

2012 BENEFITS

FIELD GUIDE



BENEFITS
OUTLOOK
Health.Wellness.Life.

NEW FOR 2012

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Here it is. Everything you need to know about your 2012 benefits program. If you were enrolled last year, you'll notice that the medical plan looks very familiar. The District worked hard to make that possible, and we're proud to be able to offer you the same high level of medical coverage with no increase in premiums.

There are changes to other parts of our plan that you'll want to consider, so please take the time to read all of the information presented here. And don't forget, there are lots of other free and easy-to-use tools available to help you feel confident that you're making the best choices for you and your family.

The *Benefits Outlook* website, powered by WebMD, is a great resource. Before you make any final decisions, check out the *Coverage Advisor* tool, which makes it easy to customize your plan to fit your needs.

Our goal, as always, is not only to provide the latest, greatest health care options at affordable rates, but also to encourage healthier habits that can go a long way in helping you avoid medical issues in the first place.

Here's to a healthy, happy 2012.

This guide provides an overview of your benefits options. Benefits are subject to change without notice. The complete provisions of the plans, including legislated benefits, exclusions and limitations, are set forth in the insurance contracts. The insurance contracts are available for your review in the Benefits Department. If the information in this guide is not consistent with the insurance contracts or state and federal regulations, the insurance contracts and state and federal regulations will prevail. This guide is not intended as a contract of employment nor a guarantee of current or future employment.

WHAT'S NEW FOR 2012

CHANGES TO THE PRESCRIPTION DRUG PROGRAM

You will pay higher out-of-pocket costs for brand name drugs when a generic is available. This means that if you or your physician request a brand name drug when a generic is available, you will pay the brand [copay](#) and prescription [deductible](#) (if it has not already been met) *plus* the difference in cost between the brand name and the generic prescription.

HEALTHFUND CONTRIBUTIONS

All employees enrolled in a Consumer Option have a HealthFund account paid for each year by Aldine ISD. For 2012, the District will contribute \$500 annually for employee-only coverage, \$750 for employee+spouse or employee+child(ren) coverage and \$1,000 for employee+family coverage.

LOWER RATES FOR VOLUNTARY PLANS

We have made minor changes and, in most cases, achieved substantial premium reductions for the Dental, Vision, Life Insurance, Disability and Legal voluntary plans.



DENTAL PLAN ENHANCEMENTS

You will now have two options for Dental HMO, including the new Dental HMO Plus that includes specialty dentists and adds adult and child orthodontia coverage. In addition, rates are decreasing for the Dental PPO, and a new benefit maximum carryover feature is being added. With this new feature, if you have less than \$750 in paid claims, you can carry over up to \$400 to your maximum coverage amount in the next plan year. If you go to an in-network provider, you can earn an additional \$100 to carry over.

GOOD NEWS:
IN 2012 ALDINE
ISD IS OFFERING
THE SAME
MEDICAL PLAN
OPTIONS AND
PROVIDER
NETWORKS WITH
NO INCREASE IN
PREMIUMS

Same flexible medical plan Same rates as last year

BENEFITS OUTLOOK



TO ACCESS *BENEFITS OUTLOOK*, POWERED BY WEBMD,
GO TO THE ALDINE ISD EPORTAL AND SIGN IN.

SELECT *MORE RESOURCES* AND THEN CLICK *BENEFITS*.

PLEASE NOTE: IF THIS IS YOUR FIRST VISIT TO THE SITE,
FOLLOW THE INSTRUCTIONS ON [PAGE 29](#) TO REGISTER.

CHANGES TO THE DISABILITY PLAN

In 2012, Standard Insurance Company will be the new disability carrier, and we're introducing a more traditional approach to long-term disability coverage. Instead of buying coverage in increments of \$100, your options will be based on a percentage of your annual earnings. As an added benefit, no evidence of insurability will be required to enroll in the plan, but disabilities in the first 12 months due to pre-existing conditions are excluded from coverage. (Note: You will automatically be moved to the 50 percent of salary level option and the new premium amount. If you want a different option, you must make the change online during the 2012 Open Enrollment period.)

INCREASE IN LIFE INSURANCE COVERAGE

The limit for life insurance coverage will be increased to five times your annual base salary, and up to a maximum of \$600,000.

