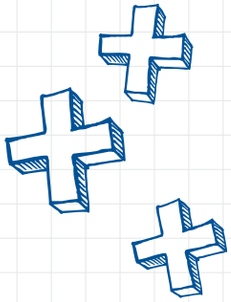
- You are paid a portion of your salary if you are unable to work due to a covered injury, illness or pregnancy.
- There are two coverage options: Limited Disability and Long-Term Disability.
- You have a choice of waiting periods and the amount of pay you want to replace in increments of $100—up to 66.67% of your annual salary (from $300 minimum to $7,500 maximum per month).

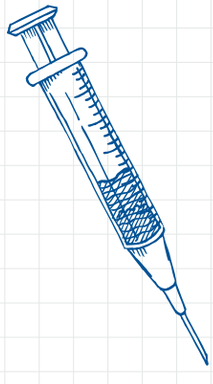
If you're concerned about higher deductibles in 2011, consider these voluntary plans designed to help fill the gap between what insurance covers and what you're expected to pay out of pocket.

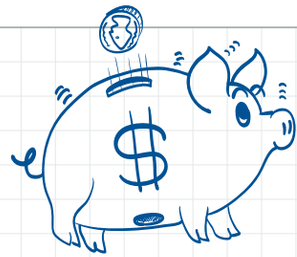
CANCER CARE
CRITICAL ILLNESS
HOSPITAL INDEMNITY
ACCIDENT

Personal Legal

The plan provides personal legal guidance on a variety of issues and services, such as will preparation, traffic ticket defense and uncontested adoptions.







403 (b) Tax Sheltered Annuities/Mutual Funds

The district provides the opportunity to participate in a savings plan as a supplement to TRS retirement benefits.

401(a) Matching Plan for Retirement

- The district contributes a base match to a 401(a) plan if you participate in a 403(b) or 457(b) plan.
- You are 100% vested in district matching contributions when you complete six years of credited service.

457(b) Savings for Retirement Plan

- This plan is a voluntary savings plan that allows pre-tax contributions through payroll deduction.
- Contributions and earnings grow tax-deferred until withdrawn, and are designed to supplement TRS retirement income and provide an alternative to 403(b) programs.

529 Savings Plan

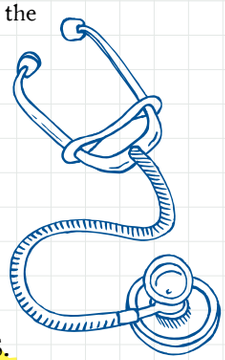
- You can save for your children's college tuition through the Texas Tomorrow Fund and a 529 Savings Plan.
- Contributions are made by payroll deduction on an after-tax basis.
- All account earnings are tax-free if they are used to pay qualified expenses as stated in plan documents and federal tax law.

GET ENROLLED

OPEN ENROLLMENT
NOVEMBER 5–16, 2010

Once you've reviewed your benefit options and made a decision about your benefit coverage for 2011, you're ready to enroll. Follow the steps to enroll on *Benefits Outlook*, powered by WebMD.

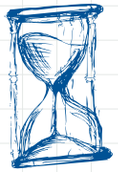
1 GO TO ALDINEBENEFITS.ORG AND LOG IN.
If this is your first visit to the new site, follow the instructions on page 27 to register.



2 CLICK ON *DECISION TOOLS*, SELECT *ENROLLMENT CENTER* AND FOLLOW THE INSTRUCTIONS TO ENTER YOUR BENEFIT ELECTIONS.

3 CHECK THE PERSONALIZED CONFIRMATION STATEMENT YOU WILL RECEIVE IN THE MAIL IN EARLY DECEMBER.
If your confirmation statement is incorrect, call *Benefits Outlook* immediately. Any corrections you make after you receive your confirmation statement will not be reflected on your paycheck for two to four weeks from the time you notify *Benefits Outlook* of the change.

If you are a new employee, you will receive a confirmation statement in the mail within two weeks of the date you submit your benefit elections via the *Benefits Outlook* website.



IF YOU NEED HELP ENROLLING, CALL A *BENEFITS OUTLOOK* REPRESENTATIVE AT 1-866-284-AISD (2473).

