DENTON
INDEPENDENT SCHOOL DISTRICT

2016 - 2017
Employee Benefits Guide

Denton ISD
Insurance Department

P. O. Box 1951
1314 N. Bolivar
Denton, TX 76202

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940-369-4980fax
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www.dentonisd.org

US Employee Benefits Services Group

www.usebsg.com

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CONTACT INFORMATION

DENTON ISD
INSURANCE DEPARTMENT
P.O. Box 1951, 1314 N. Bolivar
Denton, TX 76202
(940) 369-0028
disdinsurance@dentonisd.org
www.dentonisd.org

TRS ActiveCare - Aetna: Customer Service
(800) 222-9205
www.trsactivecareaetna.com
24-Hour Nurse Information Line
(800) 556-1555
Beginning Right Maternity Management Program
(800) 272-3531
Caremark Prescription Benefits:
(800) 222-9205
www.caremark.com/trsactivecare
Teladoc: (855) 835-2362
Mental Health/Sub Abuse: (800) 424-4047

TRS ActiveCare Scott & White HMO
(800)-321-7947 TTY/TTD (800) 735-2989
Fax (254) 298-3385
Nurse Advice Line (877) 505-7947
www.trs.swhp.org

Standard Dental:
Group Policy # 160-751174
P.O. Box 82622
Lincoln NE 68501-2622
(800) 574-9515
www.standard.com/dental

Superior Vision:
Group # 31823
PO Box 967, Rancho Cordova, CA 95741
(800) 507-3800
www.superiorvision.com

Lincoln Financial Life:
Basic Life Policy # 000010176512
Voluntary Life Policy # 000400176513
P. O. Box 2649, Omaha, NE 68103-2649
(800) 487-1485 Fax (800) 819-1987
www.lincolnfinancial.com

Standard Disability:
Policy # 751174-A
P. O. Box 2800, Portland, OR 97208
(855) 757-4717
www.standard.com

Colonial Cancer:
Policy # G0012603
P. O. Box 10095, Columbia, SC 29202 - 3195
(800) 325-4368 Fax (800) 880-9325
www.coloniallife.com

TASC Flexible Spending Accounts
2302 International Lane, Madison, WI 53704
(800) 422-4661
www.tasconline.com

Employee Assistance Program (EAP):
(877) 851-1631
www.eapbda.com

U.S. Employee Benefits Services Group:
Keith Noel
(877) 730-7780 / (972) 772-0900
www.usegsg.com

INTRODUCTION

This booklet is designed to highlight the benefits. It is not a summary plan description (SPD). Official plan and insurance documents actually govern your rights and benefits under each plan.

For more details about your benefits, including covered expenses, exclusions and limitations please refer to the SPD for each benefit plan.

If any discrepancy exists between this booklet and the official documents, the official documents SPD will prevail.

U.S. Employee Benefits Services Group (USEBSG) is the nation's leading independent provider and administrator of employer-sponsored benefits and retirement plans in the school district market place. We serve over 400 ISDs in Texas and are endorsed by TACS.
Our focus is on developing comprehensive programs providing affordable solutions for Denton Independent School District benefits, online enrollment and retirement plan needs. We have 25 years of experience and over 1,000,000 clients across the nation.

Keith Noel
(877) 730-7780 / (972) 772-0900
www.usebsg.com

US Employee Benefits Services Group.

GENERAL INFORMATION

Denton ISD offers a wide range of benefits to eligible employees and their family members. All eligible employees will either go online or come to the Insurance Department to enroll or decline/waive.

You will be required to provide the name, date of birth and social security number for any dependents (this includes spouse) that are listed. You will not be allowed to enroll without all the required information.

If you are a new or newly eligible employee, you have 31 days from your date of employment (start date) to enroll in benefits.

In the event that you do not enroll by the 31st day, your next window of opportunity to enroll in benefits will be during annual open enrollment.

The plan options and coverage levels you select for the 2016 - 2017 plan year will remain in effect from September 1, 2016 through August 31, 2017.

All eligible employees, including active, contributing TRS members, employees regularly working 10 hours per week and Substitutes, MUST either enroll for coverage or decline/waive coverage.

You can only add or change coverage during the year if you have a Qualified Family Status Change/Special Enrollment event such as: marriage, divorce, birth or adoption, death, court order (child(ren) coverage only), gain or loss of coverage due to employment change.

You must submit all required documentation and make your plan changes online within 31 calendar days from the date of the event.

As an active, full time or part time, benefits eligible employee you will receive basic life from the district, at no cost.

There are certain benefits that are offered on a guaranteed issue basis. This means that if you sign up as a new employee you will not be denied coverage. If you do not enroll and later decide to, you may be required to answer medical questions and coverage could be denied.

