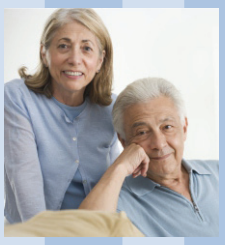
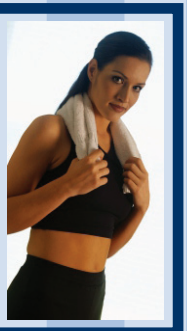




VALLEY SCHOOLS

Valley Schools

Employee Benefits Trust

Employee Benefits Guide 2011-2012

About the Valley Schools Employee Benefits Trust

The Valley Schools Employee Benefits Trust (VSEBT) provides health, dental, life, short-term disability, vision, COBRA and other employee benefits to its members. VSEBT purchases these benefits as a group, but offers member Districts the flexibility to provide different benefits to their employees. Member entities (e.g., school districts) pay their premiums to VSEBT and then VSEBT pays our benefit vendors.

VSEBT is managed by the Valley Schools Management Group (VSMG), a non-profit, governmental entity formed in accordance with Arizona Revised Statutes Title 11, Sections 951, 952, 952.01, and 953 and in accordance with Arizona Department of Education Rule R7-2-1002A. VSMG exists to serve government entities wishing to purchase services on a cooperative basis. Underneath the VSMG umbrella are several pools and trusts, for a variety of needs such as workers' compensation, liability insurance, and employee benefits. VSMG acts as procurement, administration, accounting, and investor for our member governments.

How VSEBT Works

By joining VSEBT, your District is able to take advantage of our group purchasing power. We have over 32,000 members and pass on the discounts from our preferred providers to you.

Currently, VSEBT receives over $150 million in annual premiums. We invest those payments, the result is interest income to the district. Investments are made according to state law and do not involve equities or risky investments. Interest from our investments is specifically accounted by member entity and can be used to offset benefit costs in future years.

VSEBT employs full time staff to follow-up on management review and medical utilization information. We have a dedicated full-time representative from UnitedHealthcare, and professional financial and program staff. In addition, we offer a wide-array of wellness programs and other specialized services to member districts.

The bottom line: We work for you.
We are a non-profit government instrumentality and only exist to save our member districts money, provide them with excellent services, and help you – our member district's employees.

This ***Benefits Guide*** describes your benefit options and their costs for 2011/12. It also outlines the steps you need to take to select and enroll in the appropriate coverage. Review the Guide carefully and feel free to contact your benefits representative if you have questions.

The benefits described in this booklet are effective from July 1, 2011 through June 30, 2012.

Table of Contents

Enrollment Eligibility 2
- Who is Eligible? 2
- When Are Changes Allowed . . . 2-3

What's New for 2011/12 3

An Overview of Your Benefits 4
- Annual Benefit Contribution. 4
- Medical 4
  - The Choice Plus Plan. 4
  - The Health Savings Account Plans. 5
  - HSA Plan Specifics 6
  - Comparison of Medical Benefits. 7
- Voluntary Dental - Core Plan 8
- Voluntary Dental - Premier Premium Plan. 9
- Voluntary Vision 10
- Basic Life Insurance. 10
- Voluntary Life Insurance 10
- Voluntary Short-Term Disability. 11
- Long Term Care Insurance 11
- Flexible Spending Accounts 12-13

Completing Your Enrollment . 14

Contact Information 15

2011-2012 Benefits Costs . . . 16-18

Important Notices 19

Who is Eligible?

Employees are eligible to participate in the District's benefit plans as of the **first of the month after 60 days of active employment** at 30 or more hours per week or on contract at 75% or more. As a special exception, Job Share partners receive half of the District contribution towards their elected medical plan. Employees who work 20 hours or more are eligible for voluntary benefits.

Benefit eligible employees can also extend medical, voluntary dental, voluntary vision, long term care insurance and voluntary life insurance coverage, to their eligible dependents. Eligible dependents are generally defined as:

- Your legal spouse
- Your or your spouse's dependent child(ren) under age 26. A dependent child includes your:
  - Natural child
  - Stepchild
  - Legally adopted child
  - Child placed for adoption
  - Child for whom you have legal guardianship
  - Child for whom health care coverage is required through a 'Qualified Medical Child Support Order'
  - Unmarried child of any age with a mental retardation or physical handicap who is incapable of self-sustaining employment as a result of that handicap. However, to be eligible for coverage, your child must have been covered by the District's or another medical insurance plan at the time he or she became disabled. Proof of the child's disability is required.

If you have questions, contact the Benefits Department to verify your dependents' eligibility. You may be asked to provide proof in support of your dependents' eligibility.

When Are Changes Allowed?

Benefit plans are administered on a "policy year basis" – from July 1 through June 30 of each year. Thus, the elections you make during annual Open Enrollment are effective from July 1, 2011 through June 30, 2012.

Because some of the benefits you elect are offered on a pre-tax basis, the Internal Revenue Service (IRS) does not allow changes to these benefit elections outside of the annual Open Enrollment period unless you have a qualified mid-year "change in status event," such as:

- An employee's marriage or divorce
- The birth or adoption of an employee's child
- The death of an employee's spouse or child
- Change in the employee/spouse/dependent's employment status, work schedule or residence that affects their eligibility for benefit coverage
- Coverage of a child due to a Qualified Medical Child Support Order (QMSCO)
- Entitlement or loss of entitlement to Medicare or Medicaid
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan
- Changes consistent with Special Enrollment rights and FMLA leaves

You need to notify your benefits representative within 31 days of a qualified life status change to request corresponding changes to your benefits.

When Are Changes Allowed? (Continued)

Changes Allowed under the Children's Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 creates a new special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes.

Under this Act, group health plans must permit employees and dependents who are eligible for group health plan coverage to enroll in the plan if they:

- Lose eligibility for Medicaid or SCHIP coverage, OR
- Become eligible to participate in a premium assistance program under Medicaid or SCHIP

In both cases, you must request special enrollment within 60 days (of the loss of Medicaid/SCHIP or of the eligibility determination), or wait until the plan's next annual enrollment period to make a change.

Contact your benefits representative if you have questions.

WHATS NEW FOR 2011/12

Open Enrollment is your opportunity to change your benefit elections, it is also the District's opportunity to introduce changes to our benefit programs. As of July 1, 2011, the following changes take effect:

Dependent Coverage

- Young adults will be able to stay on their parent's health plans until the age of 26 unless they have other coverage regardless of marital status.

Dental Coverage

- Dental will be offered as a voluntary benefit only.
- The District now offers two dental plans.
    - Core Plan - No orthodontics coverage.
    - Premier Premium Plan - Offers orthodontics coverage.

Choice Plus PPO Plan

- Employee premium costs for the Choice Plus PPO will be $7,545 effective July 1, 2011.
- The plan year deductible increased to $1,000 for individual and $2,000 for the family.
- Preventative Services are covered at 100%.
- No co-pay will apply.

Long Term Care

- The District now offers Long Term Care insurance
    - Employer paid base plan is offered to all benefit eligible employees (30 hours plus per week) and job share employees (20 hours per week).
    - All benefit eligible employees may elect to purchase additional coverage.
    - Part-time employees may elect to purchase long term care coverage.
    - Spouses and family members of eligible employees may elect to purchase coverage at the districts group rates.

Health Savings Account Plans

- Employees who begin or continue coverage in 2011/12 will receive two deposits a year. The first deposit will be made in August and the second in January.
- The HSA 1300 plan is now HSA 1400 plan.
    - The plan year deductible is $1,400 for an individual and $2,800 for family.
    - Dental coverage is no longer included, however, coverage is offered as a voluntary benefit.
- The HSA 2550 plan is now HSA 2600 plan.
    - The plan year deductible is $2,600 for an individual and $5,200 for family.
    - Dental Coverage is offered as a voluntary benefit.
- The HSA 2600 Plan includes an embedded deductible. *"Embedded" means individual deductibles are active within the larger, overall family deductible and can determine when coverage begins. Some services, such as preventative care, could be covered by plan benefits prior to the individual or family deductible being reached. When a family member on the plan meets his or her individual deductible, plan benefits and coinsurance will apply to his or her claims. If the family deductible amount is met before a member reaches his or her individual deductible, benefits and coinsurance will also apply but will do so for the entire family. Embedded deductible applies to the 2600 plan only.*

AN OVERVIEW OF YOUR BENEFITS

Annual Benefit Contribution

Your District provides an annual benefit contribution, which eligible employees use to offset their benefits costs each year. The 2011/12 contribution amount for eligible Chandler Unified School District employees is $4,752.00.