If you are already enrolled in Aldine ISD *Benefits Outlook* programs for 2010, you must enroll if you want to:

- Add, drop or change your existing coverage
- Add or drop a dependent. (New in 2011: You may now enroll your adult child up to age 26, whether or not they are a full-time student.)
- Participate in a Flexible Spending Account (FSA) during 2011

IMPORTANT:
If you were enrolled in an Open Access option in 2010 and do not complete the enrollment process for 2011, you will automatically be moved to the Consumer Plus Choice option. If you were enrolled in a Consumer option in 2010 and do not re-enroll, you will automatically be moved to the same option with the Choice network.

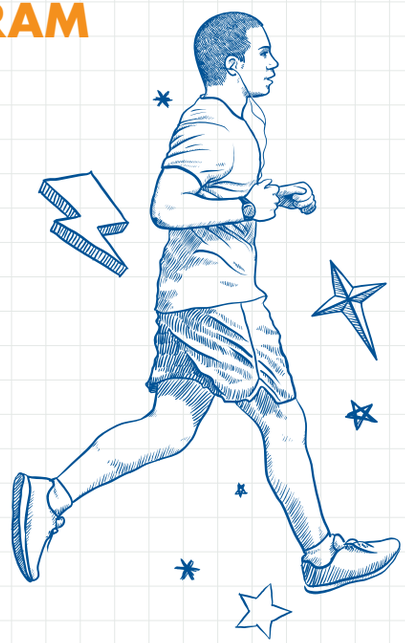
TIP
If you are a new employee and want benefits coverage during the calendar year in which you are hired, you must submit your elections before the deadline. If you do not enroll by the deadline, you will have no benefits coverage for the remainder of this calendar year.

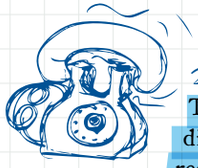
Aldine ISD employees have the opportunity to enroll or change existing coverage for the next calendar year during the annual open enrollment in November. You can change your coverage during the year only if you experience a qualified life event or family status change, such as marriage, birth or adoption of a qualified dependent, divorce or death of a spouse or dependent child. You must notify *Benefits Outlook* within 31 days of one of these events if you want to make changes to your coverage.

GET FIT AND HEALTHY WITH THE MY HEALTH PROGRAM

During open enrollment, you're naturally focused on making good choices to meet your health needs. But getting and staying healthy are goals you should think about every day.

Our benefits program includes helpful resources to keep you focused on your physical well being and your positive frame of mind. More details are on *Benefits Outlook*, powered by WebMD.





24/7 Nurse Line

The Nurse Line gives you a direct, toll-free connection to a registered nurse any time of the day or night. Carewise Health nurses are specially trained to help you choose the appropriate level of care for any illness or injury. You can also get tips on nutrition, exercise, weight loss, immunizations, smoking cessation and finding a doctor.

Call 1-866-284-2473.

Beginning Right Maternity Management

Expectant mothers receive educational materials and access to nurse case managers so that they get the assistance they need from the start of their pregnancies until their babies are born.

Call 1-800-272-3531 (1-800-CRADLE-1)

Health Club Memberships

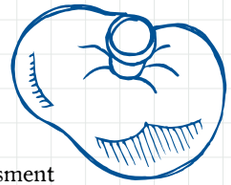
Preferred membership rates are offered through Fitness Connection, 24-Hour Fitness, Bally Total Fitness, YMCA and Pure Fitness. Your membership dues are deducted from your paycheck each pay period.

Visit aldinebenefits.org, click on *My Benefits* and select *Wellness Summary.*

Employee Assistance Program

If you are facing a crisis or need to talk to someone about life's challenges, the EAP hotline is available 24 hours a day. The EAP is a confidential resource that helps you resolve personal problems before they affect your health, relationships or job performance. It also offers financial, legal and referral services.

Call 1-866-379-0244.



Personal Health Assessment

The Carewise Health Personal Health Assessment begins with a brief confidential questionnaire, which takes an in-depth look at your family health history, your personal history and lifestyle. Carewise Health conducts an instant analysis of your answers, rates your current health status and your potential future health problems. The Personal Health Assessment also provides you with a personalized plan for healthy living, explains the relationship between your behavior and your health and outlines the steps you can take to reduce your risks. All information is confidential and not shared with the school district.

