FBISD LiveWell for a healthy life!

Employee Benefits Guide

Plan Year|2015

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

Remember the choices you make as a new hire or during the annual enrollment will remain in effect until the next Annual Enrollment period unless you experience a qualifying event. Additional information regarding qualifying events can be found on page 3 of this guide.

The information in this Benefits Guide is intended for illustrative and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage and benefit information. While every effort was taken to accurately report your benefits, discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract, nor are there any expressed or implied guarantees. In the case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have questions about this summary, please contact Benefits Department.

Carrier Contacts

You may contact each of our carriers directly using the information to the right, or email a Fort Bend ISD representative for questions or concerns regarding your benefits.

Whether you need assistance with a claim or simply have a benefits question you may use the email address below or call a Fort Bend ISD representative directly.

In certain situations, it will be necessary for the representative to contact a provider or insurance carrier on your behalf. If your issue cannot be resolved in one email or phone call, you will always be informed of the status until resolution has been reached.

Please contact Fort Bend ISD's Benefits Department at (281) 634-1418 or via email at benefits@fortbendisd.com for matters concerning benefit enrollment transactions. To speak to a benefits specialist (by last name):

A-ED: Cindy Mucka, (281) 634-2810
Cindy.mucka@fortbendisd.com

EE-LAM: Gail Maxwell, (281) 634-1214
Gail.barnesmaxwell@fortbendisd.com

LAN-REY: Janet Singleton, (281) 634-1208
Janet.singleton@fortbendisd.com

REZ-Z: Kimberly Brown, (281) 634-1241
Kimberly.brown@fortbendisd.com

Carrier	Contact Info
Medical United Healthcare Group # 902915	(888) 651-7319 www.myuhc.com
Flexible Spending Accounts United Healthcare	(888) 651-7319 www.myuhc.com
Dental Guardian Group #00470637	(800) 541-7846 – PPO (888) 618-2016 - DHMO www.guardiananytime.com
Vision VSP Group #12017151	(800) 877-7195 www.vsp.com
Life and AD&D Lincoln Financial Group # 10180460	(800) 423-2765 www.lincoln4benefits.com
Voluntary Disability Lincoln Financial Group # 10180463	(800) 423-2765 www.lincoln4benefits.com
COBRA Discovery Benefits	(866) 451-3399 www.discoverybenefits.com
EAP Alliance Work Partners	(800) 343-3822 www.alliancewp.com
Telemedicine Teladoc	(800) 835-2362 www.teladoc.com
Legal Services LegalShield	(800) 654-7757 General Info (800) 458-6982 Legal Service www.legalshield.com
Supplemental Insurance Aflac	(713) 444-2208 www.aflac.com/fortbendisd lisa_bates@us.aflac.com
Teachers Retirement System of Texas	(800) 223-8778 www.trs.state.tx.com
403(b) & 457 Plans JEM Resources	(800) 943-9179 www.jemtpa.com

Eligibility

WHEN YOU ARE ELIGIBLE

All active, full-time employees are eligible for benefits through Fort Bend ISD. For all employees, benefits will be effective on the **first of the month following your start date**. For life and disability coverage, if you are not actively at work on the effective date, your coverage will be delayed until you return to active employment. Once you are eligible for disability, Lincoln Financial will offset for any sick pay that is paid to you.

WHEN CAN YOU ENROLL? *(online enrollment)*

Online enrollment must be completed in My Self Serve **within 30 days of your start date**.

WHEN YOU CAN CHANGE YOUR BENEFITS

The benefit choices you make upon initial enrollment and during our annual enrollment period will remain in place until the next open enrollment, or when you experience a qualifying event. Your benefit change must be consistent with your change in family status. These changes include:

- Marriage, divorce, or legal separation;
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, reaching the dependent age limit;
- Significant changes in employment or employer-sponsored benefit coverage that affect you or your spouse's benefit eligibility.
- Loss of other insurance coverage.

Should one of these events apply to you, it is your responsibility to contact Benefits Department **within 30 days of the qualifying event** to request a change and complete the appropriate documentation.

WHEN YOUR EMPLOYMENT TERMINATES

The life and disability plans end at the end of the month of termination, but you may continue your life plans within 31 days of the last day of employment. Your medical, dental, vision and FSA plans end on the last day of the month in which employment ends. You may continue your medical, dental, vision and medical FSA plan for a limited period of time after termination through Federal COBRA continuation.