Medical - UnitedHealthcare Group Number 709724

You may choose from the following two different types of medical plans provided through UnitedHealthcare:

Your medical plan options are described in more detail on the following pages. The medical plan premiums are listed on page 16.

Choice Plus PPO Plan

With the Choice Plus plan, you have the choice of receiving care from a UnitedHealthcare network provider or an out-of-network provider.

You receive a higher level of coverage (meaning, the plan pays a larger portion of the cost for the service) when you visit a UnitedHealthcare network provider than when you visit an out-of-network provider.

Health Savings Account Plans (HSAs)

The District offers two Health Savings Account plan options: the HSA-1400 plan or the HSA-2600 plan. The HSA plans combine a high-deductible PPO plan with a tax-advantaged health savings account that helps you pay for eligible medical expenses.

You may visit any provider; however, you receive a higher level of coverage when you visit UnitedHealthcare network provider. In-network preventive care is covered at 100%.

The Choice Plus Medical Plan

When you enroll in the Choice Plus plan you may visit any provider, including a specialist, without a referral. You can expect the highest level of benefits when you use a UnitedHealthcare network provider versus an out-of-network provider.

Plan Year Deductible and Copayments

You pay a set **copayment** for some in-network services, such as doctor's office visits ($25 per visit), and specialist's visits ($35 per visit). No copay for preventative care visits. Your copayments do not count toward satisfaction of the plan year deductible.

You also pay for most services covered through "coinsurance" in full, until meeting the plan year deductible. The plan year deductible for in-network services is $1,000 per individual and $2,000 per family. For out-of-network services, the deductible is $2,000 per individual and $4,000 per family.

Plan Benefits Coverage (Coinsurance)

Once you meet the deductible, the plan's coinsurance benefits kick in. Coinsurance is the percentage of eligible expenses that you and the plan share when you receive care.

The plan pays 80% and you pay 20% for in-network services subject to coinsurance. When you seek care out-of-network, UnitedHealthcare pays 50% of eligible expenses and you pay the balance.

You are responsible for your share of coinsurance until reaching the **plan year "out-of-pocket maximum**."

Plan Year Out-of-Pocket Maximum

The plan year out-of-pocket maximum is the most you will pay for services covered through coinsurance during the plan year. When you reach the maximum, the plan pays 100% for eligible coinsurance expenses.

The out-of-pocket maximum for in-network services is $2,000 per individual and $4,000 per family. It's $6,000 per individual and $12,000 per family for out-of-network services.

The out-of-pocket maximum **does not** include the amounts you pay for copayments or your deductible. In addition, your share of coinsurance for **out-of-network services** in excess of UnitedHealthcare's allowable charges for a service **does not count** toward the out-of- pocket maximum. When you seek out-of-network care, be sure to discuss your possible share of the costs with your non-network provider and UnitedHealthcare before you receive care.

Choice Plus Prescription Drug Coverage

Under the Choice Plus plan, you may fill your prescriptions through any pharmacy. However, you'll pay less out of your pocket when you use a participating retail pharmacy or the Medco Health home delivery network (available online through **www.myuhc.com**).

Prescription drugs are covered under a "three-tier" schedule. A list of drugs found within each "tier" is available through the UnitedHealthcare Web site – **www.myuhc.com**. You must meet the plan's $100 prescription drug deductible per person per plan year, not to exceed $300 for all covered persons in family before coverage is provided.

Free Advice - Care24

Available with Choice Plus and HSA Plans

When you enroll in one of the District's medical plans, you will have access to UnitedHealthcare's 24-hour referral service, called "Care24." Care24 is staffed with registered nurses and master's level counselors who can help with almost any problem ranging from medical and family matters to personal, legal, financial, and emotional issues.

Care24 is confidential and provided at no additional cost to medical plan participants (employees and dependents). Call 1-888-887-4114 to access Care24.

To find a UnitedHealthcare network doctor, pharmacy, or facility (such as a hospital), refer to the online provider directory, available through www.myuhc.com, and follow the directions to locate a provider either by geography or name.

You do not need to be a registered member to access the provider directory.

The Health Savings Account Plans

The Health Savings Account plan options (the "HSA" plans) combine a high-deductible preferred provider plan with a tax-advantaged account that helps you pay for eligible medical expenses. The District pays for the cost of the employee's premiums and in addition, contributes funds to your HSA.

You can choose from two HSA plan options provided through UnitedHealthcare:

- The HSA-1400 plan
- The HSA-2600 plan

Under either plan, you can see any doctor you want. However, you will pay less if you use a UnitedHealthcare network provider.

When you enroll in one of the HSA plans, the District sets up and funds a Health Savings Account on your behalf. Each year, you can elect to contribute to your HSA until the total contributions – yours and the District's – equal the annual IRS maximum contribution. Employees who begin or continue coverage in 2011/12 will receive two equal deposits a year. The first deposit will be made in August, the second in January. If you choose to make voluntary contributions, they are deducted from your pay in equal increments throughout the year. The maximum HSA contribution for 2011 is $3,050 for individual coverage and $6,150 for family coverage. Employees age 55 and over are also eligible to make an additional "catch-up" contribution to their own HSA account. The amount allowed by the IRS in the 2011 tax year is $1,000.

An HSA is similar to a regular checking account with a debit card – as long as a balance is available, you can use your HSA funds to pay for eligible healthcare expenses, including your deductible. Any remaining balance in your HSA at the plan year's end, rolls over for use in future years. Plus, you accumulate tax-free interest on your HSA funds, so you can use your account to save for care you may need in the future.

Finally, your HSA is portable. If you leave the District or switch medical plans, you can use your funds for qualified healthcare expenses.

Your HSA account is provided through OptumHealth Bank.

Plan Year Deductible

You must meet the **plan year deductible** before the plan pays most benefits. You can use your HSA funds to pay for qualified medical expense, including those incurred while meeting your deductible. **Note: The HSA plan covers most in-network preventive care services at 100%, no deductible.** *"Embedded" means individual deductibles are active within the larger, overall family deductible and can determine when coverage begins. Some services, such as preventative care, could be covered by plan benefits prior to the individual or family deductible being reached. When a family member on the plan meets his or her individual deductible, plan benefits and coinsurance will apply to his or her claims. If the family deductible amount is met before a member reaches his or her individual deductible, benefits and coinsurance will also apply but will do so for the entire family. Embedded deductible applies to the 2600 plan only.*

Plan Benefits Coverage (Coinsurance)

After meeting the plan year deductible, the plan pays **coinsurance**. The plans pay 80% and you pay 20% for most in-network charges. Out-of-network, UnitedHealthcare pays 60% of eligible expenses, then you pay the balance.

Plan Year Out-of-Pocket Maximum

The **out-of-pocket maximum** is the most you will pay for eligible expenses, including prescription drugs, during the plan year. After reaching the maximum, the plan pays 100% for eligible expenses. In-network and out-of-network maximums accumulate separately. In addition, if you enroll in family coverage, the family out-of-pocket maximum applies. The IRS defines family coverage as individual plus one other person.

The amount you pay to satisfy your plan year deductible **is included** in the out-of-pocket maximum. However, your share of coinsurance for out-of-network services in excess of UnitedHealthcare's allowable charges **does not count** toward the out-of-pocket maximum.

HSA Plan Prescription Drug Coverage

Under an HSA plan, you may fill your prescriptions through any pharmacy. However, you'll pay less when you use a participating retail pharmacy or the Medco Health home delivery network (available online through **www.myuhc.com**).

You pay the cost for prescription drugs until meeting the plan year deductible. Then, you will pay copayments for your drugs under a "three-tier" schedule. A list of drugs found within each "tier" is available through the UnitedHealthcare Web site – **www.myuhc.com**.

Preventive Drug Coverage

"Preventive medications" are not subject to the plan year deductible under the HSA plans – only the appropriate copayment will apply. The following categories of drugs are included:

- Anti-estrogens (breast cancer prevention)
- Anti-coagulants (heart attack and stroke prevention)
- Anti-platelets (stroke prevention)
- Lipid/cholesterol lowering agents (heart attack and heart disease prevention)
- Vitamins and hemantics
- Antihypertensives (blood pressure)

Specific drugs included in the categories above fall into a specific tier of coverage (i.e., tier 1, tier 2, or tier 3); you pay the applicable copayment. (***Note:*** Copayments for prescription drugs do not count toward your annual deductible.)