Visit aldinebenefits.org, click on *Health Tools* and select *Personal Health Assessment.*

Disease Management

Carewise Health offers free and confidential programs designed to help you manage chronic health conditions that can have a significant effect on your life. If you or a covered dependent has a chronic condition, you may qualify to participate in the program; and you may receive an outreach call. A disease management nurse will review your care, discuss your medical concerns and develop a personalized care plan. Your disease management nurse will provide regular telephone assistance, free educational materials and ongoing support.

Call 1-866-284-2473.

Health Coaching

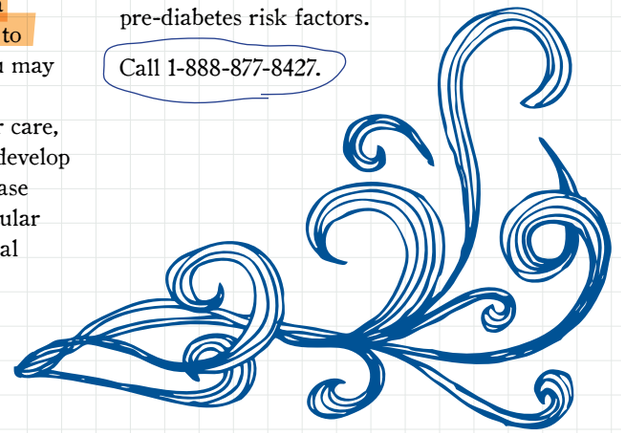
You have support to help you make the necessary changes to live a healthier and happier life. Specially trained health care professionals use proven guidelines and well established methods to help you cope with stress, stop smoking, eat healthier, manage your weight and control health risks like high blood pressure and obesity. Your Carewise Health coach will assess your current situation, prioritize the changes you need to make, set goals and help you achieve those goals.

Call 1-866-284-2473.

DiabetesAmerica

DiabetesAmerica focuses exclusively on the needs of individuals with diabetes. Participants get coordinated care, education, nutrition information and medication management to take control of their diabetes. Patients have access to medical professionals specializing in diabetes. Each medical option (except the Select Low option) includes incentives for enrollees who continue to be compliant with the program. Deductibles (and POS II High copays) are waived and generic diabetes drugs and insulin are free. Services may also be available if you have pre-diabetes risk factors.

Call 1-888-877-8427.



Reward yourself in 2011!

Improving your health can be valuable when you participate in the Healthy Rewards program. When you complete the Personal Health Assessment and participate in health and wellness activities, you not only improve your health, you also earn points toward a valuable gift card. Earn 250 points and receive one taxable $125 gift card per incentive year (November 2010 through October 2011). Cards are available quarterly. The rewards program is open only to employees enrolled in the district's medical plan. Registration on *Benefits Outlook* is required to accumulate reward points. Gift cards are earned only if a completed Carewise Personal Health Assessment has been submitted, so be sure to do that early! To learn more and to see how many points you can accumulate during the year, go to *Benefits Outlook*, powered by WebMD.

Complete these activities to earn points toward a valuable gift card

GATEWAY TO FUTURE POINTS — COMPLETE THE CAREWISE PERSONAL HEALTH ASSESSMENT	
75	Complete an online Carewise Personal Health Assessment between November 5 and December 31, 2010 to receive points for 2011. Use your Quest screening results to help complete your Personal Health Assessment questions.
50	Complete an online Carewise Personal Health Assessment between January 1 and October 31, 2011 (if you did not complete the assessment in November or December 2010).
YOU CAN EARN ADDITIONAL POINTS BY COMPLETING ANY OF THE ACTIVITIES BETWEEN NOVEMBER 1, 2010 AND OCTOBER 31, 2011:	
150	Participate in a Carewise Health Disease Management program by accepting an outreach call, participating in at least three calls with a Disease Management nurse and developing an action plan *or* participate in and comply with the DiabetesAmerica program.
125	Receive an annual mammogram screening (be sure physician's office codes it as preventive or routine).
100	Participate in Aetna's "Beginning Right" maternity program (must register in first trimester).
75	Get your annual physical or well-woman exam (be sure physician's office codes it as preventive or routine).
75	Print your new Carewise Personal Health Assessment results report, review it with your physician during your annual physical or well-woman exam and obtain his or her signature anywhere on the last page of your report. Physician should include his/her printed name, signature, phone number and date of your exam. Submit only this signed page to the Aldine Benefits department.
75	Accept outreach call from Carewise Health coach and initiate an action plan including at least three coaching calls.
75	Complete and document 70 exercise sessions at a health club (must be signed by health club professional) between November 1, 2010 and October 31, 2011.
75	Participate in Quest onsite health screenings sponsored by Aldine ISD (register for screenings in early 2011).
50	Review and obtain your physician's signature on your Quest screening results report during your annual physical or well-woman exam (register for screenings in early 2011). Submit only this signed page to the Aldine Benefits department.
50	Complete one of four online Carewise Lifestyle Management programs (action plan, track activity and complete 30- and 90-day surveys).
25	Visit a physician's office or health care facility for a flu shot or necessary immunizations (be sure physician's office codes it as preventive).