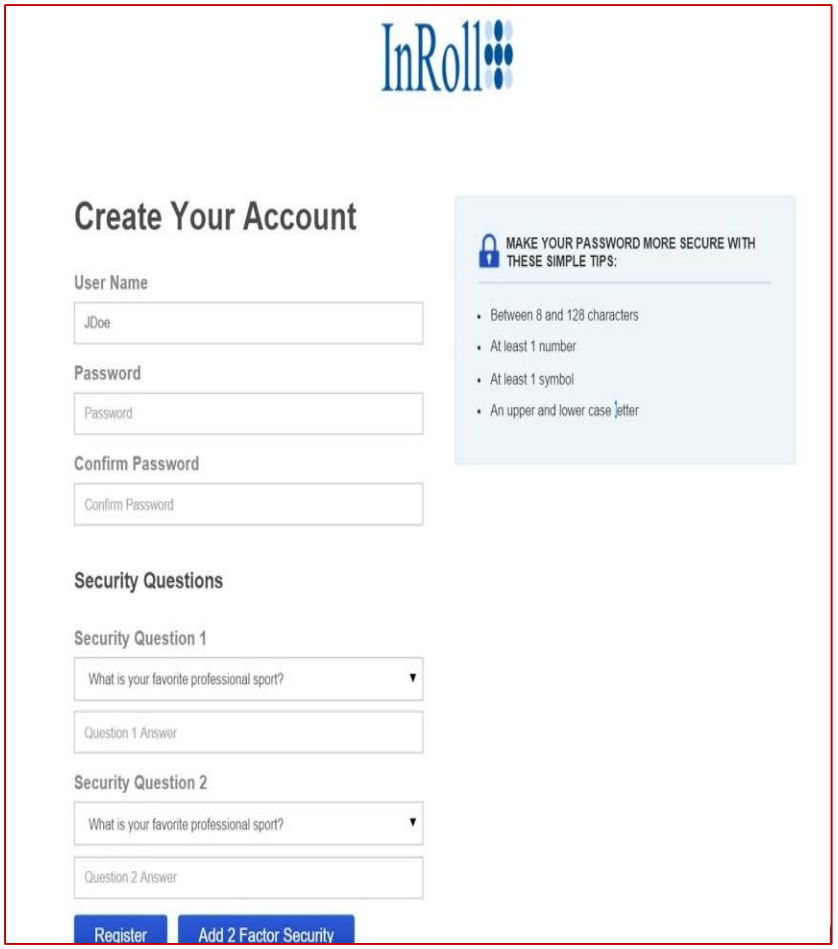
You will enroll in or decline/waive all benefit options through our **NEW** online enrollment system InRoll Plus, at www.inrollplus.com/dentonisd or come by the Insurance Department.

When signing up online please remember to:

- **Verify all information for yourself and all dependents.**
- **Only the dependents listed in In-Roll Plus will be eligible for benefits.**
- **Under each benefit section, you must enroll in or decline/waive coverage for yourself and each listed dependent spouse and/or child.**
- **You MUST click on the Complete Enrollment Option at the bottom of your Confirmation Statement to save and complete the processing of your benefit choices. IF YOU DO NOT, ALL benefits not elected for the upcoming year will end the last day in August of the prior plan year.**

HOW DO I ENROLL ONLINE?

You will sign up for all benefits through our online enrollment system, www.inrollplus.com/dentonisd or come by the Denton ISD Insurance Dept. during business hours, no appointment needed.



Creating Your Account

The first time you log in to InRoll Plus, you must enter your last name, last four digits of your social security number and your date of birth under the **New User?** Section of the Create Your Account page. You may also view the **Login Video Tutorial** for step by step instructions.

You will then be prompted to ***Create Your Account.*** You will choose a User Name and Password as well as two Security Questions in order to register.

2016 - 2017 TRS ACTIVECARE RATES

TRS ActiveCare Medical Plan Name	Monthly Premium	District Contribution per Month	Monthly Paid Employees Payroll Deduction	24 Pay Periods with Ins. Deductions Payroll Deduction	16 Pay Periods with Ins. Deductions Payroll Deduction	PART-TIME 10-14 SUBSTITUTES (NO DISTRICT CONTRIBUTION) Ineligible for payroll deductions
ActiveCare 1HD						
EE (employee only)	$341.00	$260.00	$81.00	$40.50	$60.75	$341.00
ES (employee + spouse)	$914.00	$260.00	$654.00	$327.00	$490.50	$914.00
EC (employee + child(ren)	$615.00	$260.00	$355.00	$177.50	$266.25	$615.00
FAM (family)	$1,231.00	$260.00	$971.00	$485.50	$728.25	$1,231.00
ActiveCare 1 Split Premium	**SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT**					
ES (employee + spouse)	$457.00	$260.00	$197.00	$98.50	$147.75	
FAM (family)	$615.50	$260.00	$355.50	$177.75	$266.63	
ActiveCare 1 Pooling	**BOTH WORK FOR DISD AND ONE DECLINES COVERAGE**					
ES (employee + spouse)	$914.00	$520.00	$394.00	$197.00	$295.50	
FAM (family)	$1,231.00	$520.00	$711.00	$355.50	$533.25	
ActiveCare Select						
EE (employee only)	$484.00	$260.00	$224.00	$112.00	$168.00	$484.00
ES (employee + spouse)	$1,147.00	$260.00	$887.00	$443.50	$665.25	$1,147.00
EC (employee + child(ren)	$779.00	$260.00	$519.00	$259.50	$389.25	$779.00
FAM (family)	$1,361.00	$260.00	$1,101.00	$550.50	$825.75	$1,361.00
ActiveCare Select Split Premium	**SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT**					
ES (employee + spouse)	$573.50	$260.00	$313.50	$156.75	$235.13	
FAM (family)	$680.50	$260.00	$420.50	$210.25	$315.38	
ActiveCare Select Pooling	**BOTH WORK FOR DISD AND ONE DECLINES COVERAGE**					
ES (employee + spouse)	$1,147.00	$520.00	$627.00	$313.50	$470.25	
FAM (family)	$1,361.00	$520.00	$841.00	$420.50	$630.75	
ActiveCare 2						
EE (employee only)	$645.00	$260.00	$385.00	$192.50	$288.75	$645.00
ES (employee + spouse)	$1,552.00	$260.00	$1,292.00	$646.00	$969.00	$1,552.00
EC (employee + child(ren)	$1,042.00	$260.00	$782.00	$391.00	$586.50	$1,042.00
FAM (family)	$1,597.00	$260.00	$1,337.00	$668.50	$1,002.75	$1,597.00
ActiveCare 2 Split Premium	**SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT**					
ES (employee + spouse)	$776.00	$260.00	$516.00	$258.00	$387.00	
FAM (family)	$798.50	$260.00	$538.50	$269.25	$403.88	
ActiveCare 2 Pooling	**BOTH WORK FOR DISD AND ONE DECLINES COVERAGE**					
ES (employee + spouse)	$1,552.00	$520.00	$1,032.00	$516.00	$774.00	
FAM (family)	$1,597.00	$520.00	$1,077.00	$538.50	$807.75	
HMO - Scott & White Health Plan						
EE (employee only)	$530.16	$260.00	$270.16	$135.08	$202.62	$530.16
ES (employee + spouse)	$1,192.82	$260.00	$932.82	$466.41	$699.62	$1,192.82
EC (employee + child(ren)	$839.16	$260.00	$579.16	$289.58	$434.37	$839.16
FAM (family)	$1,322.98	$260.00	$1,062.98	$531.49	$797.24	$1,322.98
Scott & White Split Premium	**SPOUSE WORKS IN A DIFFERENT PARTICIPATING DISTRICT**					
ES (employee + spouse)	$596.41	$260.00	$336.41	$168.21	$252.31	
FAM (family)	$661.49	$260.00	$401.49	$200.75	$301.12	
Scott & White Pooling	**BOTH WORK FOR DISD AND ONE DECLINES COVERAGE**					
ES (employee + spouse)	$1,192.82	$520.00	$672.82	$336.41	$504.62	
FAM (family)	$1,322.98	$520.00	$802.98	$401.49	$602.24	