A detailed list of the preventive drugs covered is available through the District's Web site.

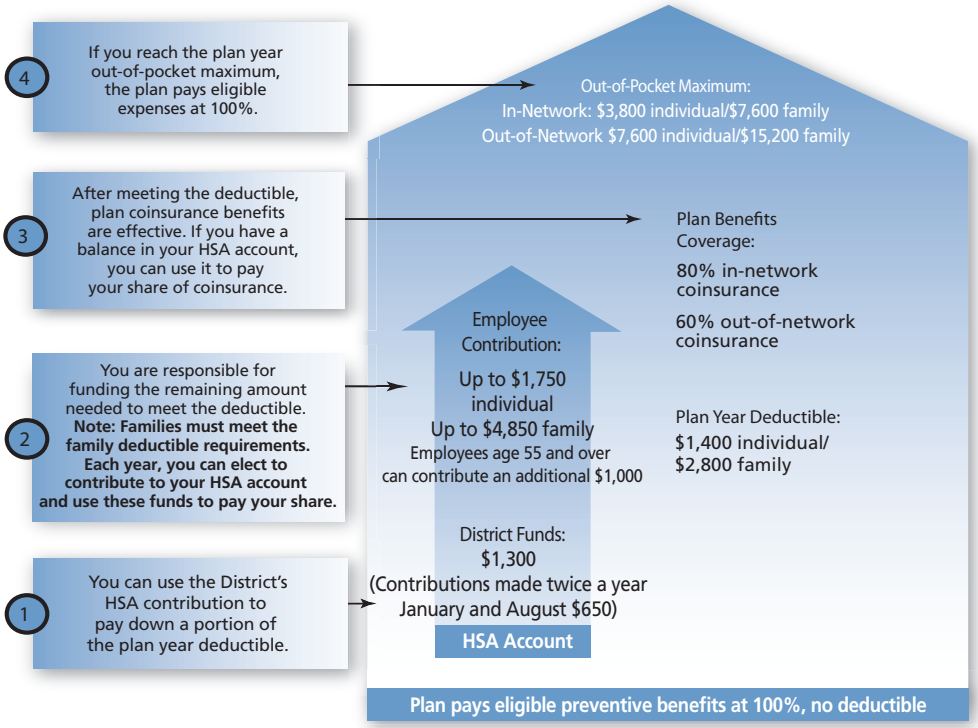
Contributing to the Medical Expense Reimbursement Accounts (Flexible Spending Account)

If you enroll in an HSA plan and wish to contribute to the District's Medical Expense Reimbursement Account (FSA), special rules apply. You can only use your Medical Expense Reimbursement Account to reimburse yourself for your eligible dental and vision expenses. See page 12 for more information.

HSA Plan Specifics

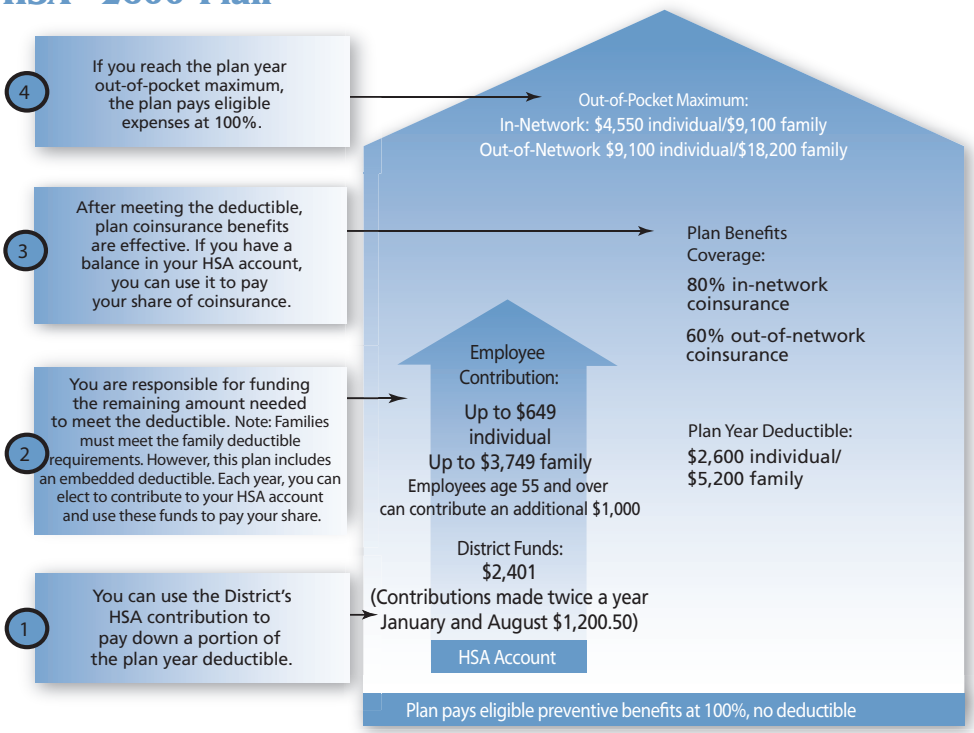
If an HSA plan sounds right for your situation, you will need to decide which plan to enroll in – the HSA–1400 plan or the HSA–2600 plan. The plans share several similar features. However, there are a few significant differences between the plans, including the contribution the District makes to your HSA and the plan year deductibles and out-of-pocket maximums.

HSA 1400 Plan



"Family" coverage includes an employee plus one or more dependent(s)
If you elect Spousal Share Family Coverage, you may contribute up to $3,550 to your HSA.

HSA 2600 Plan



"Family" coverage includes an employee plus one or more dependent(s).
If you elect Spousal Share Family Coverage, you may contribute up to $1,348 to your HSA.

Who Can Participate in a High Deductible Health Plan with an HSA?

You can participate in a high deductible health plan and contribute money to a health savings account, if you:

- ***Do not have coverage under any non-high deductible health plan that provides benefits covered by the high deductible health plan unless it is exclusively preventive care, or is "permitted coverage" or "permitted insurance" (as defined by federal regulations)***
- ***Are not enrolled in Medicare***
- ***Cannot be claimed as a dependent on someone else's tax return (except for your spouse)***

Special Note:

Individuals enrolled in Medicare and employees covered under another non-high deductible health plan may elect to enroll in a high deductible health plan (HDHP), however, they can not contribute or accept employer contributions in a Health Savings Account (HSA). If you elect to participate in the high deductible plan through the district, this plan will become your primary health insurance coverage.

Comparison of Medical Benefits

Following is a comparison of each plan's features. You can also find more information through the District's Web site at **ww2.chandler.k12.az.us**. Click on Human Resources > Benefits > General Information.

Plan Features	Choice Plus Plan		HSA-1400 Plan		HSA-2600 Plan	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Plan Year Deductible	Individual $1,000; Family $2,000	Individual $2,000; Family $4,000	Individual $1,400; Family $2,800	Individual $2,800; Family $5,600	Individual $2,600; Family $5,200	Individual $5,200; Family $10,400
Coinsurance	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Out-of-Pocket Maximum[1]	Individual $2,000; Family $4,000	Individual $6,000; Family $12,000	Individual $3,800; Family $7,600	Individual $7,600; Family $15,200	Individual $4,550; Family $9,100	Individual $9,100; Family $18,200
Office Visit	$25 copay Primary Care[2] $35 copay Specialist	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 60% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 60% of eligible expenses after deductible
Preventive Care	Plan pays 100%	No Benefits	Plan pays 100% Deductible waived	No Benefits	Plan pays 100% Deductible waived	No Benefits
Emergency Room Visit	$100 copay, waived if admitted	$100 copay, waived if admitted	Plan pays 80% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible
Urgent Care Visit	$50 copay	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 60% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 60% of eligible expenses after deductible
Inpatient Hospital	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 60% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 60% of eligible expenses after deductible
Eye Examination [3]	$25 copay	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 60% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 60% of eligible expenses after deductible
Prescription Medicine [4]	***Tier 1*** $10 copay/retail $25 copay/home delivery	$10 copay, plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then $10 copay/retail $25 copay/home delivery	You pay full retail cost before deductible then $10 copay/retail plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then $10 copay/retail $25 copay/home delivery	You pay full retail cost before deductible then $10 copay plus amount over wholesale price
	Tier 2 $35 copay/retail $87.50 copay/home delivery	$35 copay, plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then $30 copay/retail $75 copay/home delivery	You pay full retail cost before deductible then $30 copay plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then $30 copay/retail $75 copay/home delivery	You pay full retail cost before deductible then $30 copay plus amount over wholesale price
	Tier 3 $50 copay/retail $125 copay/home delivery	$50 copay, plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then $50 copay/retail $125 copay/home delivery	You pay full retail cost before deductible then $50 copay plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then $50 copay/retail $125 copay/home delivery	You pay full retail cost before deductible then $50 copay plus amount over wholesale price
	Prescription drugs subject to plan year deductible of $100 individual/$300 family		Preventive medications not subject to plan year deductible. Refer to page 4 for more information.		Preventive medications not subject to plan year deductible. Refer to page 4 for more information.	

