



**Benefits Summary for
Health and Welfare Plans
For Plan Year
October 2009 – September 2010**



Medical

Dental

Vision

**Flexible Spending
Accounts (FSA)**

**Health Savings
Accounts (HSA)**

Life/AD&D

Long Term Disability

Long Term Care

**Employee
Assistance
Program (EAP)**

Medical Plan

The college will offer two medical plan options through Aetna. For both the PPO as well as the High Deductible Health Plan, you are able to choose providers in and out of the Aetna Managed Choice POS Network (Open Access for the PPO Plan, Aetna HealthFund for the HDHP). Please note that if you receive services through non-network providers, the deductibles and coinsurance are higher than using network providers. Also, if you utilize non-network providers, only amounts at or below usual and customary expenses will be eligible expenses. Amounts above the usual and customary will be your responsibility. Please note that domestic partner eligibility is subject to employer policy. Please contact Human Resources to complete paperwork for eligibility determination. Please note that for inpatient and outpatient procedures, anesthesiologist, radiologists, and pathologists fees at in-network facilities will be paid at the in-network rate, even if the provider is not in the Aetna network. If you have concerns on how a specific claim was paid for one of these providers, please contact Aetna at 1-888-416-2277.

For provider directories, ID card requests, covered medications and explanation of benefits (EOBs), please visit www.aetna.com. For access to your HSA account information, please visit www.hsabank.com.

Below is a summary of each of the plan options. For a more detail summary of benefits, please see the following pages.

| Plan Provision | PPO Plan | | High Deductible Health Plan (HDHP) | |
|--|--|--|---|---|
| | Network | Non-Network | Network | Non-Network |
| Aetna Network | Managed Choice POS (Open Access) | | Aetna Open Access Managed Choice POS (Aetna HealthFund) | |
| Calendar Year Deductible (CYD) | \$400 Individual \$800 Family | \$800 Individual \$1,600 Family | \$1,500 EE \$3,000 Family * | \$3,000 EE \$6,000 Family |
| Employee Coinsurance % | 90% | 60% | 100% | 70% |
| Calendar Year Out-of-Pocket Limit | \$2,000 Individual \$4,000 Family (Not including co-pays or deductibles) | \$4,000 Individual \$8,000 Family (Not including co-pays or deductibles) | \$1,500 EE \$3,000 Family (Includes deductible) | \$10,000 EE \$20,000 Family (Includes deductible) |
| Wellness/ Preventive Care | \$20 | 60% after CYD | 100%; No Deductible | 70% |
| PCP Office Visit Co-pay | \$20 | 60% after CYD | Coinsurance and Deductible | |
| Specialist Office Visit Co-Pay | \$35 | 60% after CYD | Coinsurance and Deductible | |
| Emergency Room Facility Co-Pay | \$100 co-pay per visit | | Coinsurance and Deductible | |
| Urgent Care** | \$50 co-pay | | Coinsurance and Deductible | |
| Mental Health Benefit | 30 Days Inpatient/ 30 Visits Outpatient | | 30 Days Inpatient/ 30 Visits Outpatient | |
| Retail Prescription Drugs (30 Day Supply) | \$10 Level One \$25 Level Two \$40 Level Three | | Coinsurance and Deductible*** | |
| Home-Delivery Prescription Drugs (31 - 90 Day Supply) | \$20 Level One \$50 Level Two \$80 Level Three | | Coinsurance and Deductible | |
| Semi-Monthly Cost | | | | |
| EE Only | \$18.00 | | \$6.00 | |
| EE + Spouse/ Partner | \$140.00 | | \$110.00 | |
| EE + Child(ren) | \$93.00 | | \$72.50 | |
| EE + Family | \$215.00 | | \$176.50 | |

* If you cover dependents, you will be subject to the family deductible and family out-of-pocket maximum. **The family must satisfy the \$3,000 deductible before Aetna pays on any individual family member. One member or a combination of family members can satisfy the deductible.**

** The Urgent Care benefit is available at many locations throughout the Houston area. Go to www.aetna.com to find a location near you.