EMPLOYEE ASSISTANCE PLAN

This program will be eliminated in 2012 because it is not a widely used benefit. Instead, the funds will be applied toward employee premiums, helping to keep them as affordable as possible.

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 co-insurance 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 2012:

See medical plan comparisons on [pages 14 - 15](#) and coverage costs on [page 30](#).



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, BY LOGGING IN TO THE EPORTAL ([SEE PAGE 5](#)).

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.

BEST DOCTORS GIVES 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 percent of cases reviewed by Best Doctors result in a change of diagnosis, and more than 60 percent result in a change of treatment.

HOW IT WORKS

- 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 evaluate your call and determine if your situation warrants further investigation. **The service is free-of-charge to all Aldine ISD medical plan members.**
- The Best Doctors medical team completes a comprehensive case analysis, 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.
- 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 offers you maximum flexibility and puts 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. In addition, both options cover preventive care at 100 percent with no annual maximum.

HOW IT WORKS

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 19](#).)
- Unused funds roll over from year to year, as long as you stay enrolled in a Consumer option.

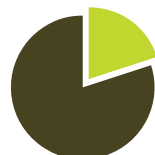
TIP: USE THE *TREATMENT COST ADVISOR ON BENEFITS OUTLOOK*, POWERED BY WEBMD, BY LOGGING IN TO THE EPORTAL ([SEE PAGE 5](#)) TO HELP YOU ESTIMATE THE COST OF DIFFERENT MEDICAL PROCEDURES, TESTS AND VISITS.

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 in prior years, you may have saved enough money in your HealthFund to cover 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 percent of any of your remaining covered expenses for the rest of the year (not including emergency room, hospital and prescription drug copays).

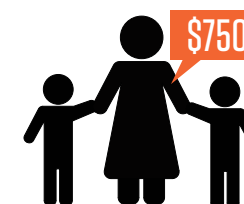
THE DISTRICT'S 2012 HEALTHFUND CONTRIBUTIONS



Employee-Only



Employee + Spouse



Employee + Child(ren)



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, building 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.

PROVIDER NETWORKS: HIGH PERFORMANCE, LOWER COST

If you choose the Consumer Plus plan, you will also have two network options, called Limited and Choice. 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 certain types of specialists, you are limited to Memorial Hermann hospitals and doctors for your care.	With this option, you can choose from a wider range of hospitals and specialists that are divided into two tiers. The amount you pay out-of-pocket for your care (in deductibles and coinsurance) depends upon which tier your provider is in.	
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 inpatient and outpatient hospital care.	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	TIER II* You pay more when you choose one of these hospitals: Methodist MD Anderson HCA
For providers in 12 designated specialties (see next page), plus hematology and oncology , you must choose from a list of select providers who have admitting privileges at Memorial Hermann facilities.	In this tier, specialists in 12 designated specialties (see next page) have received Aetna's highest ranking for performance and cost-effectiveness. You pay less to choose a provider from this list.	Your out-of-pocket costs are greater if you see a specialist in 12 designated specialties (see next page) in this tier.
Outside the designated specialties, you may see any specialist in the larger Aetna network. The plan covers inpatient and outpatient hospital services from Memorial Hermann facilities only .	Outside the 12 designated specialties, you may see any specialist in the larger Aetna network and will be charged at Tier I rates. Inpatient and outpatient hospital coverage is based on the facility tier above.	Outside the 12 designated specialties, you may see any specialist in the larger Aetna network and will be charged at Tier I rates. Inpatient and outpatient hospital coverage is based on the facility tier above.
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 slightly, 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, log in to the Aldine ISD ePortal, click on *More Resources* and select *Benefits* to access *Aetna Navigator* to find a doctor, pharmacy or facility.

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

CHOICE NETWORK: THE DECISION IS UP TO YOU.

The Choice network groups providers (in 12 designated specialties) and 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.

AVOID SURPRISES. ESTIMATE YOUR COSTS BEFORE YOU GET CARE. DON'T WAIT UNTIL YOU HAVE AN EMERGENCY TO DETERMINE WHICH TIER YOUR FAVORITE PROVIDER IS IN. YOU CAN LOOK UP THAT INFORMATION BY LOGGING IN TO *BENEFITS OUTLOOK*, POWERED BY WEBMD, THROUGH THE EPORTAL (SEE PAGE 5) AND CLICKING ON AETNA NAVIGATOR.