2016 – 2017 TRS-ActiveCare Plan Highlights

*Effective September 1, 2016 through August 31, 2017 | In-Network Level of Benefits**

Type of Service	ActiveCare 1-HD	ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott & White Quality Alliance; Memorial Hermann Accountable Care Network; Seton Health Alliance)	ActiveCare 2
Deductible (per plan year)	$2,500 employee only $5,000 family	$1,200 individual $3,600 family	$1,000 individual $3,000 family
Out-of-Pocket Maximum (per plan year; does include medical deductible/ any medical copays/coinsurance/any prescription drug deductible and applicable copays/coinsurance)	$6,550 individual $13,100 family (the individual out-of-pocket maximum only includes covered expenses incurred by that individual)	$6,850 individual $13,700 family	$6,850 individual $13,700 family
Coinsurance Plan pays (up to allowable amount) Participant pays (after deductible)	 80% 20%	 80% 20%	 80% 20%
Office Visit Copay Participant pays	20% after deductible	$30 copay for primary $60 copay for specialist	$30 copay for primary $50 copay for specialist
Diagnostic Lab Participant pays	20% after deductible	Plan pays 100% (deductible waived) if performed at a Quest facility; 20% after deductible at other facility	Plan pays 100% (deductible waived) if performed at a Quest facility; 20% after deductible at other facility
Preventive Care See reverse side for a list of services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Teladoc® Physician Services	$40 consultation fee (applies to deductible and out-of-pocket maximum)	Plan pays 100%	Plan pays 100%
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	20% after deductible	$100 copay plus 20% after deductible	$100 copay plus 20% after deductible
Inpatient Hospital (preauthorization required) (facility charges) Participant pays	20% after deductible	$150 copay per day plus 20% after deductible ($750 maximum copay per admission)	$150 copay per day plus 20% after deductible ($750 maximum copay per admission; $2,250 maximum copay per plan year)
Emergency Room (true emergency use) Participant pays	20% after deductible	$150 copay plus 20% after deductible (copay waived if admitted)	$150 copay plus 20% after deductible (copay waived if admitted)
Outpatient Surgery Participant pays	20% after deductible	$150 copay per visit plus 20% after deductible	$150 copay per visit plus 20% after deductible
Bariatric Surgery Physician charges (only covered if performed at an IOQ facility) Participant pays	$5,000 copay plus 20% after deductible	Not covered	$5,000 copay (does not apply to out-of-pocket maximum) plus 20% after deductible
Prescription Drugs Drug deductible (per plan year)	Subject to plan year deductible	$0 for generic drugs $200 per person for brand-name drugs	$0 for generic drugs $200 per person for brand-name drugs
Retail Short-Term (up to a 31-day supply) Participant pays ▪ Generic copay ▪ Brand copay (preferred list) ▪ Brand copay (non-preferred list)	20% after deductible	 $20 $40** 50% coinsurance**	 $20 $40** $65**
Retail Maintenance (after first fill; up to a 31-day supply) Participant pays ▪ Generic copay ▪ Brand copay (preferred list) ▪ Brand copay (non-preferred list)	20% after deductible	 $35 $60** 50% coinsurance**	 $35 $60** $90**
Mail Order and Retail-Plus (up to a 90-day supply) Participant pays ▪ Generic copay ▪ Brand copay (preferred list) ▪ Brand copay (non-preferred list)	20% after deductible	 $45 $105** 50% coinsurance**	 $45 $105** $180**
Specialty Drugs Participant pays	20% after deductible	20% coinsurance per fill	$200 per fill (up to 31-day supply) $450 per fill (32- to 90-day supply)

A specialist is any physician other than family practitioner, internist, OB/GYN or pediatrician. *Illustrates benefits when in-network providers are used. For some plans non-network benefits are also available; there is no coverage for non-network benefits under the ActiveCare Select or ActiveCare Select Whole Health Plan; see Enrollment Guide for more information. Non-contracting providers may bill for amounts exceeding the allowable amount for covered services. Participants will be responsible for this balance bill amount, which maybe considerable. **If the patient obtains a brand-name drug when a generic equivalent is available, the patient will be responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.