[1] Excluding deductible and copays for Choice Plus Plan.

[2] Primary Care is limited to General or Family Practice, Internal Medicine and Pediatrics.

[3] Limited to once every other plan year.

[4] 30-day supply provided through retail; 90-day supply provided through home delivery.

Dental Coverage - Delta Dental of Arizona (Group Number 4267)

Voluntary Dental Plan - Core Plan

The Delta Dental plan allows you to visit any dentist or specialist without a referral. The coverage levels provided will typically be higher when you visit a Delta Dental network provider. If you choose to visit a non-participating provider, Delta Dental will still provide benefits (at reduced levels). Note: The plan covers eligible dependents up to age 26.

When making an appointment with your dentist, verify that they are participating with Delta Dental. You can also verify your dentist's affiliation with Delta and/or find a Delta Dental provider through the Delta Dental Web site at **www.deltadentalaz.com**, or by calling Delta Dental at 800-352-6132, extension 5.

As you seek dental care, you must first meet the plan year deductible ($50 per person; $150 per family) before benefit coverage kicks in. The plan pays benefits up to an annual maximum limit of $1,500 per person.

To find a Delta Dental provider visit the Delta Dental Web site at www.deltadentalaz.com, or call Delta Dental at 800-352-6132, extension 5 .

Voluntary Delta Dental Plan Highlights — Core Plan

After meeting the plan year deductible...

Dental Services	***Coverage***
Diagnostic Care, (exams and x-rays) and Preventive Care (routine cleanings)	
■ Two exams and routine cleanings (twice in a plan year). ■ Full mouth/Panorex x-rays (once in a five-year period; Bitewing x-rays (once in a plan year); and periapical (six per plan year). ■ Topical application of fluoride for children to age 17 (twice in a plan year). ■ Emergency treatment for the relief of pain. ■ Space maintainers (for missing posterior primary (baby) teeth up to age 14).	*In-network:* 100% *Out-of-network:* 100% of charges allowed by Delta Dental; you are responsible for the balance.
Basic Services and Restorative Services	
■ Stainless steel crowns (for primary (baby) teeth only). ■ Fillings consisting of sliver amalgam or synthetic tooth color fillings; also includes non-surgical extractions. ■ Emergency treatment for the relief of pain. ■ Oral surgery: simple extractions.	*In-network:* 70%; you are responsible for the balance. *Out-of-network:* 70% of charges allowed by Delta Dental; you are responsible for the balance.
Major Services - Becomes a benefit following 6 months of continuous group coverage under this plan.	
■ *Endodontics* ■ *Periodontics* (non surgical once every two years; surgical once every three years). ■ *Prosthodontics* (seven-year waiting period from replacement last performed). ■ *Bridge and Denture Repair* (seven-year waiting period from replacement last performed). ■ *Crowns* (seven-year waiting period from replacement last performed.	*In-network:* 40%; you are responsible for the balance. *Out-of-network:* 40% of charges allowed by Delta Dental; you are responsible for the balance.
NO Orthodontic Services	
Plan Year Deductible (applies to all services)	$50 per individual/$150 per family
Plan Year Benefit Maximum	$1,500 per individual

In the event you need dental work over $250, ask your dentist to submit a pre-estimate of benefits to Delta Dental. This permits Delta to review the treatment plan and let you know what your financial responsibility for the treatment will be prior to the service being performed.

Dental Coverage - Delta Dental of Arizona (Group Number 4267)

Voluntary Dental Plan - Premier Premium Plan

The Delta Dental plan allows you to visit any dentist or specialist without a referral. The coverage levels provided will typically be higher when you visit a Delta Dental network provider. If you choose to visit a non-participating provider, Delta Dental will still provide benefits (at reduced levels). Note: The plan covers eligible dependents up to age 26.

When making an appointment with your dentist, verify that they are participating with Delta Dental. You can also verify your dentist's affiliation with Delta and/or find a Delta Dental provider through the Delta Dental Web site at **www.deltadentalaz.com**, or by calling Delta Dental at 800-352-6132, extension 5.

As you seek dental care, you must first meet the plan year deductible ($50 per person; $150 per family) before benefit coverage kicks in. The plan pays benefits up to an annual maximum limit of $1,500 per person. Some services, such as orthodontia and care of TMJ, are subject to lifetime maximum limits, as well.

To find a Delta Dental provider visit the Delta Dental Web site at www.deltadentalaz.com, or call Delta Dental at 800-352-6132, extension 5 .

Voluntary Delta Dental Plan Highlights — Premier Premium Plan

After meeting the plan year deductible...

Dental Services	***Coverage***
Diagnostic Care, (exams and x-rays) and Preventive Care (routine cleanings)	
■ Two exams and routine cleanings (twice in a plan year). ■ Full mouth/Panorex x-rays (once in a five-year period; Bitewing x-rays (once in a plan year); and periapical (six per plan year). ■ Topical application of fluoride for children to age 17 (twice in a plan year). ■ Space maintainers (for missing posterior primary (baby) teeth up to age 14).	*In-network:* 100% *Out-of-network:* 100% of charges allowed by Delta Dental; you are responsible for the balance.
Basic Services and Restorative Services	
■ Fillings consisting of sliver amalgam or synthetic tooth color fillings; also includes non-surgical extractions. ■ Stainless steel crowns (for primary (baby) teeth up to age 14). ■ Sealants for children (once per three year period for permanent molars and bicuspid up to age 19). ■ Emergency treatments for the relief of pain. ■ Oral surgery: simple extractions.	*In-network:* 80%; you are responsible for the balance. *Out-of-network:* 80% of charges allowed by Delta Dental; you are responsible for the balance.
Major Services	
■ *Endodontics* ■ *Periodontics* (non surgical once every two years; surgical once every three years). ■ *Prosthodontics* (five-year waiting period from replacement last performed). ■ *Bridge and Denture Repair* (seven-year waiting period from replacement last performed). ■ *Crowns* (seven-year waiting period from replacement last performed.	*In-network:* 50%; you are responsible for the balance. *Out-of-network:* 50% of charges allowed by Delta Dental; you are responsible for the balance.
Orthodontic Services	
■ Benefits provided for adults and children age 8 and older. ■ Lifetime maximum benefit of $750 per patient; this maximum is separate from your plan year maximum benefit. Payable in two payments - upon initial banding and twelve months after.	*In-network:* 50%; you are responsible for the balance. *Out-of-network:* 50% of charges allowed by Delta Dental; you are responsible for the balance.
Plan Year Deductible (applies to all services)	$50 per individual/$150 per family
Plan Year Benefit Maximum	$1,500 per individual

In the event you need dental work over $250, ask your dentist to submit a pre-estimate of benefits to Delta Dental. This permits Delta to review the treatment plan and let you know what your financial responsibility for the treatment will be prior to the service being performed.

Voluntary Vision - Vision Service Plan (Not Covered through UHC Medical Plans)

Eligible employees can choose to enroll in voluntary vision coverage through VSP. (***Note:*** The District's medical plans cover eye exams, once every two years and offer a small discount for some lenses, frames and contacts. If you require vision care in addition to regular exams, you should consider whether the VSP voluntary vision plan makes sense for you.)

You pay the cost for your voluntary vision plan premiums. Premiums are based on the number of dependents (if any) you choose to enroll. Under the VSP plan, you may visit any vision care provider. However, benefits are provided at significantly higher levels when you visit a VSP network doctor.