CHOICE NETWORK 12 DESIGNATED SPECIALTIES

CARDIOLOGY	OBSTETRICS & GYNECOLOGY
CARDIOTHORACIC SURGERY	ORTHOPEDICS
GASTROENTEROLOGY	OTOLARYNGOLOGY/ENT
GENERAL SURGERY	PLASTIC SURGERY
NEUROLOGY	UROLOGY
NEUROSURGERY	VASCULAR SURGERY

For the Limited network only: Providers of the designated specialties **MUST USE** Memorial Hermann for inpatient and outpatient hospital services.

WHICH HOSPITAL SHOULD I CHOOSE?

To help you choose which hospital is right for you, log in to *Benefits Outlook*, powered by WebMD (see page 5), then click on *Aetna Navigator* to find a doctor, pharmacy or facility.

IS THE CONSUMER PLAN YOUR PLAN?

Health insurance costs are a major expense for all of us. And it's important to understand all your options. To decide which medical option is right for your family, you have to consider everything—not just the cost of your 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

Initially you may be drawn to the Choice POS II - High option, even though it has the highest premiums, because its predictability may seem more comfortable than that of the other plans. But all things considered, and in real-world situations, you may actually spend less overall with one of the Consumer options.

CREATIVE THINKING CAN PAY OFF

Many Consumer plan participants seem to have found the best of all worlds—they pay

the Consumer plan'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 the saved-up funds 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.

CONSUMER PLANS: SO EASY EVEN A CAVEMAN CAN DO IT



STAY INSIDE YOUR NETWORK.

Out of network services are not covered under the Consumer Plus or Basic plans. Out-of-network hospital emergency room care can be covered, but should only be considered when you are faced with a life-threatening emergency and it's the closest facility. Out-of-network emergency room care for non-life threatening medical attention can result in excessive charges that increase health care costs for everyone.

The Choice POS II High plan includes a limited-fee schedule for out-of-network facilities. If you use an out-of-network facility for non-emergency services in the High plan, 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.

Staying inside the network is especially important if you are enrolled in the Consumer Plus - Limited network.

CHOICE POS II HIGH & SELECT LOW



You can choose from two Choice POS II options: High and Select Low, a low-cost, catastrophic plan.

↑ HIGH CHOICE POS II HOW IT WORKS

- Preventive care is covered at 100 percent, 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 CHOICE POS II HOW IT WORKS

- Preventive care is covered at 100 percent, 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.

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 for its share of covered expenses.

TIP: JUST BECAUSE YOUR DOCTOR IS IN-NETWORK, THE FACILITY IN WHICH YOU ARE TREATED OR TO WHICH YOU ARE REFERRED MIGHT NOT BE. LOG IN TO AETNA NAVIGATOR VIA BENEFITS OUTLOOK (SEE PAGE 5) TO FIND A DOCTOR OR FACILITY, OR CALL AETNA (1-800-694-3258) TO CONFIRM THAT THE TREATMENT FACILITY IS IN-NETWORK.

MEDICAL PLAN COMPARISON CHART

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		\$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			
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 (excludes 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 No Family Limit	\$3,000 Individual No Family Limit	\$4,000 Individual \$8,000 Family		
Office Visit/ Physician Services	Primary Care	20%	20% (no Tier II Primary Care physicians)		25% (no Tier II Primary Care physicians)		Copay: \$20	40%	0% for the first \$225, then 30%		
	Specialist ³	20%	20% (no Tier II Specialist physicians)		25% (no Tier II Specialist physicians)		Copay: \$30	40%			
	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%		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%		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% (no Tier II facilities)		25% (no Tier II facilities)		20%	40%	30%		
Substance Abuse – Inpatient & Outpatient ¹⁰		20%	20% (no Tier II facilities)		25% (no Tier II facilities)		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%		

● 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. ● 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. ● 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 11. ● Specialist must be within the Memorial Hermann network in 12 designated specialties. See page 11. ● Some preventive care includes PSA and pap tests, annual mammogram (age 35+), osteoporosis screenings (age 65+) and colonoscopies (age 50+).