DEPENDENT ELIGIBILITY

You may enroll your eligible dependents in the medical, dental, vision and voluntary life and AD&D plans. Your legal dependents include your legal spouse, natural child, adopted child, or a child placed with the Employee for adoption. You may enroll your eligible children in benefits up to the age shown below:

Benefit	Age
Medical	Up to age 26
Dental	Up to age 26
Vision	Up to age 26
Voluntary Life and AD&D	Up to age 26
Teladoc	Up to age 26

REQUIREMENTS TO ADD A DEPENDENT TO THE FBISD BENEFIT PLANS

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

Required Proof Documents

- **Legal Marriage Documents**
  If you are legally married, you must submit a COPY of:
  -Marriage Certificate
- **Common Law Marriage Documents**
  If you are in a common law marriage, you must submit a COPY of:
  -County Certificate from the County where the marriage was recognized or recorded; **OR**
  -If the County does not issue certificates, you can submit a Common Law Marriage Affidavit, plus the supporting documents listed on the affidavit; **AND**
  -Most Recent Federal Tax Return
- **Biological Child Documents**
  To verify the eligibility of a biological child, you must submit a COPY of:
  -Birth Certificate of Biological Child; **OR**
  -Documentation on hospital letterhead indicating the birth date of the child or children under 6 months old
- **Adopted Child Documents**
  To verify the eligibility of an adopted child or a child placed with you for adoption, you must submit a COPY of the following documents. The documents you submit will depend on the current stage of the adoption.
  -Official court or agency placement/guardianship papers for a child placed with you for adoption (initial stage); **OR**
  -Official Court Adoption Agreement for an Adopted Child (mid-stage); **OR**
  -Birth Certificate (final stage)
- **Stepchild Documents**
  To verify the eligibility of your stepchild, you must submit a COPY of:
  -Child's Birth Certificate showing the child's parent is the employee's spouse; **AND**
  -Marriage Certificate showing legal marriage between the employee and the child's parent; **AND**
  -Most Recent Federal Tax Return
- **Grandchild Documents**
  To verify the eligibility of a grandchild, you must submit a COPY of:
  -Most Recent Federal Tax Return; **AND**
  -Official court papers establishing legal guardianship
- **Other Child Documents (Child for whom you are the legal guardian)**
  To verify the eligibility of any other type of child for whom you are the legal guardian, you must submit a COPY of:
  -Court papers demonstrating legal guardianship, including the person named as the legal guardian; **AND**
  -Most Recent Federal Tax Return

ABOUT SUBMITTING TAX RETURNS

Make sure to submit the pages that display all tax dependents, your tax filing status, your address, your signature (and your spouse's, if appropriate), and the filing date. Submit either one joint return or the returns of both spouses, if you filed as "Married, Filing Separately". This is required even if you filed electronically. Make sure to **black out your financial information**. For audit verification, your personal income data is not required. If you have not filed your most recent tax return, submit your prior year's return. **Please Note:** Tax returns will not be used to verify dependent eligibility for the group health plan.

Accessing Your Medical Plan Network

HOW TO FIND A DOCTOR / HOSPITAL IN THE CHOICE PLUS NETWORK FOR THE CHOICE PLUS & CHOICE PLUS HRA:

Use doctors, hospitals, pharmacies, labs, and other providers and facilities in our network to help lower your health care costs. Here are two ways to start your search.

- **Go Online:**

If you are not a registered member

1. Visit welcometouhc.com
2. Select "Find a Doctor" on the left
3. Select **United Healthcare Choice Plus** network
4. On the next screen, enter a doctor name, facility name, specialty or condition. You can even search by distance, gender, language, etc.

If you are a registered member

1. Log in to myuhc.com
2. Select "Find a Doctor or Physicians & Facilities"
3. Select "Find a Provider"
4. On the next screen, enter a doctor name, facility name, specialty or condition. You can even search by distance, gender, language, etc.

HOW TO FIND A DOCTOR / HOSPITAL IN THE CHOICE NETWORK FOR THE CHOICE PREMIUM TIER PLAN:

The UnitedHealth Premium program evaluates doctors in 25 different medical specialties, using national standards for quality and local benchmarks for cost efficiency. With the Choice Premium Tier plan is an open-access plan, members can **only** seek care from an **In-Network** provider. From the list of In-Network providers you will want to choose a Tier 1 provider to see a lower out of pocket expense compared to the Tier 2 providers.

- **Go Online:**

If you are not a registered member

1. Visit welcometouhc.com
2. Select "Find a Doctor" on the left
3. Select **United Healthcare Choice** network
4. On the next screen, enter a doctor name, facility name, specialty or condition. You can even search by distance, gender, etc.
5. Select the "UnitedHealth Premium Tier 1 Providers" to quickly and easily find doctors who have been recognized for providing value.

If you are a registered member

1. Log in to myuhc.com
2. Select "Find a Doctor or Physicians & Facilities"
3. Select "Find a Provider"
4. On the next screen, enter a doctor name, facility name, specialty or condition. You can even search by distance, gender, etc.
5. Select the "UnitedHealth Premium Tier 1 Providers" to quickly and easily find doctors who have been recognized for providing value.

CALL UNITED HEALTHCARE:

You also have the option to call United Healthcare (UHC) to find out if the provider you selected is In-Network at (888) 651-7319.