To find a VSP provider, visit www.vsp.com or call 800-877-7195. You can also find a VSP provider through the District's Web site.

You will not receive a plan ID card from VSP when you enroll. So, when making your appointment, tell your provider you are a VSP member. Your provider and VSP take care of the rest.

Highlights of 2011/12 Vision Plan Benefits

Eye exams*	*In Network:* The Plan pays 100% after your $10 copay. *Out-of-network:* The plan pays up to $50
Lenses*	*In Network:* The Plan pays 100% after your $20 copay for single vision, lined bifocal, lined trifocal, and photochromic lenses and tints *Out-of-network:* The plan pays up to: $50 for single vision lenses, $75 for lined bifocal lenses, $100 for lined trifocal lenses
Frames*	*In Network:* The plan provides an allowance of $130 plus a 20% discount *Out-of-network:* The plan pays up to $75
Contacts*	*In Network:* In lieu of lenses and frames, the plan provides an allowance of $130, which applies to the cost of contacts and the contact lens fitting exam. You receive a 15% discount on this exam, which is in addition to your initial vision exam. *Out-of-network:* The plan pays up to $105 for the exam, contact lens fitting, and lenses.

**The benefits outlined above are provided once every 12 months, when you enroll in this plan.*

Basic Life Insurance Sun Life

The District provides eligible employees with basic life insurance coverage in the amount of $50,000.

After you reach age 65, the policy amount is reduced. An accelerated death benefit is also available in the event of your eligible terminal illness.

You must designate a beneficiary for the basic life insurance benefit who is 18 years or older. You may add or change your beneficiary by completing the 2011/12 Benefit Election/Enrollment Form and returning it to the benefits department.

* Please note: As a special exception, Job Share employees are eligible for the basic life insurance benefit.

IMPORTANT — WHEN EVIDENCE OF GOOD HEALTH IS REQUIRED

If you are not currently enrolled in voluntary life insurance coverage but wish to enroll now, OR if you wish to increase your current coverage level during this year's Open Enrollment, you must provide Sun Life with evidence of your good health, by completing the Sun Life Evidence of Insurability form. Coverage will not be issued until Sun Life approves your evidence of good health.

Voluntary Life Insurance Sun Life

If eligible, you have the opportunity to purchase voluntary life insurance coverage for yourself and your eligible spouse and dependent children. The voluntary life insurance premiums are listed on page 17.

Highlights of 2011/12 Voluntary Life Insurance Coverage

Voluntary Life Insurance Options	***How much coverage can you buy?***
Coverage for yourself if you are an active, full-time employee working at least 20 hours per week	You can purchase coverage in $10,000 "units" up to five times your annual earnings. The maximum benefit is $500,000.
Coverage for your eligible spouse under age 70.	You can purchase coverage in $10,000 "units" up to $150,000. The coverage level you elect for your spouse cannot exceed 100% of your basic and voluntary life insurance coverage combined. You are not required to elect coverage for yourself to purchase coverage for your spouse.
Coverage for your eligible unmarried, dependent children at least 14 days old and under age 25.	You can purchase coverage in $2,000 "units" up to $10,000. The maximum benefit for children under six months is $500. You can elect this coverage only if you purchase voluntary coverage for yourself and/or your spouse, unless you are eligible for basic coverage (working 30 more hours a week).

No one may be covered more than once under this plan.

After you reach age 70, the policy amount is reduced. When your spouse reaches age 70, his/her coverage ceases. Also note, an accelerated death benefit is available in the event of your eligible terminal illness. Refer to your plan certificate for a complete schedule of benefits.

Voluntary Short-Term Disability Assurant

To enroll or change your current coverage, complete and return the Assurant Employee Enrollment Form for Group Disability.

Increases to your current coverage are subject to the plan's pre-existing limitation.

The voluntary short-term disability insurance plan is underwritten by Assurant Employee Benefits. If you receive a salary increase, your short term disability does not increase automatically.

Voluntary Short-Term Disability coverage helps provide income protection for employees with unexpected health events, associated expenses and possible time away from work due to a non-occupational injury or sickness.

Eligible employees can elect to purchase voluntary short-term disability coverage. The plan provides monthly benefits from $360 to $5,000, based on your annual salary, not to exceed 66 2/3% of your salary. Benefits are paid in the event you cannot work due to a covered non-occupational sickness or injury, for up to six months of continuous disability. This plan covers maternity the same as a sickness. Benefits begin following the plan's seven day elimination period. Benefits are paid in addition to accumulated sick leave and are paid year-round, even when school is not in session.

Premium costs for short-term disability coverage are listed on page 18.

Your benefit payment will be offset by other sources as defined by the Assurant group policies. These sources include, but are not limited to Social Security and State Retirement Systems. However, the minimum monthly benefit amount payable under the voluntary short-term disability policy can not be lower than 10% of your gross monthly benefit, regardless of the amount of income you receive from other sources. Income received from salary continuation or accumulated sick leave plans will not be deducted from your gross disability benefit.

IMPORTANT – PRE-EXISTING CONDITION LIMITATIONS

The policy does not pay benefits for disabilities that begin within 12 months of your initial enrollment in the plan, if you received medical treatment, consultation, care, or services (including diagnostic measures), or took prescribed drugs or medicines for the disabling condition during the 12 months prior to your initial enrollment date. To be eligible for coverage during pregnancy, you cannot be pregnant before the benefit effective date (e.g., July 1, 2011, if you are enrolling during Open Enrollment).

During the 2011/12 Open Enrollment, employees can purchase coverage from $360 to $5000, not to exceed 66 2/3% of your salary. If you are currently enrolled in the plan, you can increase your coverage amount by one benefit level of coverage (not to exceed 66 2/3% of your salary) without evidence of good health. All new applicants and increases over the one level, must provide evidence of good health to our insurance carrier, Assurant. Pre-existing conditions limitations apply to both new applications and increases in coverage.

Long Term Care Insurance

Long Term Care Insurance - UNUM

Long Term Care insurance provides a monthly benefit to help offset the cost of personal and medical care for an individual who is unable to carry out the normal activities of daily living, such as dressing, bathing, going to the bathroom, eating, moving, etc, or when someone suffers a severe cognitive impairment. Care could be provided in the home, in an assisted living, a residential care facility, or in a skilled nursing facility.

Base Plan Long Term Care Insurance

The district provides eligible employees coverage under the base plan. Employees working full-time (30 hours or more per week) or job-share employees working 20 hours or more per week are eligible for coverage. The base plan provides a monthly benefit of $2,000 for a total lifetime maximum of $48,000.

Voluntary Long Term Care Insurance

Employees eligible for the base plan, have the opportunity to purchase additional coverage for themselves and their spouse. Employees who are not eligible for the base plan but work between 20-29 hours per week may purchase long term care at their own expense. Family members of eligible employees between the ages of 18-80 may purchase coverage at the district group rates. Spouses and family members will need to provide evidence of insurability and are subject to underwriting approval.

Flexible Spending Accounts (FSAs)

The Flexible Spending Accounts — the Medical Expense Reimbursement Account and the Dependent Care Account — are separate flexible spending accounts that can help you save money on taxes by allowing you to pay for certain expenses with before-tax dollars.

If you would like to participate in an FSA for 2011/12, you must complete the flexible spending account enrollment form, even if you are currently a participant.

How Flexible Spending Accounts Work

- You decide how much you want to contribute on an annual basis into one or both of the FSAs when you enroll.
- Your FSA contributions are deducted from your paycheck, in equal amounts on a before-tax basis.
- Your election stays in effect for the entire plan year (July 1 through June 30). You cannot increase, decrease, or cancel your contributions outside of the plan's enrollment period, unless you have a qualified life status change (see page 2 for information about status changes).
- You use your FSA contributions to pay your eligible expenses under the Medical Expense Reimbursement Account or Dependent Care Account. The IRS clearly defines eligible expenses, and only those that comply with the Internal Revenue Code are eligible for reimbursement.
- You cannot use the contributions you make to the Medical Expense Reimbursement Account to reimburse yourself for eligible expenses under the Dependent Care Account, or vice versa.
- The plans are administered by BASIC Western USA.