MEDICAL PLAN COMPARISON CHART

● Must use a Memorial Hermann facility. ● Limited to two \$500 copays per plan year. ● \$500 maximum copay per admission; \$1,500 maximum copay per plan year; pre-certification required. ● Inpatient maximum stay: 30 days/year combined with chemical dependency. Outpatient maximum visits: 30 visits/year combined with chemical dependency (individual & group combined). ● 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). ● The deductible only applies once per year per person and a copay may also be requested. ● 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 per person prescription drug deductible. (The Choice POS II - High option has no deductible. The Select Low option requires a 30 percent payment 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: IF YOU OR YOUR PHYSICIAN REQUEST A BRAND NAME DRUG WHEN A GENERIC IS AVAILABLE, YOU WILL PAY THE BRAND COPAY AND PRESCRIPTION DEDUCTIBLE PLUS THE DIFFERENCE IN COST BETWEEN THE BRAND NAME AND THE GENERIC PRESCRIPTION.



YOU WILL HAVE AN 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 WILL ALSO BE REQUESTED. SEE PLAN DETAILS FOR MORE INFORMATION.



QUESTIONS ABOUT YOUR PRESCRIPTION DRUG BENEFITS? CALL CVS CAREMARK AT 1-800-378-8651 OR LOG ON TO *BENEFITS OUTLOOK*, POWERED BY WEBMD, ON THE EPORTAL ([SEE PAGE 5](#)) AND CLICK *CVS CAREMARK*.



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 on *Benefits Outlook*, powered by WebMD ([see page 5](#)), 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.

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 *Benefits Outlook*, powered by WebMD ([see page 5](#)) and click on *CVS Caremark*. Click on *Refill a Prescription* and choose the medications you would like to enroll in the program.

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 2012. 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. (See [page 25](#) for more information about this free program.)

AUTOMATICALLY REFILL YOUR PRESCRIPTIONS. LOG IN TO *BENEFITS OUTLOOK* ON THE EPORTAL ([SEE PAGE 5](#)), CLICK ON *MORE RESOURCES* AND SELECT *BENEFITS*

- > *CVS CAREMARK*
- > *REFILL A PRESCRIPTION*
- > *REFILL OR RENEWAL PROGRAM*

OR CALL 1-800-378-8651.

YOU WILL PAY HIGHER OUT-OF-POCKET COSTS FOR BRAND NAME DRUGS WHEN A GENERIC IS AVAILABLE.

GET FREE GENERIC PRESCRIPTIONS TO MANAGE YOUR CONDITION. NOTE: PRESCRIPTIONS FILLED AT NON-PARTICIPATING PHARMACIES ARE NOT COVERED.

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 2012 benefits package. Rates are available on [pages 30-33](#). For more detailed information about your 2012 benefits options, log in to *Benefits Outlook* via the ePortal ([see page 5](#)), click on *My Benefits* and select *Plan Documents*.



DENTAL HMO AND DENTAL HMO PLUS

- New for 2012: A choice of two options – DHMO Basic, at lower rates for 2012, and DHMO Plus, which includes specialty dentists and orthodontic coverage.
- You must 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.
- For DHMO Plus, referrals to specialty dentists are required.
- For DHMO Plus there is a copayment for orthodontic coverage of \$2,400 per covered child and \$2,600 per adult. Please note that DHMO Plus orthodontia coverage does not cover orthodontia already in progress (i.e. if you already have braces, DHMO Plus will not cover your orthodontia expenses), however, this does not apply to new hires who had orthodontia coverage through their previous employer.



DENTAL PPO

- New for 2012: Lower rates and a new carryover feature. With this new feature, if you have less than \$750 in paid claims, you can carry over up to \$400 to your maximum coverage amount in the next plan year. If you go to an in-network provider, you can earn an additional \$100 to carry over.
- You pay a deductible before the plan begins to pay its share of covered dental expenses.
- Dental PPO 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.
- 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, you pay the full cost when you receive treatment and must submit your receipts and claim form to receive reimbursement for the covered amount.



DISCOUNT DENTAL

- This option is provided free of charge for employee-only coverage.
- You must use an in-network provider for your care.
- You pay set fees for selected services or receive a 20 percent discount for other services.



VISION

- New for 2012: Lower premiums and enhanced contact lens benefits.
- 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 \$10 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.



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.
- PLEASE NOTE: Beginning in 2013, the maximum Health Care FSA contribution will be reduced to \$2,500 per year. If you are considering an expensive, eligible health care service (such as LASIK), you may want to have the procedure in 2012 while the maximum limit remains at \$5,000.
- The full amount you allocate is available to you when the plan year begins on January 1, 2012.
- 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 reimbursed from your FSA first. Only after all FSA funds have been exhausted will claims be reimbursed 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, after school care 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 a minimum of \$600 and a maximum of \$5,000 per year, 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.



LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

- New for 2012: Lower premiums and higher benefits available.
- Employee coverage is available for up to five times your annual base salary, up to a maximum of \$600,000. (Please note: Base salary does not include overtime, stipends, car allowance or other supplemental pay.)
- Spouse life and AD&D coverage is also available at one to three times salary, equal to your coverage amount or \$100,000, whichever is less.
- Child life and AD&D coverage is available for 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 Evidence of Insurability (EOI) is required for employee or spouse life if the coverage is increased by only one multiple of salary (i.e. 1x to 2x, 2x to 3x, etc.).
- EOI will be required for late entrants (those who did not enroll when first eligible).



CANCER & SPECIFIED DISEASES PLAN

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



CRITICAL ILLNESS PLAN

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



HOSPITAL INDEMNITY PLAN

- 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.
- Guaranteed issue, no EOI.

Note: Under the Cancer and Specified Diseases, Critical Illness and Hospital Indemnity plans, 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).



DISABILITY PLAN

- New for 2012: Standard Insurance Company is our new insurance carrier for disability coverage and the plan design has changed.
- After a set waiting period, the plan pays a monthly benefit if you are disabled and unable to work due to an injury, illness or pregnancy.
- You have a choice of waiting periods before benefits begin (14, 30, 60, 90 or 180 days), and you select the percentage of your basic annual earnings that you want to replace each month (40, 50 or 66.67 percent). The 14-day waiting period will only be offered in 2012.
- There is no evidence of insurability to receive plan coverage. If you have been denied in the past, you can apply again.
- There is a 12 month "look back" pre-existing conditions limitation for new or increased coverage and lesser waiting periods. That means if you are a new enrollee and become disabled during your first 12 months on the plan from a pre-existing condition, there is no disability coverage. If you were covered in 2011 and elected for increased disability coverage or a lesser waiting period in 2012, and you become disabled during your first 12 months from a pre-existing condition, you will receive coverage at your 2011 rate level of benefits.
- A pre-existing condition is any condition for which you consulted a physician, received medical treatment, underwent diagnostic procedures, (including self-administered procedures) or took prescribed drugs or medication as a result of any medical examination in the 12 months prior to the effective date of new or changed coverage.
- If you have Aldine sick/personal days, you will also receive 25 percent of your disability benefit. You will receive your full disability benefits after your Aldine sick/personal days have been exhausted.
- If you increase your 2012 waiting period because you have a large number of sick days and then lessen your waiting period in 2013 because you used some of your sick days, the difference in waiting periods will be subject to pre-existing conditions limits.



ACCIDENT PLAN

- This plan covers emergency treatment, hospital admissions, confinements and diagnostic exams, as well as other expenses related to your accident, 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.



PERSONAL LEGAL PLAN

- New for 2012: Lower premiums.
- 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 percent 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.

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 ENROLLED

Once you've reviewed your benefits options and made a decision about your benefits coverage for 2012, you're ready to enroll. Follow the steps to enroll on *Benefits Outlook*, powered by WebMD, by logging in to the ePortal ([see page 5](#)).

- 1 LOG IN TO THE ALDINE ISD EPORTAL, SELECT *MORE RESOURCES*, THEN CLICK *BENEFITS*.**
If this is your first visit to the site, follow the instructions on [page 29](#) to register.

- 2 CLICK ON *ENROLL OR DECISION TOOLS*, THEN *ENROLLMENT CENTER* AND FOLLOW THE INSTRUCTIONS TO ENTER YOUR BENEFITS 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* at 1-866-284-2473 immediately. Any corrections you make after you receive your confirmation statement may not be reflected on your first two paychecks of the new year and may result in catch up deductions.

Confirmation statements will be mailed to employees after the close of the open enrollment period. Note: If you have recently moved, you should update your address with Aldine ISD to ensure you get this important document.



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

**OPEN ENROLLMENT
NOVEMBER 4-15, 2011**

If you are already enrolled in Aldine ISD *Benefits Outlook* programs for 2011, you must enroll if you want to:

- Add, drop or change your existing coverage
- Add or drop a dependent
- Participate in a Flexible Spending Account (FSA) during 2012

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 (see page 5).**



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



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 and 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 District.