Medical Plan – Choice Plus

The Choice Plus plan, formerly known as the Open Access Plan, is offered through UHC and utilizes the **Choice Plus network**. When you choose a non-network provider, you will be required to pay any charges above the amount UHC allows for covered services.

Benefit	In-Network	Out-of-Network
Deductible Individual / Family	$1,250 / $2,500	$3,000 / $6,000
Maximum Out-of-Pocket (includes deductible, medical and Rx coinsurance, and medical copays) Individual / Family	$5,000 / $10,000	$7,500 per covered person, per calendar year
Office Visit PCP / Specialist	$35 copay / $45 copay	50% after deductible
Preventive Services	Plan pays 100% (deductible and copays **do not** apply)	50% after deductible
Routine Lab & X-ray In Office Visit Outpatient basis	Plan pays 100% no deductible 20% after deductible	Plan pays 100% no deductible 50% after deductible
Inpatient Hospital	20% after deductible	$500 per admit copay; deductible and coinsurance apply
Urgent Care	$75 copay	
Advanced Imaging (MRI, CAT, PET, etc.)	20% after deductible	50% after deductible
Emergency Room (True Emergency)	$250 copay (waived if admitted); deductible and coinsurance apply	
Mental Health / Substance Abuse	20% after deductible	50% after deductible

Note: For a complete description of benefits see the Summary of Benefits & Coverage or Summary Plan Description.

Plan Rates*	24 pay period contributions	20 pay period contributions
Employee Only	$97.57	$117.08
Employee + Spouse	$322.32	$386.78
Employee + Child(ren)	$274.86	$329.83
Employee + Family	$422.81	$507.37

*Per pay period contributions with biometric screening and health risk assessment.

Medical Plan – Choice Premium Tier

The Choice Premium Tier plan, formerly known as the LocalPlus plan, is offered through UHC and utilizes the **Choice network**. Through this plan, benefits are **ONLY** for In-Network providers. Employees who are not in the area needing emergency services can utilize the out-of-network providers.

Benefit	Tier 1 (In-Network ONLY) Methodist Hospital System Premium Tier 1 Providers	Tier 2 (In-Network ONLY) All Choice Network Providers
Deductible Individual / Family	$750 / $1,500	$1,500 / $3,000
Maximum Out-of-Pocket (includes deductible, medical and Rx coinsurance, and medical copays) Individual / Family	$3,750 / $7,500	$3,750 / $7,500
Office Visit PCP / Specialist	$25 copay / $35 copay	$45 copay / $55 copay
Preventive Services	Plan pays 100% (deductible and copays **do not** apply)	
Routine Lab & X-ray In Office Visit Outpatient basis	Plan pays 100% no deductible 20% after deductible	Plan pays 100% no deductible 20% after deductible
Inpatient Hospital	20% after deductible (Methodist Hospital Only)	$250 per admit copay; deductible and coinsurance apply
Urgent Care	$75 copay	$75 copay
Advanced Imaging (MRI, CAT, PET, etc.)	20% after deductible	20% after Tier 1 deductible
Emergency Room (True Emergency)	$250 copay (waived if admitted); deductible and coinsurance apply	$250 copay (waived if admitted); Tier 1 deductible and coinsurance apply
Mental Health / Substance Abuse (inpatient)	20% after deductible	20% after Tier 1 deductible

Note: This plan provides benefits for in-network providers only, for a complete description of benefits see the Summary of Benefits and Coverage or Summary Plan Description.

Plan Rates*	24 pay period contributions	20 pay period contributions
Employee Only	$84.45	$101.34
Employee + Spouse	$261.46	$313.75
Employee + Child(ren)	$233.33	$279.99
Employee + Family	$345.88	$415.05

*Per pay period contributions with biometric screening and health risk assessment.

Medical Plan – Choice Plus HRA

The Choice Plus HRA plan, formerly known as the Choice Fund HRA plan, is offered through UHC and utilizes the **Choice Plus network**. When you choose a non-network provider, you will be required to pay any charges above the amount UHC allows for covered services.

Benefit	In-Network	Out-of-Network
Health Reimbursement Account (HRA) Individual / Family	**Amount District contributes to your account:** $500 / $1,000	
Deductible Individual / Family	$2,000 / $4,000	$4,000 / $8,000
Maximum Out-of-Pocket (includes deductible and medical and Rx coinsurance) Individual / Family	$6,000 / $12,000	$11,000 per covered person, per calendar year
Physician Office Visit	30% after deductible	50% after deductible
Preventive Services	Plan pays 100% (deductible and copays **do not** apply)	50% after deductible
Routine Lab & X-ray	30% after deductible	50% after deductible
Inpatient Hospital	30% after deductible	50% after deductible
Urgent Care	30% after deductible	50% after deductible
Advanced Imaging (MRI, CAT, PET, etc.)	30% after deductible	50% after deductible
Emergency Room (True Emergency)	30% after deductible	
Mental Health / Substance Abuse	30% after deductible	50% after deductible

Note: For a complete description of benefits see the Summary of Benefits & Coverage or Summary Plan Description.