TRS-ActiveCare Plans – Preventive Care

Preventive Care Services	In-Network Benefits When Using In-Network Providers (Provider must bill services as "preventive care")		
	ActiveCare 1-HD	**ActiveCare Select or ActiveCare Select Whole Health** (Baptist Health System and HealthTexas Medical Group; Baylor Scott & White Quality Alliance; Memorial Hermann Accountable Care Network; Seton Health Alliance)	**ActiveCare 2 Network**
Evidence–based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations**. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. Evidence–informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents. Additional preventive care and screenings for women, not described above, as provided for in comprehensive guidelines supported by the HRSA **http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/index.html#CoveredPreventiveServicesforAdults**. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009). The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified.	Plan pays 100% (deductible waived) Some examples of preventive care frequency and services: ▪ Routine physicals – annually age 12 and over ▪ Well-child care – unlimited up to age 12 ▪ Well woman exam & pap smear – annually age 18 and over ▪ Mammograms – 1 every year age 35 and over ▪ Colonoscopy – 1 every 10 years age 50 and over ▪ Prostate cancer screening – 1 per year age 50 and over ▪ Smoking cessation counseling – 8 visits per 12 months ▪ Healthy diet/obesity counseling – unlimited to age 22; age 22 and over-26 visits per 12 months ▪ Breastfeeding support – 6 lactation counseling visits per 12 months	Plan pays 100% (deductible waived; no copay required) Some examples of preventive care frequency and services: ▪ Routine physicals – annually age 12 and over ▪ Well-child care – unlimited up to age 12 ▪ Well woman exam & pap smear – annually age 18 and over ▪ Mammograms – 1 every year age 35 and over ▪ Colonoscopy – 1 every 10 years age 50 and over ▪ Prostate cancer screening – 1 per year age 50 and over ▪ Smoking cessation counseling – 8 visits per 12 months ▪ Healthy diet/obesity counseling – unlimited to age 22; age 22 and over-26 visits per 12 months ▪ Breastfeeding support – 6 lactation counseling visits per 12 months	Plan pays 100% (deductible waived; no copay required) Some examples of preventive care frequency and services: ▪ Routine physicals – annually age 12 and over ▪ Well-child care – unlimited up to age 12 ▪ Well woman exam & pap smear – annually age 18 and over ▪ Mammograms – 1 every year age 35 and over ▪ Colonoscopy – 1 every 10 years age 50 and over ▪ Prostate cancer screening – 1 per year age 50 and over ▪ Smoking cessation counseling – 8 visits per 12 months ▪ Healthy diet/obesity counseling – unlimited to age 22; age 22 and over-26 visits per 12 months ▪ Breastfeeding support – 6 lactation counseling visits per 12 months
Examples of covered services included are: **Routine annual physicals (one per year); immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for prostate cancer and colorectal cancer (including routine colonoscopies); smoking cessation counseling services and healthy diet counseling; and obesity screening/counseling.** **Examples of covered services for women with reproductive capacity are:** **Female sterilization procedures and specified FDA-approved contraception methods with a written prescription by a health care practitioner, including cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. Prescription contraceptives for women are covered under the pharmacy benefits administered by Caremark.** To determine if a specific contraceptive drug or device is included in this benefit, contact Customer Service at **1-800-222-9205**. The list may change as FDA guidelines are modified.			
Annual Vision Examination (one per plan year; performed by an opthalmologist or optometrist using calibrated instruments) Participant pays	After deductible, plan pays 80%; participant pays 20%	$60 copay for specialist	$50 copay for specialist
Annual Hearing Examination Participant pays	After deductible, plan pays 80%; participant pays 20%	$30 copay for primary $60 copay for specialist	$30 copay for primary $50 copay for specialist

Note: Covered services under this benefit must be billed by the provider as "preventive care." If you receive preventive services from a non-network provider, you will be responsible for any applicable deductible and coinsurance under the ActiveCare 1-HD and ActiveCare 2. Non-network preventive care is not paid at 100%. There is no coverage for non-network services under the ActiveCare Select plan or ActiveCare Select Whole Health.

2016 – 2017 TRS ACTIVECARE
SCOTT & WHITE – HMO
PLAN CHANGES

BENEFIT	2015-2016 PLAN YEAR	2016-2017 PLAN YEAR
Deductible	Individual - $800 Family - $2,400	Individual - $1,000 Family - $3,000
Out-of-Pocket Maximum	Individual - $5,000 Family - $10,000	No Changes
Primary Care Office Visit Copay	$20	$20; copay for the first visit for illness waived, does not apply to wellness or preventive visits
Durable Medical Equipment Coinsurance	50% after deductible	20% after deductible
Manipulative Therapy	N/A	New benefit; 20% without office visit $40 plus 20% with office visit (5 visits max per month, 35 max visit per year)
Prescription Drugs - Specialty Medications	Tier I - 10% after deductible Tier II - 20% after deductible Tier III - 30% after deductible Tier IV - 50% after deductible	20% after deductible

2016 - 2017 Voluntary Benefits Monthly Premiums

Standard Dental	High Option	Low Option
EO	$39.56	$16.68
ES	$84.52	$33.17
EC	$76.62	$35.93
EF	$142.77	$52.44

Superior Vision	High Option	Low Option
EO	$17.84	$9.52
ES	$38.40	$20.48
EC	$28.89	$15.40
EF	$52.74	$28.12