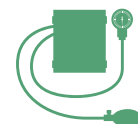
VISIT *BENEFITS OUTLOOK* (SEE PAGE 5), CLICK ON *HEALTH TOOLS* AND SELECT *PERSONAL HEALTH ASSESSMENT*



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*.



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



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 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 recommended lifestyle changes, 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 Choice POS II Select Low option) includes incentives for enrollees who continue to be compliant with the program. Medical deductibles (and Choice 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 2012!

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 2011 through October 2012).

Cards are available quarterly. The rewards program is open only to employees enrolled in the District's medical plan. Registration on *Benefits Outlook* ([see page 5](#)) 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 ([see page 5](#)).

COMPLETE
THESE
ACTIVITIES
TO EARN
POINTS
TOWARD A
VALUABLE
GIFT CARD

**REMINDER: COMPLETE THE
PERSONAL HEALTH ASSESSMENT.
NO PHA, NO GIFT CARD!**

1. GATEWAY TO FUTURE POINTS — COMPLETE THE CAREWISE PERSONAL HEALTH ASSESSMENT

- | | |
|-----|--|
| 125 | Complete an online Carewise Personal Health Assessment between November 1 and December 31, 2011 to receive points for 2012. |
| 75 | Complete an online Carewise Personal Health Assessment between January 1 and October 31, 2012 (if you did not complete the assessment in November or December 2011). |

2. YOU CAN EARN ADDITIONAL POINTS BY COMPLETING ANY OF THE ACTIVITIES BETWEEN NOVEMBER 1, 2011 AND OCTOBER 31, 2012:

- | | |
|-----|---|
| 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). |
| 100 | Get your annual physical or well-woman exam (be sure physician's office codes it as preventive or routine). |
| 100 | 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, 2011 and October 31, 2012. |
| 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. (See page 5 for log in information.)

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



TAKE A MORE ORGANIZED APPROACH TO YOUR HEALTH

You 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 gives 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, where applicable.



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 Log in to the Aldine ISD ePortal, click on *More Resources* and select *Benefits*.
- 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.






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)					
					
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)				
				
EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY	
DENTAL HMO PLUS	\$5.10	\$9.54	\$8.67	\$12.44
DENTAL HMO BASIC	\$2.63	\$4.91	\$4.46	\$6.40
DENTAL PPO	\$16.75	\$33.19	\$33.11	\$51.79
DISCOUNT DENTAL	\$0.00	\$4.00	\$4.00	\$6.00


DISABILITY PLAN – PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)		
WAIT PERIOD	COVERAGE OPTION	COST
14 day	40%	\$0.5510 x Annual Base Salary ÷ 1,200
14 day	50%	\$0.6965 x Annual Base Salary ÷ 1,200
14 day	66.67%	\$1.3370 x Annual Base Salary ÷ 1,200
30 day	40%	\$0.3210 x Annual Base Salary ÷ 1,200
30 day	50%	\$0.4065 x Annual Base Salary ÷ 1,200
30 day	66.67%	\$1.0270 x Annual Base Salary ÷ 1,200
60 day	40%	\$0.2355 x Annual Base Salary ÷ 1,200
60 day	50%	\$0.3530 x Annual Base Salary ÷ 1,200
60 day	66.67%	\$0.6955 x Annual Base Salary ÷ 1,200
90 day	40%	\$0.2195 x Annual Base Salary ÷ 1,200
90 day	50%	\$0.2890 x Annual Base Salary ÷ 1,200
90 day	66.67%	\$0.5245 x Annual Base Salary ÷ 1,200
180 day	40%	\$0.1070 x Annual Base Salary ÷ 1,200
180 day	50%	\$0.1445 x Annual Base Salary ÷ 1,200
180 day	66.67%	\$0.3265 x Annual Base Salary ÷ 1,200

No EOI. 12/12 pre-existing condition applies.