Plan Rates*	24 pay period contributions	20 pay period contributions
Employee Only	$44.10	$52.92
Employee + Spouse	$149.35	$179.22
Employee + Child(ren)	$113.40	$136.08
Employee + Family	$190.60	$228.72

*Per pay period contributions with biometric screening and health risk assessment.

Prescription Drug Plan

The Prescription Drug plan is offered through UHC. You are automatically enrolled in the prescriptions drug program when you enroll in one of the Fort Bend ISD medical plans. The prescription drug program provides both retail and mail order pharmacy services.

Below is a table showing the applicable copay by tier for a 30 day supply:

Retail Benefit (% of drug cost)	
Tier 1	30%
Tier 2	40%
Tier 3	50%

With retail benefits, you can obtain up to a 31-day supply at any participating pharmacy in the UHC National Pharmacy Network. Pharmacies include: Walgreens, Rite Aid, Walmart, Target, Duane Reade, Medicine Shoppe, Ralphs, Kroger, Meijer, Shopko, CVS, & HEB.

Below is a table showing the applicable copayments by tier when using mail order for a 90 day supply:

Mail Order Benefit* (% of drug cost)	
Tier 1	25%
Tier 2	35%
Tier 3	45%

*Mail order prescriptions have a maximum per 90-day supply of $150.

You can order routine medications through OptumRx Mail Service Pharmacy. With this feature, you can receive up to a 90-day supply. This is an easy way to pay less for precriptions you use on a routine basis, such as allergy or blood pressure medications. If you have any trouble please contact UHC at: **(888) 651-7319.**

Tier 4 – Specialty Medications*	Limited to 30-day at home delivery, at 45% coinsurance with a maximum of $50

*You must order specialty medications directly through OptumRx Specialty Pharmacy. Call toll-free at **(800) 651-7319**.

Note: if you choose a brand-name prescription when a generic prescription is available, you will be responsible for paying the difference between the brand-name and the generic prescription plus the applicable coinsurance.

Prescription Step Therapy Program

Step Therapy is a program designed especially for people who take prescription drugs regularly to treat ongoing medical conditions. The program makes prescription drugs more affordable for most members and helps Fort Bend ISD control the rising cost of medications. It allows you and your family to receive the affordable treatment you need and helps Fort Bend ISD to continue to provide employees prescription drug coverage. If you are taking a "grandfathered" medication, these step therapies do not apply to you in regards to that medication as long as you continue to take it regularly.

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

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

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

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

WHAT HAPPENS AT THE PHARMACY?

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

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

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

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

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

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

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

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

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

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

If one of these situations applies to you, you and or your doctor have the right to request an appeal of that decision by contacting UHC at: **(800) 651-7319**.

Health Flexible Spending Account (FSA)

**** NOT eligible if you or your spouse contribute to an HSA ****

Fort Bend ISD's Flexible Spending Account is administered by UHC. Your FSA contributions, deducted on a pre-tax basis, may be used to pay for qualified health care expenses.

For the 2015 plan year, you may elect up to $2,500 for your Health FSA. For more information, please visit the IRS website at: http://www.irs.gov/publications/p969/ar02.html#en_US_publink100038864.

A Health FSA allows you to set aside tax-free dollars into an account that will reimburse you for out-of-pocket qualified medical expenses "incurred" during the plan year (1/1/15 – 12/31/15). The term "incurred" means that the service must be performed during the plan year. Eligible expenses may be incurred by you, your spouse, or your eligible dependent child(ren). Reimbursements received from your Health FSA are tax-free. In addition, you can use your debit card to pay for qualified expenses directly from your reimbursement account.

Examples of eligible expenses include deductibles, copays, lasik eye surgery, prescription drugs, and orthodontia. **Over-the-counter medications, with the exception of insulin, will require a prescription to be considered a qualified medical expense for reimbursement from your FSA.**

See IRS Code Section 213(d) or 502 for a list of eligible expenses. The expenses must be for "medical care" and be for the diagnosis, care, mitigation, treatment or prevention of a disease, or for the purpose of affecting any structure or function of the body.

Use-it-or-lose-it and Filing Deadline

If you have unused contributions in your Health FSA at the end of the current plan year you can continue to incur expenses during the first 2.5 months immediately following the end of the plan year, and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through March 31. After March 31, funds remaining in your account for current plan year will be forfeited.

Health FSA - Claims must be **received** by UHC's FSA department within 90 days of the end of the plan year. If your employment terminates during the year your claims must be incurred prior to the end of the month in which your termination occurs, your request for reimbursement must be received by UHC's FSA department within 90 days of the end of the plan year.

Debit Card

Your FSA debit card allows you to quickly and conveniently access funds in your FSA for health care expenses. You may use it to pay for eligible expenses at the time of service and at locations that accept it.