TAKE ADVANTAGE OF *BENEFITS OUTLOOK*, POWERED BY WEBMD

Imagine having everything you need to know about your health status and how you can improve it—all located in one place that's easy to navigate, helpful, reliable, secure and confidential. Welcome to *Benefits Outlook*, an online tool powered by WebMD, one of the most trusted sources of health and medical news and information.

WebMD has tools to keep you better informed about your health.

Take a more organized approach to your health

For the 2011 plan year, you can have a single, secure and convenient place to track and view your Personal Health Record, including information such as immunization records, allergies, medication history and much more. If you are enrolled in the district's medical plan, the Personal Health Record will import information from your doctor visits, insurance provider, hospitals, labs and pharmacies, based on your personal settings. It also tracks your health trends over time. It's your story in one place and is available to you 24/7.

Keep track of your progress

Health Trackers give you the ability to chart your progress over time. With easy-to-use charts, you can track and monitor important health measurements, such as blood pressure, cholesterol and weight. The tracking tools monitor vital health information and medical records in one secure location.

Eliminate the element of surprise when it comes to medical expenses

The Treatment Cost Advisor can help you evaluate and prepare for the expense of most common medical conditions, treatments, procedures, prescriptions and more. The data includes in-network and out-of-network comparisons.

Find the right provider for you

WebMD's Provider Selection Advisor makes it easier than ever to find a physician or hospital that meets your individual needs and preferences. This tool allows you to search by location, specialty and network eligibility.

Find the hospital that's right for you

The Compare Hospitals tool allows you to make informed decisions about where to seek the best in-network health care services. You can research hospital quality ratings based on location, procedure and areas of expertise.

Get the news you need to know right away to stay healthy

Health Alerts sends you secure, confidential messages when your health-related activities stray from evidence-based medicine guidelines. Working in conjunction with your WebMD Personal Health Record, Health Alerts notifies you of potentially dangerous medication interactions or gaps in your medical care. Each alert is clearly explained with specific information and recommendations about the next steps you should take.

READY TO GET STARTED?

Using *Benefits Outlook* couldn't be easier.
If you haven't registered yet, here's how to get started:

1. Go to aldinebenefits.org.
2. Click on the *Register Now* button.
3. Follow the instructions to register.
   Your Registration ID is your Social Security number.
4. Once you have registered, an Authentication PIN will be sent to you immediately through your district e-mail address.
5. Enter your Authentication PIN. It's a required step if you want to enroll for benefits, complete the Personal Health Assessment or access your personal health information; otherwise, you'll only have limited access to the tools and information available on the new site.
6. You're in. Take a look around and start enjoying *Benefits Outlook*, powered by WebMD.

Why do I need a PIN? The Benefits Outlook website allows you to access personal health data, like your claims history and pharmacy records, with a single password. To ensure that your privacy is protected, your Authentication PIN is sent directly to you through your district e-mail.

Benefits Outlook is also accessible to your covered family members who are age 18 or older. However, because they do not have a district-provided e-mail address, they will need to follow the registration steps carefully.

MEDICAL PLAN – PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)

OPTION	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + 1 CHILD	EMPLOYEE + 2 OR MORE CHILDREN	EMPLOYEE + FAMILY
CONSUMER PLUS - LIMITED	$76.75	$324.75	$232.00	$300.75	$572.25
CONSUMER PLUS - CHOICE	$80.50	$341.00	$243.50	$315.75	$600.75
CONSUMER BASIC - CHOICE	$56.75	$292.75	$207.00	$272.25	$524.25
CHOICE POS II - HIGH (TRS-3)	$294.50	$911.75	$682.00	$855.50	$1,474.00
SELECT LOW (CATASTROPHIC)	$33.00	$189.00	$127.00	$173.25	$319.25