Lincoln Financial Voluntary Term Life		Rate Per $1,000 EE	$50,000 Policy EE	Rate Per $1,000 SP	$25,000 Policy SP
EO	Age 0-29	$0.050	$2.50	$0.055	$1.38
	30-34	$0.060	$3.00	$0.065	$1.63
	35-39	$0.070	$3.50	$0.075	$1.88
	40-44	$0.110	$5.50	$0.115	$2.88
	45-49	$0.150	$7.50	$0.155	$3.88
	50-54	$0.240	$12.00	$0.245	$6.13
	55-59	$0.037	$18.50	$0.375	$9.38
	60-64	$0.580	$29.00	$0.585	$14.63
	65-69	$1.140	$57.00	$1.145	$28.63
	70-74	$1.140	$57.00	$1.145	$28.63
	75+	$1.140	$57.00	$1.145	$28.63
Child Life - $10,000		$1.80			

Standard Disability	Example rates are based on $1,000 benefit	
Elimination Period	3/65	65/65
0/7	$26.40	$35.90
14	$21.60	$31.60
30	$17.70	$26.80
60	$14.50	$17.40
90	$12.10	$15.00
180	$9.10	$11.00

Colonial Cancer	
EO	$29.85
EF	$49.55

Denton Independent School District
Dental Highlight Sheet

High Plan: Dental Plan Summary **Effective Date: 9/1/2016**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$10/visit Type 1 $50 Benefit Year Type 2,3 No Family Maximum
Maximum *(per person)*	$1,700 per Benefit year
Allowance	90th U&C
Waiting Period	None
Max Builder[SM]	Included
Annual Open Enrollment	None

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,500
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Restorative Amalgams	• Onlays
• Bitewing X-rays (2 per benefit period)	• Restorative Composites	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Endodontics (nonsurgical)	• Crown Repair
• Periapical X-rays	• Endodontics (surgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Cleaning (2 per benefit period)	• Periodontics (nonsurgical)	
• Fluoride for Children 18 and under (1 per benefit period)	• Periodontics (surgical)	
• Sealants (age 15 and under)	• Denture Repair	
• Space Maintainers	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

Monthly Rates

Employee Only (EE)	$39.56
EE + Spouse	$84.52
EE + Children	$76.62
EE + Spouse & Children	$142.77

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Max Builder℠

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. A participant earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning dental rewards who submits a claim for services received through the dental contracted provider network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$400	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$200	Additional bonus is earned if the participant sees a Contracted Provider
Maximum Carryover	$1,200	Maximum possible accumulation for Max Builder and PPO Bonus combined

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist." California Residents: When prompted to select your network, choose the network found on your ID Card.

Dental Network

In Texas, our network and plans are referred to as the Ameritas Dental Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

This form is a benefit highlight, not a certificate of insurance.

High Plan Exclusions
Covered Expenses will not include and no benefits will be payable for expenses incurred:

- for any procedure except exams, cleaning and fluoride applications for the first 12 months when an employee or dependent becomes classified as a late entrant. An employee or dependent who does not enroll within 31 days from the date the person qualifies for the insurance, or who elects to become covered again after canceling a premium contribution agreement, will be classified as a late entrant.
- for any treatment which is for cosmetic purposes, except as specifically listed in the Table of Dental Procedures.
- to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the plan participant is covered under the dental expense benefit, it will be a Covered Expense.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the plan participant is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
- for any procedure begun before the plan participant was covered under the dental expense benefit.
- for any procedure begun after the participant's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the participant's insurance under the dental expense benefit terminates.
- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to:
  - alter vertical dimension;
  - restore or maintain occlusion;
  - splint or replace tooth structure lost because of abrasion or attrition
- for any procedure which is not shown on the Table of Dental Procedures.
- for orthodontic treatment (unless otherwise specified in this contract.)
- for which the plan participant is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
- for charges for which the plan participant is not liable or which would not have been made had no insurance been in force.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.
- for a Program which was begun on or after the participant's 19th birthday.
- in any quarter of a Program if the participant was not covered under the orthodontic expense benefits for the entire quarter.
- after the participant's insurance under the orthodontic expense benefits terminates.

Denton Independent School District
Dental Highlight Sheet

Low Plan: Dental Plan Summary **Effective Date: 9/1/2016**

Plan Benefit	
Type 1	90%
Type 2	70%
Type 3	40%
Deductible	$10/visit Type 1 $50 Benefit Year Type 2,3 No Family Maximum
Maximum *(per person)*	$950 per Benefit year
Allowance	PPO Max
Waiting Period	None
Max Builder[SM]	Included
Annual Open Enrollment	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months)	• Full Mouth/Panoramic X-rays (1 in 5 years)	• Onlays
• Bitewing X-rays (1 in 12 months)	• Sealants (age 15 and under)	• Crowns (1 in 7 years per tooth)
• Periapical X-rays	• Restorative Amalgams	• Crown Repair
• Cleaning (1 in 6 months)	• Restorative Composites	• Endodontics (nonsurgical)
• Fluoride for Children 13 and under (1 in 12 months)	• Denture Repair	• Endodontics (surgical)
• Space Maintainers	• Simple Extractions	• Periodontics (nonsurgical)
		• Periodontics (surgical)
		• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 7 years)
		• Complex Extractions
		• Anesthesia

Monthly Rates

Employee Only (EE)	$16.68
EE + Spouse	$33.17
EE + Children	$35.93
EE + Spouse & Children	$52.44

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Max Builder℠

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. A participant earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning dental rewards who submits a claim for services received through the dental contracted provider network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	$250	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$125	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$50	Additional bonus is earned if the participant sees a Contracted Provider
Maximum Carryover	$500	Maximum possible accumulation for Max Builder and PPO Bonus combined

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist." California Residents: When prompted to select your network, choose the network found on your ID Card.