IMPORTANT NOTE: If you are enrolled in the Choice Fund Plan HRA, you must exhaust the funds in your Health Reimbursement Account (HRA) before you can use your FSA funds for medical expenses. You will not be able to use your FSA debit card for medical expenses if you are enrolled in the Choice Fund Plan HRA. You must pay out-of-pocket for medical expenses and seek reimbursement from the FSA by submitting a claim form and your receipts.

Keep copies of ALL of your receipts and explanation of benefits worksheets for eligible transactions. UHC will most likely ask you for this documentation. The only reason UHC will not ask for documentation is if the amount swiped on your debit card is equal to a copay or deductible in Fort Bend ISD's medical plans. You are required to provide receipts during an IRS audit.

Dependent Care Flexible Spending Account

The Dependent Care FSA allows you to save taxes on up to $5,000 in "qualified" day care expenses every year. **Dependent Care FSAs reimburse only up to the account balance on the date your claim is received.** Claims exceeding the balance are reimbursed when there is enough in the account to cover them.

Under Code Section 21(b)(1) "qualifying individual" means a dependent of the taxpayer as defined in Code Section 152(a)(1) (i.e., a qualifying child) who has not attained age 13; a dependent of the taxpayer who is physically or mentally incapable of caring for himself or herself and has the same principal abode as the taxpayer for more than half of the year.

Qualified day care expenses include:

- Care provided while both parents are working or looking for work
- Care that has been provided during the plan year (1/1/15 – 12/31/15)
- Actual day care expenses (separate fees for services such as transportation, meals, classes, lessons, trips or supplies are not reimbursable unless the charges are included as part of your base fee – not itemized)
- Day camps, including those that focus on specific activities, such as sports and arts (overnight camps are excluded even if the camp apportions the day camp and overnight charges)
- Day care providers tax ID or individual's social security number must be provided

Sample of ineligible expenses include:

- Child care provided by your tax dependent or your child under age 19
- Overnight camps and tuition for kindergarten
- Childcare when one parent is not working or looking for work

Use-it-or-lose-it and Filing Deadline

If you have unused contributions in your Dependent Care FSA at the end of the current plan year you can continue to incur expenses during the first 2.5 months immediately following the end of the plan year, and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through March 31. After March 31, funds remaining in your account for current plan year will be forfeited.

Dependent Care FSA - Claims must be **received** by UHC's FSA department within 90 days of the end of the plan year.

Debit Card

Your FSA debit card allows you to quickly and conveniently access funds in your FSA for dependent care expenses. You may use it to pay for eligible dependent care expenses at the time of service and at locations that accept it.

Keep copies of ALL of your receipts and explanation of benefits worksheets for eligible transactions. UHC will most likely ask you for this documentation. The only reason UHC will not ask for documentation is if the amount swiped on your debit card is equal to a copay or deductible in Fort Bend ISD's medical plans. You are required to provide receipts during an IRS audit.

Flexible Spending Account Example

HOW A FLEXIBLE SPENDING ACCOUNT CAN SAVE YOU MONEY

Bob and Jane's combined gross income is $30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend $2,000 in adult orthodontia and $3,300 for day care next plan year, they decide to direct a total of $5,300 into their FSAs.

	Without FSAs	With FSAs
Gross income:	$30,000	$30,000
FSA contributions:	0	-5,300
Gross income:	30,000	24,700
Federal Taxes*	4,500*	3,705*
FICA Taxes*	-2,295	-1,890
After-tax earnings:	23,205	19,105
Medical and dependent care expenses:	-5,300	0
Remaining spendable income:	$17,905	$19,105
Spendable income increase:		$1,200

*Assumes 15% Federal Income Tax and 7.65% FICA. The example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice.

Dental Plan: PPO

Your Dental coverage is provided through Guardian. The dental plan options include the **Value Plan** and the **Network Access Plan (NAP)**. You have the freedom to visit the dentist of your choice; however, the plan benefits work differently should you decide to go outside of the network.

With the **Value Plan** DPPO, you must see an in-network dentist. However, you have lower out-of-pocket costs for Basic and Major dental services than you would with the NAP Plan option. If you already see an in-network dentist or if you are willing to change to an in-network dentist, the Value Plan is a good option to save money on dental expenses. Some benefits are available for out-of-network services, but these benefits will be offered at a significant reduction.

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

To locate In-Network providers visit www.guardiananytime.com click on "Find a Provider" at the very top of your screen. Then click on the box that says "Find a Dentist", under "Select your Dental Plan" choose PPO. Then fill in the applicable blanks and select **DentalGuard Preferred** under "Select Your Dental Network". You can also call the customer service line at 1-800-541-7846.