DENTAL PLAN – PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)

OPTION	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
DENTAL HMO	$4.23	$7.91	$7.19	$10.31
DENTAL PPO	$16.97	$35.58	$35.49	$55.50
MANAGED COST DENTAL	$0.00	$4.00	$4.00	$6.00

VISION PLAN – PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)

OPTION	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
High Option	$3.73	$7.38	$7.75	$11.88
Low Option	$2.54	$4.80	$5.02	$9.37

DISABILITY PLAN COSTS

LIMITED DISABILITY	COSTS (RATES PER $100 OF COVERED SALARY*)	LONG-TERM DISABILITY	COSTS (RATES PER $100 OF COVERED SALARY)
14-day waiting period	$2.38	14-day waiting period	$3.12
30-day waiting period	$2.06	30-day waiting period	$2.82
60-day waiting period	$1.00	60-day waiting period	$1.38
90-day waiting period	$0.64	90-day waiting period	$0.88
180-day waiting period	$0.42	180-day waiting period	$0.60

*Salary as of January 1, 2010.

EMPLOYEE LIFE AND AD&D INSURANCE COVERAGE

BENEFIT LEVEL	AGE	RATE MODE	PER 24 PAY-PERIOD COST
1x, 2x, or 3x annual base salary ($400,000 maximum)	<30	Per $1,000	$0.0295
	30-34	Per $1,000	$0.0395
	35-39	Per $1,000	$0.0445
	40-44	Per $1,000	$0.0595
	45-49	Per $1,000	$0.0845
	50-54	Per $1,000	$0.1245
	55-59	Per $1,000	$0.2245
	60-64	Per $1,000	$0.2845
	65-69	Per $1,000	$0.5045
	70+	Per $1,000	$0.7095

AD&D rate of $0.019 per $1,000 included in Employee rates above.

SPOUSE LIFE AND AD&D INSURANCE COVERAGE

BENEFIT LEVEL	AGE	RATE MODE	PER 24 PAY-PERIOD COST
1x, 2x, or 3x annual base salary ($400,000 maximum)	<30	Per $1,000	$0.0495
	30-34	Per $1,000	$0.0595
	35-39	Per $1,000	$0.0645
	40-44	Per $1,000	$0.1045
	45-49	Per $1,000	$0.1795
	50-54	Per $1,000	$0.2645
	55-59	Per $1,000	$0.4495
	60-64	Per $1,000	$0.5295
	65-69	Per $1,000	$0.9295
	70+	Per $1,000	$1.4095

AD&D rate of $0.019 per $1,000 included in Spouse rates above.

CHILD LIFE AND AD&D INSURANCE COVERAGE

BENEFIT LEVEL	AGE	RATE MODE	PER 24 PAY-PERIOD COST
Option A: $5,000	N/A	Flat rate	$0.40
Option B: $10,000	N/A	Flat rate	$0.80

AD&D rate of $0.019 per $1,000 included in Child rates above.

HEALTH CARE OR LIMITED FLEXIBLE SPENDING ACCOUNTS (FSA)

MINIMUM CONTRIBUTION	MAXIMUM CONTRIBUTION
$600 per year or $25 per pay period	$5,000 per year or $208.33 per pay period

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

MINIMUM CONTRIBUTION	MAXIMUM CONTRIBUTION
$600 per year or $25 per pay period	$5,000 per year or $208.33 per pay period

HOSPITAL INDEMNITY PLAN COSTS – PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)

OPTION	AGE ON 01/01/11	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
LOW OPTION	18-39	$2.41	$4.46	$4.51	$6.55
	40-49	$3.02	$5.74	$5.10	$7.83
	50-59	$4.32	$8.36	$6.40	$10.44
	60-69	$6.74	$13.06	$8.84	$15.15
HIGH OPTION	18-39	$4.46	$8.20	$8.25	$11.99
	40-49	$5.64	$10.70	$9.44	$14.49
	50-59	$8.13	$15.70	$11.92	$19.49
	60-69	$12.73	$24.63	$16.53	$28.42

CRITICAL ILLNESS PLAN COSTS – PAY PERIOD COST (24 PAY PERIODS PER YEAR)