*** Deductible is waived for certain preventive medications.



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

| PLAN FEATURES | PREFERRED CARE | NON-PREFERRED CARE |
|---|---|--------------------------------------|
| Deductible (per calendar year) | \$400 Individual \$800 Family | \$800 Individual \$1,600 Family |
| All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. | | |
| Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. | | |
| Member Coinsurance | 10% | 40% |
| Applies to all expenses unless otherwise stated. | | |
| Payment Limit (per calendar year, excludes deductible) | \$2,000 \$4,000 | \$4,000 Individual \$8,000 Family |
| All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements including deductibles, copays, mental health, substance abuse, DME and pharmacy do not apply toward the Payment Limit. | | |
| Only those preferred & non-preferred expenses resulting from an application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Payment Limit. | | |
| Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year. | | |
| Lifetime Maximum | \$5,000,000 | |
| Payment for Non-Preferred Care | N/A | Recognized Charge* |
| *Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such service or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges. | | |
| Primary Care Physician Selection | Optional | Not applicable |
| Certification Requirements - | Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence. | |
| Referral Requirement | None | None |
| PREVENTIVE CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Routine Adult Physical Exams/ Immunizations 1 exam every 12 months. | \$20 office visit copay; deductible waived | 40% |
| Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 2 exams in the 13th - 24th month of life, 1 exam per 12 months thereafter to age 18. | \$20 office visit copay; deductible waived | 40% |
| Routine Gynecological Care Exams One routine annual exam. | \$35 office visit copay; deductible waived | 40% |
| Routine Mammograms One mammogram per calendar year for covered females age 35 and above. | \$20 office visit copay; deductible waived | 40% |
| Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over. | Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived | 40% |



**PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED**

| | | |
|--|--|---------------------------|
| Colorectal Cancer Screening For all members age 50 and over. | Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived | 40% |
| Newborn Hearing Screening 1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months | Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived | 40% |
| Routine Eye Exams 1 routine exam per 24 months | \$35 office visit copay; deductible waived | 40% |
| Routine Hearing Exams 1 routine exam per 24 months | \$35 office visit copay; deductible waived | 40% |
| PHYSICIAN SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery. | \$20 office visit copay; deductible waived | 40% |
| Specialist Office Visits | \$35 office visit copay; deductible waived | 40% |
| Allergy Testing | Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived | 40% |
| Allergy Injections | Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived | 40% |
| DIAGNOSTIC PROCEDURES | PREFERRED CARE | NON-PREFERRED CARE |
| Diagnostic Laboratory Services If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing | Covered 100%; deductible waived | 40% |
| Diagnostic X-ray Services | \$20 office visit copay; deductible waived | 40% |
| Diagnostic X-ray for Complex Imaging Services | 10% | 40% |
| EMERGENCY MEDICAL CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Urgent Care Provider | \$50 copay; deductible waived | 40% |
| Non-Urgent Use of Urgent Care Provider | Not Covered | Not Covered |
| Emergency Room | \$100 copay; deductible waived | Same as preferred care. |
| Non-Emergency care in an Emergency Room | Not Covered | Not Covered |
| Ambulance | 10% | 10% |
| HOSPITAL CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | 10% | 40% |
| Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | 10% | 40% |



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

| | | |
|---|-------------------------------|---|
| Outpatient Hospital Expenses (including surgery) | 10% | 40% |
| The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit | | |
| MENTAL HEALTH SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Serious Mental Illness | 10% | 40% |
| Limited to 45 combined days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| Inpatient Non-Serious Mental Illness | 10% | 40% |
| Limited to 30 combined days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| Outpatient Serious Mental Illness | \$35 copay; deductible waived | 40% |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | | |
| Outpatient Non-Serious Mental Illness | \$35 copay; deductible waived | 40% |
| Limited to 30 combined visits per calendar year The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | | |
| Crisis Stabilization Units/Residential Treatment Centers (for children and adolescents) | 10% | 40% |
| Partial Hospitalization (for day/night care treatment) | 10% | 40% |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| ALCOHOL/DRUG ABUSE SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Detoxification | 10% | 40% |
| Limited to 3 combined series of treatments per lifetime for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| Outpatient Detoxification | \$35 copay; deductible waived | 40% |
| Limited to 3 combined series of treatments per lifetime for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| Inpatient Rehabilitation | 10% | 40% |
| Limited to 3 combined series of treatments per lifetime for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| Outpatient Rehabilitation | \$35 copay; deductible waived | 40% |
| Limited to 3 combined series of treatments per lifetime for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| OTHER SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Convalescent Facility | 10% | 40% |
| Limited to 60 combined days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay | | |
| Home Health Care | 10% | 40% |
| Limited to 60 combined visits per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay | | |
| Infusion Therapy-Home or Physician Office | 10% | 40% |
| Includes total parenteral nutrition, chemotherapy, drug therapy, pain management and hydration therapy. | | Covered up to a maximum of \$50 per visit. Amounts over the allowable do not apply to the Out-of-pocket maximum. Prescription drugs will be covered 70% based on the Aetna Wholesale Price. |



**PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED**

| | | |
|--|---|---|
| Infusion Therapy-Outpatient Facility Includes total parenteral nutrition, chemotherapy, drug therapy, pain management and hydration therapy. | 10% | 40% |
| | | Covered up to a maximum of \$50 per visit. Amounts over the allowable do not apply to the Out-of-pocket maximum. Prescription drugs will be covered 70% based on the Aetna Wholesale Price. |
| Hospice Care - Inpatient Limited to 30 combined days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | 10% | 40% |
| Hospice Care - Outpatient Limited to \$5,000 per lifetime. | 10% | 40% |
| Private Duty Nursing - Outpatient Limited to 70 combined eight hour shifts per calendar year | 10% | 40% |
| Outpatient Short-Term Rehabilitation Includes Physical, Occupational, and Spinal Manipulation Therapy limited to 20 combined visits per calendar year. | \$35 copay; deductible waived | 40% |
| Outpatient Speech Therapy Limited to 20 combined visits per calendar year | \$35 copay; deductible waived | 40% |
| Durable Medical Equipment Limited to \$2,500 combined per calendar year | 10% | 40% |
| Diabetic Supplies -- (if not covered under Pharmacy benefit) | Covered same as any other medical expense ; deductible waived | Covered same as any other medical expense. |
| Mouth, Jaws and Teeth (oral surgery procedures, medical in nature only) | Member cost sharing is based on the type of service performed and the place of service where it is rendered | 40% |
| Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits) | 10% (payable as any other covered expense); deductible waived | 40% (payable as any other covered expense) |
| Transplants | 10% Preferred coverage is provided at an IOE contracted facility only | 40% Non-Preferred coverage is provided at a Non-IOE facility. Limited to a \$25,000 transplant specific maximum benefit |
| Bariatric Surgery | Not covered | Not covered |
| Out of Area Dependents | Coverage provided at the non-preferred benefit level of the plan. | |
| FAMILY PLANNING | PREFERRED CARE | NON-PREFERRED CARE |
| Infertility Treatment Diagnosis and treatment of the underlying medical condition only. | Member cost sharing is based on the type of service performed and the place of service where it is rendered | 40% |
| Voluntary Sterilization Including tubal ligation and vasectomy. | Member cost sharing is based on the type of service performed and the place of service where it is rendered | 40% |



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

| PHARMACY | PREFERRED CARE | NON-PREFERRED CARE |
|-------------------|---|--|
| Retail | \$10 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies. | 40% of submitted cost after \$10 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name drugs up to a 30 day supply. |
| Mail Order | \$20 copay for generic drugs, \$50 copay for formulary brand-name drugs, and \$80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®. | 40% of submitted cost after \$20 copay for generic drugs, \$50 copay for formulary brand-name drugs, and \$80 copay for non-formulary brand-name drugs up to a 31-90 day supply. |

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies. Precert for growth hormones included

GENERAL PROVISIONS

| | |
|--|--|
| Dependents Eligibility | Spouse, children from birth to age 25 regardless of student status |
| Pre-existing Conditions Exclusion | On effective date: Waived After effective date: Full Postponement |

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

Members may choose from a network of available providers (physicians and facilities) or may visit a nonparticipating provider. The nonparticipating provider will be paid based on Aetna's Recognized Charge (Aetna Market Fee Schedule (AMFS) and Aetna Facility Fee Schedule), which is the charge Aetna determines to be the usual charge level for the geographic area where the covered service is furnished. The member may be balance billed for the difference between the nonparticipating provider's usual fee and the amount allowed by the plan, in addition to any coinsurance or co-payments due under the plan provisions.



PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

| PLAN FEATURES | PREFERRED CARE | NON-PREFERRED CARE |
|---|--------------------------------------|--|
| Deductible (per calendar year) | \$1,500 Individual \$3,000 Family | \$3,000 Individual \$6,000 Family |
| All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is no individual deductible to satisfy within the family deductible. | | |
| Member Coinsurance | Covered 100% | 30% |
| Applies to all expenses unless otherwise stated. | | |
| Out of Pocket maximum (per calendar year, includes deductible) | \$1,500 Individual \$3,000 Family | \$10,000 Individual \$20,000 Family |
| All covered expenses accumulate simultaneously toward both the preferred and non-preferred Out of Pocket maximum. The Individual Out of Pocket maximum can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Out of Pocket maximum can be met by a combination of family members or by any single individual within the family. Once the Family Out of Pocket maximum is met, all family members will be considered as having met their Out of Pocket maximum for the remainder of the calendar year. | | |
| Lifetime Maximum | \$5,000,000 | |
| Payment for Non-Preferred Care | N/A | Recognized Charge* |
| *Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such service or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges. | | |
| Primary Care Physician Selection | Optional | Not applicable |
| Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence. | | |
| Referral Requirement | None | None |
| PREVENTIVE CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Routine Adult Physical Exams/ Immunizations 1 exam every 12 months. | Covered 100%; deductible waived | 30% |
| Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 2 exams in the 13th - 24th month of life, 1 exam per 12 months thereafter to age 18. | Covered 100%; deductible waived | 30% |
| Routine Gynecological Care Exams One annual routine exam. | Covered 100%; deductible waived | 30% |
| Routine Mammograms One mammogram per calendar year for covered females age 35 and above. | Covered 100%; deductible waived | 30% |
| Routine Digital Rectal Exam / Prostate- Colorectal Cancer Screening For all members age 50 and over. | Covered 100%; deductible waived | 30% |
| Newborn Hearing Screening 1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months | Covered 100%; deductible waived | 30% |
| Routine Eye Exams 1 routine exam per 24 months | Covered 100%; deductible waived | 30% |
| Routine Hearing Exams 1 routine exam per 24 months | Covered 100%; deductible waived | 30% |