In-Network Benefit	Value Plan	NAP Plan
Calendar Year Maximum Per Person	$2,000	$2,000
Annual Deductible Individual / Family Maximum	$50 / $150	$50 / $150
Frequency Cleanings	Twice per calendar year (Jan. 1 – Dec. 31)	
Class A - Preventive and Diagnostic Care Prophylaxis, Oral exam, Sealants, Diagnostic Casts, Radiographs	0% no deductible applies	0% no deductible applies
Class B - Basic Services Endodontic, Periodontal, Space Maintainers, Surgical Extractions	0%	20%
Class C - Major Services Crown, Inlay, Dentures, Bridge	40%	50%
Class D – Orthodontia* Child (less than age 19)	50%	50%

* For NAP and Value Plan, Lifetime Payment Limit of $2,000 for orthodontic treatment.

Dental Plan: DHMO

With your DHMO plan, you enjoy negotiated discounts from in-network dentists. Out-of-network visits are not covered. You must designate and use a participating provider. You pay a fixed copay for each covered service. There are no deductibles or plan maximums. Under the DHMO Dental Plan, should your treatment plan require the services of a specialist, you will be referred to one. **Please note that there is no coverage available outside of Texas.**

To locate In-Network providers visit www.guardiananytime.com click on "Find a Provider" at the very top of your screen. Then click on the box that says "Find a Dentist", under "Select your Dental Plan" choose DHMO. Then fill in the applicable blanks and select **Managed Dental Guard** under "Select Your Dental Network". You can also call the customer service line at 1-888-618-2016.

DHMO Benefits
When using a participating dentist, the amount you will be responsible for paying is the applicable copay associated with the type of service you receive. See the certificate of coverage for a list of copay amounts. **Cleaning Frequency:** Twice per calendar year (Jan. 1 – Dec. 31)

DENTAL RATES PER PLAN

Dental PPO Plans (Network Access & Value Plans)		
	24 pay periods	**20 pay periods**
Employee Only	$20.65	$24.78
Employee + 1	$41.29	$49.55
Employee + Family	$61.93	$74.32

Dental HMO Plan		
	24 pay periods	**20 pay periods**
Employee Only	$4.90	$5.88
Employee + 1	$8.15	$9.77
Employee + Family	$15.17	$18.20

Voluntary Vision Plan

Your Vision coverage is provided through Vision Service Plan (VSP). VSP offers benefits through a national network of eye specialists and national and regional optical chains. You may receive care and services from providers outside of the VSP network, but at a reduced level of benefit. To locate an In-Network provider visit www.vsp.com or call (800) 877-7195.

Benefit	In-Network	Out-of-Network
Exam	$20 copay	
Materials	$20 copay	
Exam Frequency	1 every calendar year	
Frame Frequency	1 every calendar year	
Contact Lens Exam Frequency (in lieu of lenses & frames)	1 every calendar year	
Lenses		**Member Reimbursed:**
Single Vision	Covered in Full*	Up to $50
Bifocal	Covered in Full*	Up to $75
Trifocal	Covered in Full*	Up to $100
Frames		
Frame Allowance	$130 allowance*	Up to $70
Contact Lenses		
Medically Necessary	100%	Up to $210
Elective	$130 allowance*	Up to $105

*These benefits are subject to copay, if any.

Vision Rates		
	24 pay periods	**20 pay periods**
Employee Only	$5.20	$6.24
Employee + 1	$8.33	$9.99
Employee + Children	$9.00	$10.80
Employee + Family	$13.70	$16.44

Life Insurance

Fort Bend ISD provides each eligible employee with Basic Life and Accidental Death & Dismemberment (AD&D) insurance through Lincoln Financial Group. This plan is paid 100% by Fort Bend ISD and is no cost to you.

Basic Life / AD&D	
Benefit Amount	$25,000
Age Reduction	50% at age 70
Accelerated Death Benefit	75% of benefit amount

Voluntary Life and AD&D

You have the option to purchase Voluntary Life and AD&D coverage for yourself and your dependents through Lincoln Financial Group. You must elect Voluntary Life and AD&D coverage for yourself in order to purchase Life on your eligible dependents. **Voluntary Life and AD&D is combined and is not offered separately.** As a new hire, any amount selected over the guarantee issue amount will require an Evidence of Insurability Form to be completed. You pay the full cost of this benefit.

Benefit Amount Maximum (could be subject to medical questions – see Guarantee Issue below for new hires and certificate of coverage for plan provisions)	**Employee**	$10,000 increments to the lesser of 5 x annual salary or $500,000
	Spouse	$10,000 increments to 100% of the Employee Amount not to exceed $250,000
	Child(ren)	Dependent child age 1 to 14 days $100; 14 days to 6 months $1,000; 6 months to 26 years $10,000
Guarantee Issue*	**Employee**	$250,000
	Spouse	$30,000
	Child(ren)	$10,000
Age Reduction	50% at age 70	
Accelerated Death Benefit	75% of benefit amount up to $250,000	
Late Entrant Penalty	All amounts will require the submission of an Evidence of Insurability form. Coverage will not become effective until and unless approved by Lincoln Financial Group.	