The Medical Expense Reimbursement Account

The Medical Expense Reimbursement Account lets you set aside before-tax dollars to help you pay for eligible medical, dental, and vision care expenses. You can contribute between $500 and $5,000 for 2011/12. You do not need to be enrolled in a District healthcare plan to contribute to this FSA, however, you must work a minimum of 20 hours per week to enroll.

You can sign up and participate in the Medical Expense Reimbursement Account if you take a High Deductible plan and set up the HSA Fund Account. However, you can ONLY be reimbursed for you dental and vision expenses through the Medical Expense Reimbursement Account until you submit an Explanation of Benefits (EOB) from the carrier that shows you have met the annual IRS specified deductible. In 2011/12, the amounts are $1,200 of your medical deductible for your high deductible plan if you are covered as a single OR $2,400 of your medical deductible if you have family coverage. (The IRS defines family as individual plus one other person on the High Deductible/ HSA Plan.) Medical expenses incurred after this requirement is met are eligible for payment through the Medical Expense Reimbursement Account.

Eligible Expenses

Healthcare expenses that are eligible for reimbursement under an FSA are clearly defined by the IRS. In general, you can use the money in the Medical Expense Reimbursement Account to pay for eligible healthcare expenses that are not covered by your or your spouse's healthcare plans or used as healthcare deductions on your income tax return.

A quick one page reference to flex eligible expenses is provided on the BASIC website at **www.basiconline.com/downloads/flex/flex_eligible_expenses.pdf**.

Upon using your FSA debit card you will be required to substantiate your purchase. Documentation must include the following information: provider name, service provided, date of service and amount charged. Failure to substantiate your purchase may result in deactivation of your FSA debit card.

Getting Reimbursed

You can use the plan's Flex Convenience debit card to pay most eligible expenses through your Medical Expense Reimbursement Account. Alternatively, you may submit your expenses for reimbursement.

To request reimbursement, you must submit a Flex Card Claim Form with receipt. The form is found at: **https://www.basiconline.com/downloads/flex/cardclaimform.pdf**. You may mail or fax the form (address or fax number indicated on the form). You may also use the secure website to upload your reimbursement request: **http://claims.basiconline.com/**. The same process may be used to substantiate purchases made using FSA debit card.

Refer to the BASIC Western USA Web site at www.basiconline.com, or contact a BASIC representative at 800-473-0455 for more detailed information regarding FSAs.

NOTE: Keep all receipts in the event of an IRS Audit

Using the Medical Expense Reimbursement Account with an HSA Plan

If you choose to enroll in one of the HSA medical plans and you also wish to contribute to the Medical Expense Reimbursement Account, you can use your Medical Expense Reimbursement Account funds on a "limited purpose" basis – to pay your eligible dental and vision care expenses only.

FSA: USE IT OR LOSE IT RULE

The IRS governs the administration of Flexible Spending Account plans, and once you elect to set aside money in an FSA, you must use it for eligible expenses during the plan year. You should make every effort to file your FSA claims as you incur expenses. However, you have 90 days after the plan year end (June 30) to file claims for reimbursement. After that point, you forfeit, or "lose," any unused funds. Because of this IRS "use it or lose it" rule, be sure to carefully estimate the amount you want to contribute to the FSAs before making your elections.

FSA: USE IT OR LOSE IT RULE

The IRS governs the administration of Flexible Spending Account plans, and once you elect to set aside money in an FSA, you must use it for eligible expenses during the plan year. You should make every effort to file your FSA claims as you incur expenses. However, you have 90 days after the plan year end (June 30) to file claims for reimbursement. After that point, you forfeit, or "lose," any unused funds. Because of this IRS "use it or lose it" rule, be sure to carefully estimate the amount you want to contribute to the FSAs before making your elections.

The Dependent Care Account

The Dependent Care Account lets you set aside before-tax dollars to help you pay the cost of care for your eligible dependents so that you (and your spouse) can work outside your home. You can contribute between $500 and $5,000 annually. However, your contributions can be limited by your tax-filing status, by your spouse's participation in a similar plan, if your spouse is disabled or a full-time student, or if you use the federal dependent care tax credit. Consult your tax or financial advisor to determine how much to contribute to the Dependent Care Account.

Eligible Expenses

The Dependent Care Account is strictly monitored by the IRS, and only those expenses that comply with the Internal Revenue Code are covered. Eligible expenses may include your costs for child day care, or care for an elder dependent while you are working during the day.

A detailed summary of eligible expenses is available through the IRS website at: **www.irs.gov/pub/irs-pdf/p503.pdf.**

Getting Reimbursed

If accepted by your dependent care provider, you can use the plan's Flex Convenience debit card to pay most eligible expenses through your Dependent Care Account. Alternatively, you may submit your expenses for reimbursement through paper claim forms. To request reimbursement, you must submit a flex card claim form with receipt. The form is found at: **https://www.basiconline.com/downloads/flex/cardclaimform.pdf**. You may mail or fax the form (address and fax number is listed on the form). You may also use the secure website to upload your reimbursement request: **http://claims.basiconline.com/**. The same process may be used to substantiate transactions made using the FSA debit card.

To avoid the need to continuously submit receipts for the same exact service, provider and amount you must submit a Reoccurring Expense form. The form can be found on the BASIC website at: **https://www.basiconline.com.downloads/flex/Flex%Recurring%20Expense%20Form-2.pdf**. Submit this form to BASIC to include your documentation/ receipts for the transaction you would like to establish as your recurring expense(s).

Making Your Annual FSA Election

The IRS requires you to elect your FSA contributions every year. If you wish to participate, you need to make your 2011/12 election during Open Enrollment or your initial benefit enrollment period. Your current contribution, if any, will not carry forward. If you choose to enroll for 2011/12, your contribution will be deducted from your pay in equal increments throughout the plan year on a pre-tax basis.

NOTE: Keep all receipts in the event of an IRS Audit

COMPLETING YOUR ENROLLMENT

We encourage all employees to take an active role in their initial benefits enrollment process and on an ongoing basis as you use your benefits throughout the coming year.

Required forms can be found on the District website under benefit forms. The benefit elections you wish to make for 2011/12 will determine which forms you need to complete and return to the benefits department. **All employees must complete and return the 2011/12 Benefit Election/Enrollment Form.** Also, depending on the elections you wish to make, you may need to complete and return additional forms, as well. See the checklist below.

Complete and return 2011/12 Benefit Election/Enrollment Form

- If you wish to enroll or continue benefits for 2011/12, you must submit an enrollment form.
- If you are enrolling dependents in medical, voluntary dental and/or voluntary vision coverage, be sure to complete Sections 3 and 5.
- If wish to waive medical coverage, you must complete Section 7, and provide proof of other coverage if this is the first time you've elected to waive coverage.
- There is no additional form required to enroll in voluntary vision coverage.
- If you choose to make voluntary contributions to your HSA account you must elect to do so every year.

Voluntary Life Insurance Coverage Application – SunLife

- Employees who wish to change their current voluntary life insurance election(s), as well as employees who are not currently enrolled must attach the Voluntary Life Insurance Coverage Application to your 2011/12 Benefit Election/Enrollment Form.

Voluntary Life Insurance Evidence of Insurability Form

- Employees who are not currently enrolled in the plan, or those who wish to increase their coverage level for employee and/or spouse life coverage must attach the Voluntary Life Insurance Evidence of Insurability form to your 2011/12 Benefit Election/Enrollment Form.

Application for Short-Term Disability Insurance – Assurant

- Employees who are not currently enrolled in the plan, or those who wish to increase or decrease their current coverage level must attach this form to your 2011/12 Benefit Election/Enrollment Form.
- Be sure to complete the back side of the form if you are increasing your current coverage by more than one level, or if you are electing coverage over $3,000.

Flexible Spending Account Enrollment Form – BASIC

- Employees who wish to contribute to the Medical Expense Reimbursement Account and/or Dependent Care Account must attach the Flexible Spending Account Enrollment form to your 2011/12 Benefit Election/ Enrollment Form.

Long Term Care Insurance - UNUM

- Eligible employees who wish to purchase Long Term Care coverage during the guarantee issue enrollment period must complete an employee enrollment form. Evidence of insurability is not required during the guarantee issue enrollment period.
- Eligible employees who wish to purchase coverage due to a qualifying event after the guarantee issue enrollment period, must complete an employee enrollment form and submit a long term application (medical questionnaire).