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

| PHYSICIAN SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
|--|-----------------------|---------------------------|
| Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery. | Covered 100% | 30% |
| Specialist Office Visits | Covered 100% | 30% |
| Allergy Testing | Covered 100% | 30% |
| Allergy Injections | Covered 100% | 30% |
| DIAGNOSTIC PROCEDURES | PREFERRED CARE | NON-PREFERRED CARE |
| Diagnostic Laboratory Services If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing | Covered 100% | 30% |
| Diagnostic X-ray Services | Covered 100% | 30% |
| Diagnostic X-ray for Complex Imaging Services | Covered 100% | 30% |
| EMERGENCY MEDICAL CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Urgent Care Provider | Covered 100% | 30% |
| Non-Urgent Use of Urgent Care Provider | Not Covered | Not Covered |
| Emergency Room | Covered 100% | Same as preferred care. |
| Non-Emergency care in an Emergency Room | Not Covered | Not Covered |
| Ambulance | Covered 100% | Same as preferred care. |
| HOSPITAL CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% | 30% |
| Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% | 30% |
| Outpatient Hospital Expenses (including surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit | Covered 100% | 30% |
| MENTAL HEALTH SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Serious Mental Illness Limited to 45 combined days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% | 30% |
| Inpatient Non-Serious Mental Illness Limited to 30 combined days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% | 30% |
| Outpatient Serious Mental Illness The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | Covered 100% | 30% |
| Outpatient Non-Serious Mental Illness Limited to 30 combined visits per calendar year The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | Covered 100% | 30% |
| Crisis Stabilization Units/Residential Treatment Centers (for children and adolescents) | Covered 100% | 30% |
| Partial Hospitalization (for day/night care treatment) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% | 30% |



PLAN DESIGN AND BENEFITS
 PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

| ALCOHOL/DRUG ABUSE SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
|---|-----------------------|--|
| Inpatient Detoxification Limited to 3 combined series of treatments per lifetime for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | Covered 100% | 30% |
| Outpatient Detoxification Limited to 3 combined series of treatments per lifetime for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | Covered 100% | 30% |
| Inpatient Rehabilitation Limited to 3 combined series of treatments per lifetime for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | Covered 100% | 30% |
| Outpatient Rehabilitation Limited to 3 combined series of treatments per lifetime for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | Covered 100% | 30% |
| OTHER SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Convalescent Facility Limited to 60 combined days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay | Covered 100% | 30% |
| Home Health Care Limited to 60 combined visits per calendar year. | Covered 100% | 30% |
| Infusion Therapy-Home or Physician Office Includes total parenteral nutrition, chemotherapy, drug therapy, pain management and hydration therapy. | Covered 100% | 30% Covered up to a maximum of \$50 per visit. Amounts over the allowable do not apply to the Out-of-pocket maximum. Prescription drugs will be covered 70% based on the Aetna Wholesale Price. |
| Infusion Therapy-Outpatient Facility Includes total parenteral nutrition, chemotherapy, drug therapy, pain management and hydration therapy. | Covered 100% | 30% Covered up to a maximum of \$50 per visit. Amounts over the allowable do not apply to the Out-of-pocket maximum. Prescription drugs will be covered 70% based on the Aetna Wholesale Price. |
| Hospice Care - Inpatient Limited to 30 combined days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% | 30% |
| Hospice Care - Outpatient Limited to \$5,000 combined per lifetime | Covered 100% | 30% |
| Private Duty Nursing - Outpatient Limited to 70 combined eight hour shifts per calendar year | Covered 100% | 30% |
| Outpatient Short-Term Rehabilitation Includes Physical, Occupational, and Spinal Manipulation Therapy limited to 20 combined visits per calendar year. | Covered 100% | 30% |
| Outpatient Speech Therapy Limited to 20 combined visits per calendar year | Covered 100% | 30% |
| Therapy for Developmental Delays Speech, Physical, and Occupational Therapy evaluations and services for children to age 18 | Covered 100% | 30% |