Dental Network

In Texas, our network and plans are referred to as the Ameritas Dental Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

This form is a benefit highlight, not a certificate of insurance.

Standard Insurance Company
Benefit and Cost Summary Highlight Sheet

LOW PLAN EXCLUSIONS

Covered Expenses will not include and no benefits will be payable for expenses incurred:

- for any procedure except exams, cleaning and fluoride applications for the first 12 months when an employee or dependent becomes classified as a late entrant. An employee or dependent who does not enroll within 31 days from the date the person qualifies for the insurance, or who elects to become covered again after canceling a premium contribution agreement, will be classified as a late entrant.
- for any treatment which is for cosmetic purposes, except as specifically listed in the Table of Dental Procedures.
- to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within seven years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the person is covered, it will be a Covered Expense.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the plan participant is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
- for any procedure begun before the plan participant was covered under the dental expense benefit.
- for any procedure begun after the participant's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the participant's insurance under the dental expense benefit terminates.
- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to:
  - alter vertical dimension;
  - restore or maintain occlusion;
  - splint or replace tooth structure lost because of abrasion or attrition
- for any procedure which is not shown on the Table of Dental Procedures.
- for orthodontic treatment (unless otherwise specified in this contract.)
- for which the plan participant is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
- for charges for which the plan participant is not liable or which would not have been made had no insurance been in force.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.

SUPERIOR VISION

See yourself healthy.

Vision Plan Benefits for Denton Independent School District

You have the option of choosing either the high option or the low option plan. The high option allows you to receive the contact lens allowance **AND** one complete pair of glasses every 12 months. The low option allows you to receive the contact lens allowance **OR** the frame allowance every 12 months

High Option Plan	
Co-Pays	
Exam	$10
Materials[1]	$20
Contact Lens Fitting	$25
Monthly Premiums	
Emp. Only	$17.84
Emp. + spouse	$38.40
Emp. + child(ren)	$28.89
Emp. + family	$52.74
Services/Frequency	
Exam	12 months
Frames	12 months
Contact Lens Fitting	12 months
Lenses	12 months
Contact Lenses	12 months

Low Option Plan	
Co-Pays	
Exam	$15
Materials[1]	$20
Contact Lens Fitting	$25
Monthly Premiums	
Emp. Only	$9.52
Emp. + spouse	$20.48
Emp. + child(ren)	$15.40
Emp. + family	$28.12
Services/Frequency	
Exam	12 months
Frames	12 months
Contact Lens Fitting	12 months
Lenses	12 months
Contact Lenses	12 months

Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam (MD)	Covered in full	Up to $42	Covered in full	Up to $42
Exam (OD)	Covered in full	Up to $37	Covered in full	Up to $37
Frames	$150 retail allowance	Up to $60	$125 retail allowance	Up to $50
Contact Lens Fitting (standard[2])	Covered in full	Not covered	Covered in full	Not covered
Contact Lens Fitting (specialty[2])	$50 retail allowance	Not covered	$50 retail allowance	Not covered
Lenses (standard) per pair				
Single Vision	Covered in full	Up to $26	Covered in full	Up to $26
Bifocal	Covered in full	Up to $34	Covered in full	Up to $34
Trifocal	Covered in full	Up to $50	Covered in full	Up to $50
Progressive lens upgrade	See description[3]	Up to $50	See description[3]	Up to $50
Photochromic	Covered in full	Not covered	Not covered	Not covered
Polycarbonate	Covered in full	Not covered	Not covered	Not covered
Factory scratch coat	Covered in full	Not covered	Not covered	Not covered
Contact Lenses	$150 retail allowance	Up to $100	$150 retail allowance[4]	Up to $100

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] *Materials co-pay applies to lenses and frames only, not contact lenses*

[2] *See your benefits materials for definitions of standard and specialty contact lens fittings*

[3] *Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay*

[4] *Contact lenses are in lieu of eyeglass lenses and frames benefit*

Discount Features

Look for providers in the Provider Directory who accept discounts, as some do not; please verify their services and discounts (range from 10%-30%) prior to service as they vary.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums[5] on standard (not premium, brand, or progressive) lenses.

	Maximum Member Out-of-Pocket	
	Single Vision	Bifocal & Trifocal
Scratch coat	$13	$13
Ultraviolet coat	$15	$15
Tints, solid or gradients	$25	$25
Anti-reflective coat	$50	$50
Polycarbonate	$40	20% off retail
High index 1.6	$55	20% off retail
Photochromics	$80	20% off retail

[5] *Discounts and maximums may vary by lens type. Please check with your provider.*

Discounts on Non-Covered Exam and Materials

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%, and are the best possible discounts available to Superior Vision.

The Plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

Discounts are subject to change without notice.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.

SUMMARY OF BENEFITS

Sponsored by: Denton ISD

All Active Full-time Employees

Life Benefit	**Employee**
Amount	$15,000
Guarantee Issue	$15,000
AD&D Benefit	**Employee**
Amount	$15,000
Guarantee Issue	$15,000
Benefit Reduction	**Employee**
Benefits will reduce:	Benefits will terminate upon retirement.
Additional Benefits	**Employee**
See Definitions page for:	Accelerated Death Benefit Conversion Seat Belt, Airbag, and Common Carrier
Eligibility	**Employee**
	All full-time active employees working 15 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work.

Definitions	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.
Seat Belt, Airbag, Common Carrier	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Term Life	Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Additional Benefits	
***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Group Insurance products are issued by The Lincoln National Life Insurance Company (Ft. Wayne, IN), which is not licensed and does not solicit business in New York. In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group companies. Product availability and/or features may vary by state. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Each affiliate is solely responsible for its own financial and contractual obligation.