During the 2011/12 Open Enrollment period, if you do not complete your enrollment by April 29, 2011, your current elections, with the exception of your Flexible Spending Account elections and your voluntary Health Savings Account contribution election, will carry forward effective July 1, 2011 through June 30, 2012. You will not have an opportunity to elect coverage until next year's Open Enrollment period unless you have a qualified life status change. You must choose, "waive" or "change" or your current benefits (with the exception of you FSA and HSA contribution elections) will carry over automatically.

When enrolling as a new hire, the 2011/12 Benefit/Election Form will be collected at your benefits orientation. If you elect optional plans, those required forms may be returned via District mail. Forms must be returned within 31 days of your eligibility for benefits.

For other enrollment periods, in most cases, you must return all of your paperwork within 31 days of your benefit eligibility date. If you do not complete the enrollment process, you will not have an opportunity to elect coverage until next year's Open Enrollment period unless you have a qualified life status change.

Waiving Medical Coverage

You are not required to enroll in medical coverage through the District. For example, if you have medical coverage through another source (e.g., your spouse's employer-sponsored plan), you might find it more practical or cost-effective for you to cover your family under that plan. If you choose to waive coverage, you must complete and return the Waiver of Coverage portion of the 2011/12 Benefits Election/Enrollment Form and provide proof of your other coverage.

Note: If you choose to enroll in one of the District's medical plans, your employer plan will become your primary coverage.

During Open Enrollment, return all required forms to your site's administrative assistant by April 29, 2011.

If you would like to contribute to a Flexible Spending Account for 2011/12, you must return your Benefit Election/ Enrollment Form and BASIC Flexible Spending Account Enrollment Form by the deadline.

CONTACT INFORMATION

Contact our plan providers directly if you have questions or would like more detailed information about our plans.

If you have general questions about the enrollment process or your plan selections, feel free to contact your site's Human Resources Technician as noted in the table to the left.

If you need further assistance regarding your benefits plans, contact the benefits department.

Plan Contacts

Plan Providers	For Questions About...	Phone	Web site
UnitedHealthcare	■ Choice Plus PPO Plan ■ HSA-1400 Plan ■ HSA-2600 Plan	866-844-4864	www.myuhc.com
UnitedHealthcare Vision		877-532-9300	
Delta Dental of Arizona	■ Delta Dental Plans	602-938-3131 800-352-6132	www.deltadentalaz.com
Vision Service Plan (VSP)	■ Voluntary Vision Plan	800-877-7195	www.vsp.com
Sun Life	■ Basic Life Insurance Plan ■ Voluntary Life Insurance Plans	800-247-6875	www.sunlife-usa.com
Assurant (Brockhurst and Associates, local agent)	■ Voluntary Short-Term Disability Plan	602-263-9265	N/A
BASIC Western USA	■ Flexible Spending Accounts	800-444-1922 Ext. 1	www.basiconline.com
OptumHealth Bank	■ HSA Account Information	800-791-9361	www.myuhc.com www.definityhsa.com www.optumhealthbank.com
Care24	■ Nurse Advice ■ Financial Advice ■ Legal Advice	888-887-4114	N/A
UNUM	■ Long Term Care Insurance Plan	800-227-4165	http://w3.unum.com/enroll/cusd/

Chandler Unified School District Human Resources Technicians

Questions related to Health Plans should be directed to THE BENEFITS DEPARTMENT. Question regarding enrollment and eligibility should be directed to your HR Technician.

Contact	Phone	Sites Assigned
Dianne Steiman	**X7639**	PHS; PJHS; Frye; Independence; Liberty; Patterson; Riggs; Ryan; San Marcos; Weinberg; Warehouse; CHS
Maricela Garcia	**X7605**	WJHS; CTJHS; Bologna; Galveston; Hull; Humphrey; Sanborn; Support Services
Kathy Beickman	**X7638**	BHS; SJHS; Freedom; Fulton; Santan; Tarwater; Academy; IRC; Transportation;Early College; Hill Academy; District Office
Lynn Evans	**X7665**	HHS; Hamilton Prep; Basha Elem: Hancock; Jacobson; Food Service; Navarette
Cindy Plimmer	**X7648**	AJHS; BJHS; Andersen; Conley; Erie; Goodman; Haley; Hartford; Knox; Kids Express; Community Education; Shumway; Lil' Express; PIRC; Chandler Care Center

Chandler Unified School District Benefits Department

Dee Ostrowicki ***Benefits Assistant***	**X7036**	Contact for complex benefits questions and issues.

2011-2012 BENEFITS COSTS

Medical Plan

Medical Plan Coverage Options and Premiums

Eligible Employee Only Coverage when you work 30+ hours per week	**Choice Plus**	**HSA 1400**	**HSA 2600**
Annual ***District Contribution*** to Eligible Employee	$4,752.00	$4,752.00	$4,752.00
Annual Premium (Cost) for "***Employee Only***" Coverage	$7,545.00	$3,452.00	$2,351.00
Remaining Balance = Annual ***District Contribution*** to Employee HSA	N/A	$1,300.00	$2,401.00
Difference = ***Employee Cost***	$2,793.00	N/A	N/A
Bi-weekly payments are deducted from employee's checks over 22 pays.	**$126.95**	N/A	N/A
Employees who begin(or continue) coverage 2011/12 will receive 2 deposits a year. The fist deposit will be in August, the second in January. Each deposit will be:	**N/A**	**$650.00**	**$1,200.50**
VOLUNTARY annual maximum ***employee contribution*** to HSA account.	N/A	$1,750.00	$649.00

Dependent Coverage (Employee-paid)

Important: The costs below for the Choice Plus plan include the cost of the employee only coverage. District contribution for employee coverage is reflected in the rates below. The district contribution remains the same regardless of the level of coverage.

1. Spousal Coverage	**Choice Plus**	**HSA 1400**	**HSA 2600**
Employee-Paid Annual ***Cost*** for Employee & Spousal Coverage	$11,988.00	$3,840.00	$2,880.00
Monthly Cost for comparison purposes.	$999.00	$320.00	$240.00
Bi-weekly payments are deducted from employee's checks over 22 pays.	**$544.91**	**$174.55**	**$130.91**
VOLUNTARY annual maximum ***employee contribution*** to HSA account.	N/A	$4,850.00	$3,749.00

2. Child(ren) Coverage	**Choice Plus**	**HSA 1400**	**HSA 2600**
Employee-Paid Annual Cost for Employee & Child(ren) Coverage	$11,388.00	$3,576.00	$2,688.00
Monthly Cost for comparison purposes.	$949.00	$298.00	$224.42
Bi-weekly payments are deducted from employee's checks over 22 pays.	**$517.64**	**$162.54**	**$122.41**
VOLUNTARY annual maximum ***employee contribution*** to HSA account.	N/A	$4,850.00	$3,749.00

3. Family Coverage	**Choice Plus**	**HSA 1400**	**HSA 2600**
Employee-Paid Annual ***Cost*** for Family Coverage	$16,956.00	$5,964.00	$4,398.00
Monthly Cost for comparison purposes.	$1,413.00	$497.00	$366.50
Bi-weekly payments are deducted from employee's checks over 22 pays.	**$770.73**	**$271.09**	**$199.91**
VOLUNTARY annual maximum ***employee contribution*** to HSA account.	N/A	$4,850.00	$3,749.00

4. Spousal Share family Coverage (Spouses both employed by District who elect family coverage.)	**Choice Plus**	**HSA 1400**	**HSA 2600**
Employee-Paid Annual ***Cost*** for Family Coverage	$12,258.60	$2,566.60	$2,095.60
Monthly Cost for comparison purposes.	$1,021.55	$213.88	$174.63
Bi-weekly payments are deducted from employee's checks over 22 pays.	**$557.21**	**$116.66**	**$95.25**
Annual District Contribution to Employees HSA	N/A	$1,300.00 per spouse	$2401.00 per spouse
Annual district contribution to HSA is made twice a year. The first deposit will be made in August, the second in January. Bi-annual contribution is:	N/A	$650.00 per spouse	$1,200.50 per spouse
VOLUNTARY annual maximum ***combined employee contribution*** to HSA account.	N/A	$3,550.00	$1,348.00

Employees between 55 and 65 may also make an additional catch up contribution of $1,000.00 per year. Employees who begin(or continue) coverage in 2011/12 will receive two deposits a year. The first deposit will be in August, the second in January. Voluntary HSA contributions are spread equally over 22 pays.