OPTION	AGE ON 01/01/11	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
LOW OPTION	18-34	$2.31	$3.74	$2.31	$3.74
	35-39	$3.92	$6.17	$3.92	$6.17
	40-44	$5.17	$8.05	$5.17	$8.05
	45-49	$7.92	$12.16	$7.92	$12.16
	50-54	$9.98	$15.25	$9.98	$15.25
	55-59	$11.55	$17.61	$11.55	$17.61
	60-64	$17.53	$26.58	$17.53	$26.58
	65-69	$17.53	$26.58	$17.53	$26.58
HIGH OPTION	18-34	$4.91	$7.65	$4.91	$7.65
	35-39	$8.94	$13.70	$8.94	$13.70
	40-44	$12.08	$18.41	$12.08	$18.41
	45-49	$18.94	$28.70	$18.94	$28.70
	50-54	$24.09	$36.41	$24.09	$36.41
	55-59	$28.03	$42.33	$28.03	$42.33
	60-64	$42.97	$64.73	$42.97	$64.73
	65-69	$42.97	$64.73	$42.97	$64.73

ACCIDENT – PAY PERIOD COST (24 PAY PERIODS PER YEAR)

OPTION	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Low Option	$3.86	$5.73	$7.47	$9.34
High Option	$6.65	$9.77	$12.61	$15.73

CANCER AND SPECIFIED DISEASES PLAN - PAY PERIOD COST (24 PAY PERIODS PER YEAR)

OPTION	EMPLOYEE ONLY	1-PARENT FAMILY (EMPLOYEE + CHILDREN)	2-PARENT FAMILY (EMPLOYEE + SPOUSE OR EMPLOYEE + FAMILY)
Low Option and Specified Diseases	$5.76	$7.38	$9.60
Low Option and Specified Diseases + ICU Rider	$8.76	$13.56	$15.78
Medium Option and Specified Diseases	$8.28	$10.62	$14.28
Medium and Specified Diseases + ICU Rider	$11.28	$16.80	$20.46
High Option and Specified Diseases	$9.42	$12.48	$17.10
High Option and Specified Diseases + ICU Rider	$12.42	$18.66	$23.28

HEALTH CLUB - PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)

OPTION	EMPLOYEE ONLY	EMPLOYEE + SPOUSE
Fitness Connection	$7.50	$12.50
24-Hour Fitness Inc.[1]	$17.50	$27.50
Bally Total Fitness	$10.00	$15.00
Pure Fitness	$10.00	N/A

1. Spouse or other family members will pay $49 enrollment fee directly to health club.

HEALTH CLUB (YMCA ONLY) - PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)

FROZEN SALARY	EMPLOYEE ONLY	EMPLOYEE + FAMILY
$60,000 and up	$27.50	$38.50
$50,000 - $59,000	$25.00	$34.50
$40,000 - $49,000	$22.00	$31.00
$30,000 - $39,000	$19.50	$27.00
$20,000 - $29,000	$16.50	$23.00
$0 - $19,000	$14.00	$19.50

PERSONAL LEGAL PLAN COSTS – PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)

OPTION	EMPLOYEE ONLY	EMPLOYEE + FAMILY
Personal Legal Plan	$4.98	$6.48

¡NOTICIAS IMPORTANTES SOBRE LA INSCRIPCIÓN!

Las opciones que elija para sus beneficios tienen un papel importante en su acceso a los servicios médicos, sus gastos para dichos servicios y su protección financiera para usted y sus dependientes.

Empleados Actuales

Si está inscrito en el plan de beneficios del distrito para el año 2010, conviene que se registre en el periodo de Inscripción Abierta (5 a 16 de noviembre de 2010) si desea:

- Agregar, eliminar o cambiar su cobertura actual
- Agregar o eliminar a un dependiente
- Participar en una Cuenta de Gasto Flexible (FSA, por sus siglas en inglés) durante 2011

Cabe destacar que la opción de Acceso Abierto (Open Access) será descontinuada en 2011. Si, en la actualidad, está inscrito(a) en este plan y no selecciona una opción nueva antes de la fecha límite de Inscripción Abierta, su cuenta será cambiada automáticamente a la opción de Elección Plus del Consumidor (Consumer Plus Choice). Además, hemos agregado dos redes nuevas de proveedores para 2011. Si a la sazón está inscrito en una opción del Consumidor para 2010 y quiere reinscribirse, quedará reinscrito automáticamente en la misma opción para 2011, con la nueva red de Elección. No podrá hacer cambios después de dicho período, a menos que haya un cambio drástico en su situación, o un cambio sobre su estatus familiar durante el año.