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

| | | |
|---|--|--|
| Durable Medical Equipment Limited to \$2,500 combined per calendar year | Covered 100% | 30% |
| Diabetic Supplies -- (if not covered under Pharmacy benefit) | Covered same as any other medical expense ; deductible waived | Covered same as any other medical expense. |
| Mouth, Jaws and Teeth (oral surgery procedures, medical in nature only) | Member cost sharing is based on the type of service performed and the place of service where it is rendered | 30% |
| Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits) | Covered 100% (payable as any other covered expense) | 30% (payable as any other covered expense) |
| Transplants | Covered 100%; Preferred coverage is provided at an IOE contracted facility | 30% Non-Preferred coverage is provided at a Non-IOE facility. Limited to a \$25,000 transplant specific maximum benefit |
| Out of Area Dependents | Coverage provided at the non-preferred benefit level of the plan. | |
| FAMILY PLANNING | PREFERRED CARE | NON-PREFERRED CARE |
| Infertility Treatment | Member cost sharing is based on the type of service performed and the place of service where it is rendered | 30% |
| Diagnosis and treatment of the underlying medical condition only. | | |
| Voluntary Sterilization Including tubal ligation and vasectomy. | Member cost sharing is based on the type of service performed and the place of service where it is rendered | 30% |
| PHARMACY | PREFERRED CARE | NON-PREFERRED CARE |
| The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan. | | |
| Retail | Covered 100% after combined medical/RX/dental deductible for generic drugs, formulary brand-name drugs and non-formulary brand-name drugs up to a 30 day supply at participating pharmacies | 30% of submitted cost after combined medical/RX/dental deductible for generic drugs , formulary brand-name drugs and non-formulary brand-name drugs up to a 30 day supply. |
| Mail Order | Covered 100% after combined medical/RX/dental deductible for generic drugs, formulary brand-name drugs and non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®. | N/A |
| Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available on Aetna Navigator™ or from your employer. | | |
| No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only. | | |
| Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies. Precert for growth hormones included | | |



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 25 regardless of student status

Pre-existing Conditions Exclusion On effective date: Waived
After effective date: Full Postponement

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

Members may choose from a network of available providers (physicians and facilities) or may visit a nonparticipating provider. The nonparticipating provider will be paid based on Aetna's Recognized Charge (Aetna Market Fee Schedule (AMFS) and Aetna Facility Fee Schedule), which is the charge Aetna determines to be the usual charge level for the geographic area where the covered service is furnished. The member may be balance billed for the difference between the nonparticipating provider's usual fee and the amount allowed by the plan, in addition to any coinsurance or co-payments due under the plan provisions.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.

Dental Plan

Guardian Life Insurance Company is the college's dental insurance carrier. The dental plan contains a lifetime deductible for each covered member, as well as orthodontia benefits for dependents under the age of 19.

| Type of Service | Benefit |
|--|---|
| One-Time Deductible | \$100/ Individual |
| Preventive and Basic Services | 70% first year, and increase by 10% annually until 100% at the beginning of your fourth year of employment. |
| Major Services | 60% |
| Plan Year (10/1 – 9/30) Maximum Benefit | \$2,000 |
| Orthodontia Services | 50% |
| Orthodontia Life Time Maximum | \$1,500 |

- Preventive and Basic Services – If you do not have an oral examination and prophylaxis completed one time per plan year (10/1 – 09/30), then the coinsurance for preventive and basic services will revert back to the first year payment rate during the following benefit year. You would then have to advance through year 2, 3 and 4 payment rates again.
- Prophylaxis – limited to two treatments in any benefit year (10/1 – 9/30)
- If you utilize non-network providers, only amounts at or below usual and customary expenses will be eligible. Amounts above usual and customary will be your responsibility.

Your contribution is based on the level of coverage you select. Below are the **semi-monthly** employee contributions.

| Coverage Level | Semi-Monthly Contribution |
|-----------------------------------|---------------------------|
| Employee Only | \$0.00 |
| Employee + Spouse/ Partner | \$17.50 |
| Employee+ Child(ren) | \$16.50 |
| Employee + Family | \$34.00 |

Vision Plan

The vision plan will continue to be through United Healthcare Vision, formerly known as Spectera. If you choose a network provider, you pay the co-pay plus the cost of any non-covered options. If you choose a non-network provider, you pay the full fee to the provider, and submit itemized receipts to United Healthcare Vision to receive reimbursement for non-network allowances. The following chart is an overview of the network and non-network benefits.