Monthly Voluntary Life and AD&D Rates (per $1,000)

Age	Employee Rate	Spouse Rate*
<25	$0.035	$0.090
25 – 29	$0.038	$0.077
30 – 34	$0.043	$0.079
35 – 39	$0.064	$0.099
40 – 44	$0.093	$0.143
45 – 49	$0.150	$0.227
50 – 54	$0.230	$0.357
55 – 59	$0.350	$0.551
60 – 64	$0.496	$0.973
65 – 69	$0.839	$1.651
70 – 74	$1.490	$3.039
75 +	$3.030	$5.898
AD&D Rate	$0.028	$0.030

*spouse rate based on employee age

Child Rate: $2.70 per family unit	AD&D: $0.035

*Voluntary life and AD&D insurance is guaranteed at initial enrollment (new hire) only.

Calculation Examples:

36 year old employee purchasing $200,000 in Life and AD&D insurance:

Life: 200,000 ÷ 1,000 x $0.064 = **$12.80**

AD&D: 200,000 ÷ 1,000 x $0.028 = **$5.60**

Total: $18.40 per month

53 year old employee purchasing $20,000 in Life and AD&D insurance:

Life: 20,000 ÷ 1,000 x $0.23 = **$4.60**

AD&D: 20,000 ÷ 1,000 x $0.028 = **$0.56**

Total: $5.16 per month

Voluntary Disability Insurance

Fort Bend ISD provides each eligible employee the option to select voluntary disability plans through Lincoln Financial Group. Disability insurance is designed to help supplement your income when you are unable to work because of an accident or illness that is not work related. You are responsible for the cost of this coverage.

Voluntary Disability Benefit	
Definition of Disability	Prevented from performing one or more of the Main Duties of: 1) Your Occupation during the Elimination Period; 2) Any Gainful Occupation, following the Elimination Period.
Elimination Period	Option 1: 14 days injury or sickness Option 2: 90 days injury or sickness
Base Benefit	66.67% of covered monthly earnings (per $100 of monthly salary)
This means after 14 or 90 days of disability, Lincoln will pay you 66.67% of your monthly earnings (per $100 of monthly salary) up to the max shown below. Once you are eligible for disability, Lincoln Financial will offset for any sick pay that is paid to you.	
Maximum Weekly Benefit (before week 26)	$1,730 per week
Maximum Monthly Benefit (after week 26)	$7,500 per month
Limitations Pre-Existing Conditions Mental Illness, Substance Abuse & Self-Reported	3 / 12 (any condition that was diagnosed or treated within the last 3 months prior to eligibility under the policy will not be covered for 12 months under this disability plan). Up to 24 months of coverage combined.

Your disability benefit may be reduced by other income benefits. See certificate of coverage for details.

Voluntary Disability Monthly Rates (per $100)		
	24 Pay Periods	**20 Pay Periods**
Option 1 – 14 day Elimination Period	$1.084	$1.300
Option 2 – 90 day Elimination Period	$1.010	$1.212

Age at Disability	Maximum Benefit Duration
<60	To age 65, but not less than 60 months
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

Employee Assistance Program (EAP)

Fort Bend ISD provides employees and their family access to an employee assistance program through Alliance Work Partners. This program is paid for by Fort Bend ISD and many of the services such as the face to face counseling sessions and phone consultations for legal and financial will not cost you anything.

What Is An EAP?	An EAP offers confidential services to you and your family at no cost to you. Dependents and partners residing in the employee's household are covered.
Counseling Sessions Offered At No Cost To You	Up to 6 face to face counseling sessions per problem per year. This service can successfully help you manage life's challenges. Some of the issues that can be addressed through an EAP are stress management, depression, family issues, workplace issues, alcohol & drug abuse.
Other Services That Are Offered	Legal Services, Financial Services & Worklife Services. 3 free phone consultations for legal and financial services.
Can I Obtain Materials Regarding the Program?	Yes, please see the Alliance Work Partners brochure or obtain material at www.alliancewp.com.

To obtain information or to utilize the program call the 24 hr. helpline & Crisis hotline: **1-800-343-3822**

For the Teen line contact **800-334-8336**

Send an email to **EAP@alliancewp.com**

Online services are available to you at www.alliancewp.com

Effective 1/1/2015

awp

A wap Program

Telemedicine Service

Fort Bend ISD is providing you and your eligible dependents with an added medical benefit. Teladoc allows you to talk to a doctor anytime, anywhere by phone consult. It's an affordable, convenient option for treating many medical conditions. You are responsible for a $40 copay per consultation.

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & Flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Set up your account BEFORE USING THE SERVICES

1. Visit the Teladoc website and click "Set up account".
2. Select "No" when asked for a username. Then provide your name and date of birth.
3. Follow the directions online to complete account setup and to provide your medical history.

Request a consult

Once your account is set up, a doctor is always just a call or click away.

1. Visit the Teladoc website and click "Request a consult".
2. Select the type of consult you want.
3. Talk to a doctor within an hour.