Nuevos Empleados

Si usted es un nuevo empleado y desea ser incluido en el programa de beneficios del distrito por el resto del año, deberá presentar sus selecciones antes de la fecha límite. En caso contrario, no tendrá ninguna cobertura médica por el resto de 2010. Tendrá la oportunidad de inscribirse en el programa de beneficios o cambiar su cobertura actual durante el período anual de inscripción que generalmente tiene lugar en noviembre. Este es el único período en que usted podrá hacer cambios en sus selecciones para beneficios, a menos que haya un cambio drástico en su situación, o un cambio sobre su estatus familiar durante el año.

Antes de hacer cualquier selección, lea con cuidado esta guía sobre beneficios, así como su hoja de inscripción, para informarse acerca de todas las opciones que tiene a su disposición.

Antes de Inscribirse

- **Visite el sitio electrónico Benefits Outlook (aldinebenefits.org).** Infórmese sobre sus opciones y use los recursos y enlaces que están a su disposición. Use el enlace Coverage Advisor para acceder a recursos que le ayudarán a elegir el programa médico más apropiado para usted.
- **Vaya a la Feria de Salud y Bienestar 2010** que tendrá lugar el viernes, 5 de noviembre, de 10:00 a.m. a 6:00 p.m. y sábado, 6 de noviembre, de 9:00 a.m. a 1:00 p.m.
- **Haga preguntas, visite el sitio aldinebenefits.org** para buscar respuestas. También, podrá dirigirse personalmente a un miembro del departamento de beneficios durante la feria, o llamar a Benefits Outlook al 1-866-284-AISD (2473).

Cuando Está Listo a Inscribirse

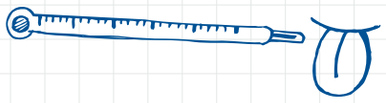
Una vez que usted esté listo a inscribirse, siga los siguientes pasos:

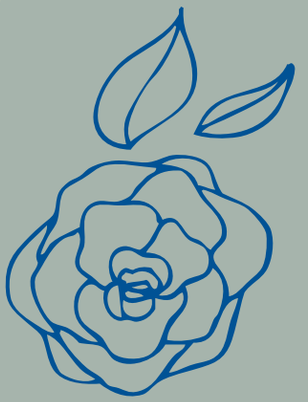
1. Vaya a aldinebenefits.org y entre al sistema. Si ésta es su primera visita al sitio nuevo, primero debe inscribirse antes de entrar.
   - Haga clic en el botón que dice *Register Now* (Inscribirse ahora) y siga las instrucciones para inscribirse. Su Registration ID (Identificación de inscripción) es su número de Seguro Social. Una vez que se haya inscrito, un número de identificación personal (PIN) de autenticación le será enviado inmediatamente, por medio de su dirección electrónica del distrito.
   - Escriba su PIN de autenticación. Es un paso requerido si desea inscribirse a las prestaciones, complete la Evaluación de Salud Personal (Personal Health Assessment) o accese a su información de salud personal.
2. Haga clic en *Decision Tools* (Herramientas de Decisión), seleccione *Enrollment Center* (Centro de Inscripción) y siga las instrucciones para anotar sus elecciones de prestaciones. Si necesita ayuda para inscribirse, llame al representante de *Benefits Outlook*, al 866-284-AISD (2473).
3. Recibirá una carta de confirmación por correo a principios de diciembre. Si es incorrecta, llame inmediatamente a *Benefits Outlook* al 866-284-AISD (2473). Todas las correcciones se reflejarán entre cuatro a ocho semanas después haber notificado a un representante de *Benefits Outlook*.

   Si usted es un empleado nuevo, recibirá una confirmación en el correo dentro de un periodo de dos semanas a partir de la fecha en que presentó sus elecciones de prestaciones, vía el sitio web de *Benefits Outlook*.

Preguntas?

Llame a Benefits Outlook al 866-284-AISD (2473)





OPEN ENROLLMENT:
NOVEMBER 5-16, 2010

2010 Health and Wellness Fair

Friday, November 5, 2010
10 a.m. – 6 p.m.

Saturday, November 6, 2010
9 a.m. – 1 p.m.

M.O. Campbell Educational Center
1865 Aldine Bender Road
Houston, Texas 77032