VISION PLAN – PAY PERIOD COST (BASED ON 24 PAY PERIODS PER YEAR)				
				
EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY	
HIGH OPTION	\$3.07	\$6.08	\$6.39	\$9.79
LOW OPTION	\$2.10	\$3.96	\$4.14	\$7.72

EMPLOYEE LIFE AND AD&D INSURANCE COVERAGE			
BENEFIT LEVEL	AGE	RATE MODE	PER 24 PAY-PERIOD COST
1x, 2x, 3x, 4x or 5x annual base salary (\$600,000 maximum) 	<30	Per \$1,000	\$0.0210
	30-34	Per \$1,000	\$0.0290
	35-39	Per \$1,000	\$0.0330
	40-44	Per \$1,000	\$0.0450
	45-49	Per \$1,000	\$0.0650
	50-54	Per \$1,000	\$0.0970
	55-59	Per \$1,000	\$0.1770
	60-64	Per \$1,000	\$0.2250
	65-69	Per \$1,000	\$0.4010
	70+	Per \$1,000	\$0.5650

AD&D rate of \$0.010 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 (\$100,000 maximum) 	<30	Per \$1,000	\$0.0430
	30-34	Per \$1,000	\$0.0525
	35-39	Per \$1,000	\$0.0575
	40-44	Per \$1,000	\$0.0955
	45-49	Per \$1,000	\$0.1665
	50-54	Per \$1,000	\$0.2475
	55-59	Per \$1,000	\$0.4230
	60-64	Per \$1,000	\$0.4990
	65-69	Per \$1,000	\$0.8790
	70+	Per \$1,000	\$1.3350

AD&D rate of \$0.010 per \$1,000 included in Spouse rates above.

CHILD LIFE AND AD&D INSURANCE COVERAGE			
	BENEFIT LEVEL	RATE MODE	PER 24 PAY-PERIOD COST
	OPTION A: \$5,000	Flat rate	\$0.40
	OPTION B: \$10,000	Flat rate	\$0.80






AD&D rate of \$0.010 per \$1,000 included in Child rates above.

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

	AGE ON 01/01/12	 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






Guaranteed issue, no EOI.

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

	AGE ON 01/01/12	 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

Low option guaranteed issue, no EOI.

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






	 EMPLOYEE ONLY	 EMPLOYEE + SPOUSE	 EMPLOYEE + CHILD(REN)	 EMPLOYEE + FAMILY
LOW OPTION AND SPECIFIED DISEASES	\$5.76	\$9.60	\$7.38	\$9.60
LOW OPTION AND SPECIFIED DISEASES + ICU RIDER	\$8.76	\$15.78	\$13.56	\$15.78
MEDIUM OPTION AND SPECIFIED DISEASES	\$8.28	\$14.28	\$10.62	\$14.28
MEDIUM AND SPECIFIED DISEASES + ICU RIDER	\$11.28	\$20.46	\$16.80	\$20.46
HIGH OPTION AND SPECIFIED DISEASES	\$9.42	\$17.10	\$12.48	\$17.10
HIGH OPTION AND SPECIFIED DISEASES + ICU RIDER	\$12.42	\$23.28	\$18.66	\$23.28

EOI required.

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

	 EMPLOYEE ONLY	 EMPLOYEE + FAMILY
PERSONAL LEGAL PLAN	\$4.56	\$6.21

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

	 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




**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

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

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

 FROZEN SALARY	 EMPLOYEE ONLY	 EMPLOYEE + FAMILY
Fitness Connection	\$7.50	\$12.50
24-Hour Fitness Inc.	\$17.50	\$27.50
Bally Total Fitness	\$10.00	\$15.00
Pure Fitness	\$10.00	N/A

¡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 2011, conviene que se registre en el periodo de Inscripción Abierta (4 a 15 de noviembre de 2011) 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 2012

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 2011. Tendrá la oportunidad de inscribirse en el programa de beneficios o cambiar su cobertura actual durante el periodo anual de inscripción que generalmente tiene lugar en noviembre. Este es el único periodo 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 2011** que tendrá lugar el viernes, 4 de noviembre, de 9:00 a.m. a 6:00 p.m. y sábado, 5 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 ESTA LISTO A INSCRIBIRSE

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

1. Vaya al Aldine ISD ePortal y entre al sistema.
Si ésta es su primera visita al sitio seleccione *Recursos y Beneficios*, 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 4-15, 2011**

BENEFITS OUTLOOK

Health. Wellness. Life.

Aldine Independent School District does not discriminate against persons because of race, creed, national origin, age, sex, disabilities, economic status or language disability in employment, promotion or educational programming.

Any complaints or grievances that cannot be solved at the campus level through the principal may be submitted in writing to Dr. Archie Blanson, Deputy Superintendent of Schools, 14910 Aldine Westfield Road, Houston, Texas 77032.