Effective 1/1/2015 talk to a doctor for $40

www.Teladoc.com | 1-800-835-2362

Voluntary Legal Services

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

- **Unlimited Toll-free Phone Consultations**

  With a Provider Law Firm for personal and business questions.

- **Phone Calls and Letters**

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

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

  For you and your covered family members.

- **Motor Vehicle Legal Service Expense Benefits**

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

  Eligibility begins 15 days after effective date.

- **Trial Defense Benefit**

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

- **IRS Audit Protection Service**

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

- **Discounted Legal Services**

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

LegalShield Rates		
	24 pay periods	**20 pay periods**
Employee Only	$8.50	$10.20

LegalShield℠
Total access. Total freedom.

AFLAC Supplemental Plans

ACCIDENT

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

SICKNESS AND HOSPITAL INDEMNITY

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

CANCER

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

CRITICAL ILLNESS

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

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

Think you are completely covered by your major medical plan?

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

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

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

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

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

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

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

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

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

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

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

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

** Benefits may not be available in all states.

Teachers Retirement System of TX (TRS)

The TRS retirement plan serves a vital role to nearly 1.2 million active and retired state educators and their families by providing service and disability retirement benefits, and death benefits. TRS is one of the largest retirement systems in the nation. The system's core mission is to deliver retirement and related member benefits authorized by the Texas Legislature and to manage the trust fund that finances those benefits. As an employee of FBISD you are automatically enrolled into this Retirement Plan. As a member you will contribute **7.2**% of eligible wages to your account each pay period and the State will contribute 6% for retirement benefits. The member's contribution is made on a pre-tax basis. Please visit the TRS web site for additional information at **www.trs.state.tx.com** or contact them at **(800) 223-8778**.

OPTIONAL RETIREMENT SAVINGS PLANS:

403(b) Tax-Deferred Annuities

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

EMPLOYEE SAVINGS PLAN 457:

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

ADVANTAGES OF 403(b) AND 457 PLANS:

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

The 403(b) and 457 plans are provided through JEM Resources. To setup or make changes to these accounts, you can contact JEM Resources directly at 1-800-943-9179 or visit them on the web at **www.jemtpa.com**.

2015 Employee Contributions

	24 PAY-PERIODS	20 PAY-PERIODS
Medical – Choice Plus		
Employee Only	$97.57	$117.08
Employee + Spouse	$322.32	$386.78
Employee + Child(ren)	$274.86	$329.83
Employee + Family	$422.81	$507.37
Medical – Choice Premium Tier		
Employee Only	$84.45	$101.34
Employee + Spouse	$261.46	$313.75
Employee + Child(ren)	$233.33	$279.99
Employee + Family	$345.88	$415.05
Medical – Choice Plus HRA		
Employee Only	$44.10	$52.92
Employee + Spouse	$149.35	$179.22
Employee + Child(ren)	$113.40	$136.08
Employee + Family	$190.60	$228.72
Dental – PPO Network Access Plan & Value Plan		
Employee Only	$20.65	$24.78
Employee + 1	$41.29	$49.55
Employee + Family	$61.93	$74.32
Dental - HMO		
Employee Only	$4.90	$5.88
Employee + 1	$8.15	$9.77
Employee + Family	$15.17	$18.20
Vision		
Employee Only	$5.20	$6.24
Employee + 1	$8.33	$9.99
Employee + Children	$9.00	$10.80
Employee + Family	$13.70	$16.44
LegalShield		
Employee Only	$8.50	$10.20

***Actual cost may vary due to rounding. Medical premium amounts assume timely completion of employee and spouse biometric screenings and health risk assessments. All premium amounts are subject to change.**

Terms You Should Know

Coinsurance: The money that an individual is required to pay for services, after a deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20 percent of the contracted rate while the health plan pays 80 percent.

Copayments: An arrangement where an individual pays a specified amount for various health care services and the health plan pays the remainder. The individual must usually pay his or her share when services are rendered. The concept is similar to coinsurance, except that copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.

Deductible: The annual amount of medical expenses that an individual is responsible to pay for certain services. Deductibles are reset on an annual basis.

Flexible Spending Accounts (FSA): This is an account in an employee's name that can reimburse the employee for qualified health care or dependent care expenses. It essentially allows an employee to pre-fund those qualified expenses with pre-tax dollars deducted from the employee's paychecks. The employee can receive cash reimbursement for covered expenses, up to the total value of the account, but majority of funds are only usable during the benefit plan year.

In Network: Refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

Out-of-Network: Refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

Out-of-Pocket Maximum: The maximum amount a member can pay each year for the deductible and coinsurance, and medical copays. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services during the remainder of the calendar year.

FBISD LiveWell for a healthy life!

The information in this Benefits Guide is intended for illustrative and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage and benefit information. While every effort was taken to accurately report your benefits, discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract, nor are there any expressed or implied guarantees. In the case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have questions about this summary, please contact Benefits Department.

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