2015/06/18

SUMMARY OF BENEFITS

Sponsored by: Denton ISD

All Active Full-time Employees

Life/AD&D Benefit	Employee	Spouse	Dependent
Amount	Choice of $10,000 increments	Choice of $5,000 increments Employee must elect coverage for spouse to be eligible. Not to exceed 50% of employee approved amount	$1,000 Child: 14 days to six months $10,000 Child: Six months to age 26 Employee must elect coverage for dependents to be eligible.
Minimum Amount	$10,000	$5,000	$1,000
Maximum Amount	$500,000	$250,000	$10,000
Guarantee Issue for Newly Eligible Employees	$200,000	$50,000	$10,000
Guarantee Issue for Current Eligible Employees	You or your spouse may elect or increase insurance coverage up to 2 increments on a guaranteed acceptance basis during your company's defined annual open enrollment period, provided that you or your spouse have not been previously declined or withdrawn coverage.		

AD&D Benefit	Employee	Spouse
Amount	Benefit amount equal to the life amount elected by you.	Same as employee

Benefit Reduction	Employee	Spouse
Benefits will reduce:	Coverage will terminate upon retirement.	Coverage will terminate upon employee retirement.

Additional Benefits	
See Definition:	Accelerated Death Benefit Conversion Portability Seat Belt, Airbag, and Common Carrier

Eligibility	Employee	Spouse and Dependents
	All full-time active employees working 15 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work.	Cannot be in a period of limited activity on the day coverage takes effect.

Definitions	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.
Limited Activity	A period when a spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Portability	If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.
Seat Belt, Airbag, Common Carrier	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Term Life	Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Additional Benefits	
***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

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Voluntary Long Term Disability Insurance

Standard Insurance Company has developed this document to provide you with information about the optional insurance coverage you may select through Denton Independent School District. Written in non-technical language, this is not intended as a complete description of the coverage. If you have additional questions, please check with your benefits department.

Employer Plan Effective Date

The group policy effective date is September 1, 2013.

Eligibility

To become insured, you must be:

- A regular employee of Denton Independent School District, excluding temporary or seasonal employees, full-time members of the armed forces, leased employees or independent contractors
- Actively at work at least 15 hours each week
- A citizen or resident of the United States or Canada

Employee Coverage Effective Date

Please contact your benefit department for more information regarding the following requirements that must be satisfied for your insurance to become effective. You must satisfy:

- Eligibility requirements
- An eligibility waiting period of the first day of the month that follows the date you become an eligible employee
- An evidence of insurability requirement, if applicable
- An active work requirement. This means that if you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Benefit Amount

You may select a monthly benefit amount in $100 increments from $200 to $8,000; based on the tables and guidelines presented in the Rates section of these Coverage Highlights. The monthly benefit amount must not exceed 66 2/3 percent of your monthly earnings.

Plan Maximum Monthly Benefit: 66 2/3 percent of predisability earnings

Plan Minimum Monthly Benefit: $100

Benefit Waiting Period and Maximum Benefit Period

The benefit waiting period is the period of time that you must be continuously disabled before benefits become payable. Benefits are not payable during the benefit waiting period. The maximum benefit period is the period for which benefits are payable. The benefit waiting period and maximum benefit period associated with your plan options are shown below:

Option	Accidental Injury	Other Disability	Maximum Benefit Period
1	0 days	7 days	3 Years for Sickness & To Age 65 for Accident
2	14 days	14 days	3 Years for Sickness & To Age 65 for Accident
3	30 days	30 days	3 Years for Sickness & To Age 65 for Accident
4	60 days	60 days	3 Years for Sickness & To Age 65 for Accident
5	90 days	90 days	3 Years for Sickness & To Age 65 for Accident
6	180 days	180 days	3 Years for Sickness & To Age 65 for Accident
7	0 days	7 days	To Age 65 for both Sickness and Accident
8	14 days	14 days	To Age 65 for both Sickness and Accident
9	30 days	30 days	To Age 65 for both Sickness and Accident
10	60 days	60 days	To Age 65 for both Sickness and Accident
11	90 days	90 days	To Age 65 for both Sickness and Accident
12	180 days	180 days	To Age 65 for both Sickness and Accident

Options 1-6: Maximum Benefit Period of 3 years for Sickness

If you become disabled before age 64, LTD benefits may continue during disability for 3 years. If you become disabled at age 64 or older, the benefit duration is determined by your age when disability begins:

Age	Maximum Benefit Period
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Options 1-6: Maximum Benefit Period To Age 65 for Accident
Options 7-12: Maximum Benefit Period To Age 65 for Sickness and Accident

If you become disabled before age 62, LTD benefits may continue during disability until you reach age 65. If you become disabled at age 62 or older, the benefit duration is determined by your age when disability begins:

Age	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

First Day Hospital Benefit

With this benefit, if an insured employee is hospital confined for at least four hours, is admitted as an inpatient and is charged room and board during the benefit waiting period, the benefit waiting period will be satisfied. Benefits become payable on the date of hospitalization; the maximum benefit period also begins on that date. This feature is included only on LTD plans with benefit waiting periods of 30 days or less.

Preexisting Condition Exclusion

A general description of the preexisting condition exclusion is included in the Group Voluntary Long Term Disability Insurance for Educators and Administrators brochure. If you have questions, please check with your benefits department.