| Type of Service | Network | Non-Network |
|--|--|---|
| Exams – Every 12 months | \$10 Co-pay | \$40 Reimbursement |
| Lenses – Every 12 months | \$25 Co-pay | \$40 to \$80 Reimbursement based on lens type |
| Frame – Every 24 months | Selected frames covered in full. Private Practice Provider - \$50 wholesale allowance. Retail Chain Provider - \$130 retail frame allowance. | Up to a \$45 Reimbursement |
| Contact Lenses (in lieu of eyeglasses) – Every 12 months | Selected lenses covered in full after \$25 Co-pay. Other lenses - \$105 Reimbursement ¹ | \$105 Reimbursement ¹ |
| Refractive Eye Surgery | Discounted refractive eye surgery is available from numerous providers in Houston. To find a participating laser eye surgeon, visit www.myuhcspecialtybenefits.com . | |

To locate a network provider, call United Healthcare Vision at 1-800-839-3242 or visit their website at www.myuhcspecialtybenefits.com. Always identify yourself as a United Healthcare Vision member when making an appointment with a provider so that claim authorization can be obtained prior to your visit.

Your **semi-monthly** employee contribution is as follows:

| Coverage Level | Semi-Monthly Contribution |
|-----------------------------------|---------------------------|
| Employee Only | \$3.54 |
| Employee + Spouse/ Partner | \$6.73 |
| Employee + Child(ren) | \$7.05 |
| Employee + Family | \$10.85 |

¹You must include all claims in a single claim filing to receive the full \$105 reimbursement. If you file a claim for less than \$105, you will exhaust your entire contact lens benefit for the year.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that allows you to pay health care and dependent care expenses on a pre-tax basis and lower your taxable income. With an FSA, money is taken out of your paycheck on a pre-tax basis to pay for eligible expenses. Flex Corp will continue to be the FSA provider for South Texas College of Law.

Health Care Reimbursement Account (HCRA)

You can pay for, with pre-tax dollars, certain IRS-approved medical care expenses not covered by an insurance plan. **You may contribute up to \$5,000 per plan year** (10/1 – 9/30). Please note that if you are actively participating in the HCRA at the end of the plan year, 9/30/09, then you are eligible to continue incurring claims through 12/15/09, and reimbursing yourself from your 2008 plan year HCRA account. You have until 1/31/10 to file your claims for reimbursement. This plan feature allows you the additional opportunity to use up the previous year's account balance.

Reimbursement Timeline*

| Actively Enrolled in Plan | Incur Claims Through | Reimbursed From | Deadline for Filing Claims |
|---------------------------|----------------------|-----------------------------|----------------------------|
| 10/1/08 – 9/30/09 | 12/15/09 | 2008 Plan Year HCRA Account | 1/31/10 |
| 10/1/09 – 9/30/10 | 12/15/10 | 2009 Plan Year HCRA Account | 1/31/11 |

***To optimize your reimbursement, submit your claims by date incurred, starting with the oldest claims first.**

Some examples of eligible expenses under the HCRA include:

- Your deductibles and copayments under the medical plan. **Please note if you enroll in the High Deductible Health Plan (HDHP), you will not be able to use the HCRA to reimburse yourself (or your dependents) for medical expenses. You will only be able to use this account for dental and vision expenses.**
- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations, eyeglasses and LASIK eye surgery
- Dental services and orthodontia
- Acupuncture
- Prescription contraceptives
- Certain over-the-counter medications

Dependent Care Reimbursement Account (DCRA)

You can pay, with pre-tax dollars, qualified dependent care such as caring for children under the age of 13 or caring for elders. **The maximum amount you may contribute to the DCRA is \$5,000** (or \$2,500 if married and filing separately) per plan year (10/1-9/30). Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten and above)

Note: All expenses for both the health care and dependent care reimbursement accounts must be used for expenses incurred during the plan year. You will forfeit any unused funds. Be sure to plan carefully.

IMPORTANT FOR YOU TO KNOW: Medical, Dental, Vision and FSA contributions are taken on a pre-tax basis and, therefore, cannot be changed until the next open enrollment, unless you have an IRS qualified family status change such as marriage, divorce, death, birth, change in child's dependent or student status, change in your or your spouse's employment status, or loss of spouse's health coverage.

On the following pages are examples of eligible expenses for FSAs.