Voluntary Vision Plan

Voluntary Vision Plan Premiums – 22 deductions per year

	Employee Only	Employee + Spouse or Child	Employee + 2 or More
Payroll Deduction	$4.28	$6.21	$11.14

Dental Plan - Core Plan

Voluntary Dental Plan Premiums – Core Plan

	Employee Only	Employee + Spouse	Employee + Dependents	Employee + Family
22 deductions per year	$16.37	$31.86	$36.29	$59.29

Dental Plan - Premier Premium Plan

Voluntary Dental Plan Premiums – Premier Premium Plan

	Employee Only	Employee + Spouse	Employee + Dependents	Employee + Family
22 deductions per year	$18.61	$36.44	$41.54	$68.06

Voluntary Life Insurance

Monthly Voluntary Life Insurance Premiums Per $10,000 of Coverage – Employee Coverage

Age	*Cost per $10,000 of Coverage*	*Age*	*Cost per $10,000 of Coverage*	*Age*	*Cost per $10,000 of Coverage*
Under age 20	$0.40	***40-44***	$1.03	***65-69***	$8.87
20-24	$0.47	***45-49***	$1.66	***70-74***	$13.65
25-29	$0.50	***50-54***	$2.40	***75-79***	$19.52
30-34	$0.58	***55-59***	$4.12	***80 & Over***	$29.58
35-39	$0.70	***60-64***	$6.20		

Monthly Voluntary Life Insurance Premiums Per $10,000 of Coverage – Spouse Coverage

Age	*Cost per $10,000 of Coverage*	*Age*	*Cost per $10,000 of Coverage*	*Age*	*Cost per $10,000 of Coverage*
Under age 20	$0.40	***40-44***	$1.03	***65-69***	$8.87*
20-24	$0.47	***45-49***	$1.66		
25-29	$0.50	***50-54***	$2.40		
30-34	$0.58	***55-59***	$4.12		
35-39	$0.70	***60-64***	$6.20		

** Coverage ceases for your spouse at age 70; at that time he/she may convert this coverage to a permanent life insurance policy.*

- *Coverage for your dependent children is $0.53 per $2,000 of coverage, regardless of the number of children you enroll.*

Long Term Care Insurance

To access long term care rates, visit the UNUM website at: ***http://w3.unum.com/enroll/cusd*** *and click on calculator to calculate your rate.*

Voluntary Short-Term Disability

Voluntary Short-Term Disability Coverage Levels and Premiums – 22 deductions per year

Minimum Gross Annual Salary	*Maximum Monthly Benefit*	*Your cost per pay period – 22 deductions*	*Minimum Gross Annual Salary*	*Maximum Monthly Benefit*	*Your cost per pay period – 22 deductions*
$6,480	$360	$3.83	$49,500	$2,750	$29.25
$9,180	$510	$5.43	$54,000	$3,000	$31.91
$13,500	$750	$7.98	$58,500	$3,250	$34.57
$18,000	$1,000	$10.64	$63,000	$3,500	$37.23
$21,600	$1,200	$12.76	$67,500	$3,750	$39.89
$27,000	$1,500	$15.95	$72,000	$4,000	$42.55
$30,600	$1,700	$18.08	$76,500	$4,250	$45.21
$36,000	$2,000	$21.27	$81,000	$4,500	$47.86
$40,500	$2,250	$23.93	$85,500	$4,750	$50.53
$45,000	$2,500	$26.59	$90,000	$5,000	$53.18

This ***Benefits Guide*** *provides only the highlights of certain provisions of the benefit programs available to eligible District members effective July 1, 2011. Complete details are contained in the respective plan documents and insurance contracts. In case of conflict between the information in this Benefits Guide and the wording in the official plan documents, the plan documents will govern. 2011/12 benefits contracts supersede all previous plan documents and contracts.*

Private Health Information

A portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) addresses the protection of confidential health information. It applies to all health benefit plans. In short, the idea is to make sure that confidential health information that identifies (or could be used to identify) you is kept completely confidential. This individually identifiable health information is known as "protected health information" (PHI), and it will not be used or disclosed without your written authorization, except as described in the HIPAA Privacy Notice or as otherwise permitted by federal and state health information privacy laws.

The HIPAA Privacy Notice is available through your District's web site or by request from your employer's benefits department. It spells out what the plans are required by law to do and how the plans will comply, as well as provides an explanation of your rights regarding your own health information. If you have any immediate questions or concerns, please contact your employer's benefits department.

Womens Health and Cancer Rights Act

The District health plans, as required by the Women's Health and Cancer Rights Act of 1998, provide benefits for mastectomy-related services. These services include:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications resulting from mastectomy (including lymphedema)

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information, call UnitedHealthcare at 866-844-4864.

Changes Allowed under the Childrens Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 creates a new special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes.

Under this Act, group health plans must permit employees and dependents who are eligible for group health plan coverage to enroll in the plan if they:

- Lose eligibility for Medicaid or SCHIP coverage, OR
- Become eligible to participate in a premium assistance program under Medicaid or SCHIP

In both cases, you must request special enrollment within 60 days (of the loss of Medicaid/SCHIP or of the eligibility determination), or wait until the plan's next annual enrollment period to make a change.

Contact your benefits representative if you have questions.

Declining Coverage and Special Enrollment Periods

You may elect to decline coverage in the group health plans. If you decline coverage due to your participation (and/or your eligible spouse's or dependents' participation) in other coverage, you will be entitled to enroll in the group health plan at other specified times.

For additional information regarding the situations under which you may be eligible to enroll through a "special enrollment period," contact your benefits representative.

All Eligible Young Adults Will Have A Special Enrollment Opportunity

For plan or policy years beginning on or after September 23, 2010, plans and insurers must give children who qualify an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan or policy year beginning on or after September 23, 2010. The new policy does not otherwise change the enrollment period or start of the plan or policy year.

Continuation Coverage Under COBRA

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family, who are covered under the plan, when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, refer to the "General Notice of COBRA Continuation Coverage Rights" available upon request from your employer's benefits department.

Medicare Notice of Creditable Coverage

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the three plan options sponsored by Valley Schools Employee Benefit Trust is or is not creditable (as valuable as) Medicare's prescription drug coverage. Contact the benefits department for more information.

Dependent to Age 26 Special Enrollment Notice

Rights to Enroll Adult Child in Health Plan 30 Day Special Enrollment Opportunity

As a result of the enactment of the Patient Protection and Affordable Care Act, current employees must be given a special 30-day opportunity to enroll certain adult children under their employer's health plan that may not have previously been eligible to participate in the plan, or continue participating in the plan.

Enrollment of Child

Once you have enrolled in the health plan, you may add to the plan any dependent children who have not attained the age of 26. The District's Medical and Prescription Drug Plan Description defines dependent children as biological or legally adopted children, children placed with you for adoption, foster children, or any other children for whom you are the legal guardian as determined by a court of competent jurisdiction.

Coverage Options

Under the terms of your employer's plans, you are eligible to enroll your eligible child in the following coverage options: MEDICAL only.

Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

If you are a current employee and your child who has not attained the age of 26 is currently receiving COBRA benefits from your employer because he/she lost dependent status due to age, you may add your adult child to the plan coverage options noted above.

Dates of Enrollment Opportunity

You will have 30 days from the Open Enrollment start date to enroll your dependent child(ren) on your coverage. The effective date of the coverage will be July 1, 2011.

The Valley Schools Family

VALLEY SCHOOLS

NWED

Fountain Hills
Unified School District #98

Queen Creek Schools

Apache Junction Unified School District

CHILDREN FIRST FUSD

Deer Valley Unified School District No. 97

BALSZ
SCHOOL DISTRICT CHILDREN FIRST

CHANDLER UNIFIED SCHOOL DISTRICT

GLENDALE ELEMENTARY SCHOOL DISTRICT

WORLD-CLASS EDUCATION FOR TOMORROW'S LEADERS
MARANA UNIFIED SCHOOL DISTRICT

LITTLETON 65 ELEMENTARY SCHOOL DISTRICT

TOLLESON UNION HIGH SCHOOL DISTRICT

Scottsdale Unified
SCHOOL DISTRICT

SVUSD

Peoria Unified School District #11
6330 West Thunderbird Road - Glendale, Arizona 85306
Telephone: (623) 486-6000

Paradise Valley
Unified School District
"Where individual excellence is our goal"