List of Qualified Health Care Expenses for HSA and FSA

| Eligible Health Care Expenses | | |
|--|---|--|
| <ul style="list-style-type: none"> • Abdominal supports • Abortion • Acupuncture • Air conditioner (when necessary for relief from difficulty in breathing) • Alcoholism treatment • Ambulance • Anesthetist • Arch supports • Artificial limbs • Autoeette (when used for relief of sickness/disability) • Birth Control Pills (by prescription) • Blood tests • Blood transfusions • Braces • Cardiographs • Chiropractor • Christian Science Practitioner • Contact Lenses • Contraceptive devices (by prescription) • Convalescent home (for medical treatment only) • Crutches • Dental Treatment • Dental X-rays • Dentures • Dermatologist • Diagnostic fees • Diathermy • Drug addiction therapy • Drugs (prescription) | <ul style="list-style-type: none"> • Elastic hosiery (prescription) • Eyeglasses • Fees paid to health institute prescribed by a doctor • FICA and FUTA tax paid for medical care service • Fluoridation unit • Guide dog • Gum treatment • Gynecologist • Healing services • Hearing aids and batteries • Hospital bills • Hydrotherapy • Insulin treatment • Lab tests • Lead paint removal • Legal fees • Lodging (away from home for outpatient care) • Metabolism tests • Neurologist • Nursing (including board and meals) • Obstetrician • Operating room costs • Ophthalmologist • Optician • Optometrist • Oral surgery • Organ transplant (including donor's expenses) • Orthopedic shoes • Orthopedist • Osteopath | <ul style="list-style-type: none"> • Oxygen and oxygen equipment • Pediatrician • Physician • Physiotherapist • Podiatrist • Postnatal treatments • Practical nurse for medical services • Prenatal care • Prescription medicines • Psychiatrist • Psychoanalyst • Psychologist • Psychotherapy • Radium Therapy • Registered nurse • Special school costs for the handicapped • Spinal fluid test • Splints • Sterilization • Surgeon • Telephone or TV equipment to assist the hard-of-hearing • Therapy equipment • Transportation expenses (relative to health care) • Ultra-violet ray treatment • Vaccines • Vasectomy • Vitamins (if prescribed) • Wheelchair • X-rays |

List of Qualified Health Care Expenses for HSA or FSA

Eligible Over-the-Counter Drugs

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Antacids • Allergy medications • Pain Relievers • Cold medicine • Anti-diarrhea medicine • Cough drops and throat lozenges | <ul style="list-style-type: none"> • Sinus medications and Nasal sprays • Nicotine medications and nasal sprays • Pedialyte • First aid creams • Calamine lotion | <ul style="list-style-type: none"> • Wart removal medication • Antibiotic ointments • Suppositories and creams for hemorrhoids • Sleep aids • Motion sickness pills |
|---|---|--|

Ineligible Health Care Expenses

- | | |
|---|--|
| <ul style="list-style-type: none"> • Advancement payment for services to be rendered next year • Athletic Club membership • Automobile insurance premium allocable to medical coverage • Boarding school fees • Bottled Water • Commuting expenses of a disabled person • Cosmetic surgery and procedures • Cosmetics, hygiene products and similar items • Funeral, cremation, or burial expenses • Health programs offered by resort hotels, health clubs, and gyms • Illegal operations and treatments • Illegally procured drugs • Maternity clothes | <ul style="list-style-type: none"> • Non-prescription medication • Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits • Scientology counseling • Social activities • Special foods and beverages • Specially designed car for the handicapped other than an autoette or special equipment • Stop-smoking programs • Swimming pool • Travel for general health improvement • Tuition and travel expenses for a problem child to a particular school • Weight loss programs |
|---|--|

Ineligible Over-the-Counter Drugs

- | | |
|--|---|
| <ul style="list-style-type: none"> • Toiletries (including toothpaste) • Acne treatments • Lip balm (including Chap stick or Carmex) • Cosmetics (including face cream and moisturizer) • Suntan lotion • Medicated shampoos and soaps | <ul style="list-style-type: none"> • Vitamins (daily) • Fiber supplements • Dietary supplements • Weight loss drugs for general well being • Herbs |
|--|---|

Group Life and Accidental Death & Dismemberment

Prudential Financial will continue to be the college's life insurance carrier. **South Texas College of Law will continue to pay 100% of the cost** for both your Group Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance provided through Prudential Financial, and employees will continue to be covered at two times their annual salary.

Optional Life and Accidental Death & Dismemberment

The college recognizes that deciding to purchase life insurance is one of the most important decisions you can make for your family's future. Therefore, we provide you with the opportunity to obtain additional coverage through Prudential Financial.

All employees can elect to upgrade their optional life coverages at any time during the year. Please contact Human Resources for Prudential Optional Life forms. All late entrants will be required to go through medical underwriting, prior to being approved for any elected benefit. Enrollment is available year-round for buy-up options dependent on Evidence of Insurability (EOI).

Employee Optional Life

You may elect coverage in increments of \$10,000. The maximum you may elect is limited to the lesser of 5 times your salary or \$500,000. This coverage is available to you with a guaranteed issue of \$100,000 benefit, provided enrollment takes place within 30 days of your initial eligibility date. Amounts over \$100,000 are subject to Evidence of Insurability.

Dependent Optional Life

You have an option of purchasing a basic dependent life benefit. Under this option, your spouse/ partner has a \$10,000 life benefit, and your child(ren) have a \$5,000 benefit. This benefit is \$0.81 per semi-monthly payroll.

Spouse/ Partner Optional Life

In addition to the basic dependent life benefit, you may purchase additional coverage on your spouse/ partner in increments of \$10,000 up to \$250,000 or 100% of the amount you purchase on yourself. Elected amounts greater than \$20,000 are subject to Evidence of Insurability. The cost of the additional spouse/ partner coverage is based on the age of the employee.

Rates for employee optional life as well as the spouse optional life are listed on the following page. **Note: Rates include reductions for age. The life insurance benefits for all life insurance (basic and optional) options reduces to 65% at age 70 and 50% at age 75. These rates are marked with an asterisk on the following page.**

Long Term Disability

South Texas College of Law values your service and wants to ensure you are taken care of in the event of an eligible life changing accident or disability. The college will continue to pay 100% of the cost for the LTD policy which provides an eligible **LTD benefit level of 66 2/3% of pay for all faculty and staff.** The long term disability carrier will continue to be Prudential Financial.

| | |
|----------------------------------|---|
| Elimination Period: | 90 Days |
| Monthly Eligible Benefit: | 66 2/3% of Monthly Earnings |
| Maximum Eligible Benefit: | \$12,500 Per Month |
| Minimum Eligible Benefit: | \$100 Per Month |
| Own Occupation Period: | 24 Months, After 24 Months Any Occupation |
| Benefit Duration: | Prior to Age 65, to Normal Retirement Age |

Long Term Care

The Long Term Care (LTC) benefit provides you with assistance or long-term care after your loss of ability to perform certain activities of daily living or you suffer a cognitive impairment. This benefit is provided through UNUM.

The college provides all employees with a base benefit of \$1,000 per month for three years of care in a nursing facility. All employees can elect to upgrade their LTC coverage at any time during the year. Please contact Human Resources for a UNUM information packet if interested in additional information for any increase in coverage availability.

You may purchase additional LTC benefits to accompany the base benefit by:

- Electing coverage for your spouse/ domestic partner or respective parents or grandparents.
- Enrolling in a combination of home care and nursing facility care (Indicated as Plan 2 on the Long-Term Care enrollment form).
- By increasing the amount of the monthly benefit. Additional monthly benefit amounts are \$2,000, \$3,000, \$4,000, \$5,000, and \$6,000.
- Increasing the duration of the benefit from three years to an unlimited time.

All late entrants will be required to go through medical underwriting, prior to being approved for any elected benefit. Enrollment is available year round for buy-up options dependent on Evidence of Insurability.

Additional Benefits

401(a) Defined Contribution Retirement Plan

Full time and part time staff members become eligible after one year of employment, after having worked 1,000 hours in a 12 consecutive month period, and the attainment of age 25. The college contributes an amount equal to 10% of your salary, up to a maximum defined by the IRS, into a retirement fund managed by TIAA-CREF. You have the right to direct your own investment amounts in a variety of investment vehicles. Vesting of the college contributions on your behalf is immediate upon becoming eligible for the plan. You may not borrow against the amount you have in this plan.

403(b) Deferred Annuities

These supplemental retirement annuities may be purchased through TIAA-CREF at an amount not to exceed IRS laws and regulations. For most employees, this maximum amount will be 20% of earned salary but not exceeding the IRS annual maximums depending on age and length of service.

Employee Assistance Plan (EAP)

The EAP is provided through MHNet to you and members of your immediate household at no cost. This plan is designed to assist employees and family members in dealing with a variety of personal problems such as depression, marital difficulties, concerns with children, substance abuse, legal questions, or financial crisis. The details of any personal problems are confidential and remain between the user and the professional EAP counselor. A 24-hour toll free number is provided to receive further information or to receive immediate assistance in a time of crisis.

Credit Union

The college employees are eligible to join Smart Financial Credit Union, which offers a full line of banking services such as savings programs and checking accounts, a variety of loans at competitive or lower rates, and credit cards available at a lower cost than most other credit cards.

Direct Deposit

We encourage utilization of our direct deposit program. Paychecks can be automatically deposited each payday into a qualifying bank, savings, or credit union account assigned to your name and you can have up to three individual direct deposit accounts at the same or separate institutions.

Texas Lawyers Assistance Program (TLAP)

A confidential 24-hour service made up of lawyers and judges throughout the state, as well as a network of volunteers, all of whom are committed to helping troubled lawyers get assistance and support. This program offers help to lawyers suffering from chemical dependence, stress, depression and similar problems. Referrals may be made by the impaired attorney, or by anyone concerned about the attorney by calling 1-800-343-TLAP at any time of the day. By law, all information is kept strictly confidential.

Parking

Parking in our designated lot is currently provided on a space available basis for employees of the college at no cost.