Preexisting Condition Period: The 90-day period just before your insurance becomes effective

Exclusion Period: 12 months

Preexisting Condition Waiver

If your insurance has been in force for 12 months or more, for the first 90 days of disability after the benefit waiting period, the Preexisting Condition provision will not be applied to an increase in your benefit amount. After 90 days of benefits, the Preexisting Condition provision will apply to increases of more than $300. The Preexisting Condition Provision applies immediately if you:

- Decrease your Benefit Waiting Period by more than one level; or
- Increase your Maximum Benefit Period

If your insurance has been in force for less than 12 months and your disability is found to be a Preexisting Condition, you may be eligible for up to 90 days of benefits if you are disabled and meet all applicable policy provisions. If the Benefit Waiting Period you elect under this policy is less than the Benefit Waiting Period you were insured for under the Prior Plan, your benefits will begin on the later of these two plans.

If a disability is deemed to be a Preexisting Condition, benefits are payable under your prior elections, if any.

Own Occupation Period

For the plan's definition of disability, as described in your brochure, the own occupation period is the first 12 months for which LTD benefits are paid. After that, the any occupation period begins at the end of the own occupation period and continues until the end of the maximum benefit period.

Other LTD Features

- **Employee Assistance Program (EAP)** – This program offers support, guidance and resources that can help an employee resolve personal issues and meet life's challenges.
- **Reasonable Accommodation Expense Benefit** – Subject to The Standard's prior approval, this benefit allows us to pay up to $25,000 of an employer's expenses toward work-site modifications that result in a disabled employee's return to work.
- **Survivor Benefit** – A Survivor Benefit may also be payable. This benefit can help to address a family's financial need in the event of the employee's death.
- **Return to Work (RTW) Incentive** – The Standard's RTW Incentive is one of the most comprehensive in the employee benefits history. For the first 12 months after returning to work, the employee's LTD benefit will not be reduced by work earnings until work earnings plus the LTD benefit exceed 100 percent of predisability earnings. After that period, only 50 percent of work earnings are deducted.
- **Rehabilitation Plan Provision** – Subject to The Standard's prior approval, rehabilitation incentives may include training and education expense, family (child and elder) care expenses, and job-related and job search expenses.

When Benefits End

LTD benefits end automatically on the earliest of:

- The date you are no longer disabled
- The date your maximum benefit period ends
- The date you die
- The date benefits become payable under any other LTD plan under which you become insured through employment during a period of temporary recovery
- The date you fail to provide proof of continued disability and entitlement to benefits

Rates

Employees can select a monthly LTD benefit ranging from a minimum of $200 to a maximum amount based on how much they earn. Referencing the appropriate attached charts, follow these steps to find the monthly cost for your desired level of monthly LTD benefit and benefit waiting period:

1. Find the maximum LTD benefit by locating the amount of your earnings in either the Annual Earnings or Monthly Earnings column. The LTD benefit amount shown associated with these earnings is the maximum amount you can receive. If your earnings fall between two amounts, you must select the lower amount.
2. Select the desired monthly LTD benefit between the minimum of $200 and the determined maximum amount, making sure not to exceed the maximum for your earnings.
3. In the same row, select the desired benefit waiting period to see the monthly cost for that selection.

If you have questions regarding how to determine your monthly LTD benefit, the benefit waiting period, or the premium payment of your desired benefit, please contact your benefits department.

Group Insurance Certificate

If you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage. The information presented above is controlled by the group policy and does not modify it in any way. The controlling provisions are in the group policy issued by Standard Insurance Company.

Group Cancer Insurance

Colonial Life
Making benefits count.

If diagnosed with cancer, how will you pay for what your health insurance won't?

The risk of developing cancer, unfortunately, is very real.

Nearly everyone has experienced or knows somebody who has experienced a cancer diagnosis in their family. The good news is that cancer screenings and cancer-fighting technologies have gotten a lot better in recent years. However, with advanced technology come high costs. Major medical health insurance is a great start, but even with this essential safety net, cancer sufferers can still be hit with unexpected medical and non-medical expenses.

Cancer coverage from Colonial Life offers the protection you need to concentrate on what is most important — your care.

Features of Colonial Life's Cancer Insurance:

1. Pays benefits to help with the cost of cancer screening and cancer treatment.
2. Provides benefits to help pay for the indirect costs associated with cancer, such as:
   - Loss of wages or salary
   - Deductibles and coinsurance
   - Travel expenses to and from treatment centers
   - Lodging and meals
   - Child care
3. Pays regardless of any other insurance you have with other insurance companies.
4. Provides a cancer screening benefit that you can use even if you are never diagnosed with cancer.
5. Benefits paid directly to you unless you specify otherwise.
6. Flexible coverage options for employees and their families.

This is a brief description of some available benefits.

We will pay benefits if one of the following routine cancer screening tests is performed or if cancer is diagnosed while your coverage is in force.

Cancer Screening Benefit Tests

This benefit is payable once per calendar year per covered person.

- Pap Smear
- ThinPrep Pap Test[1]
- CA125 (Blood test for ovarian cancer)
- Mammography
- Breast Ultrasound
- CA 15-3 (Blood test for breast cancer)
- PSA (Blood test for prostate cancer)
- Chest X-ray
- Biopsy of Skin Lesion
- Colonoscopy
- Virtual Colonoscopy
- Hemoccult Stool Analysis
- Flexible Sigmoidoscopy
- CEA (Blood test for colon cancer)
- Bone Marrow Aspiration/Biopsy
- Thermography
- Serum Protein Electrophoresis (Blood test for Myeloma)

To file a claim for a covered cancer screening/wellness test, it is not necessary to complete a claim form. Call our toll-free Customer Service number, 1.800.325.4368, with the medical information

Inpatient Benefits

- Hospital and Hospital Intensive Care Unit Confinement
- Ambulance
- Private Full-Time Nursing Services
- Attending Physician

Treatment Benefits (In-or Outpatient)

- Radiation/Chemotherapy
- Antinausea Medication
- Blood/Plasma/Platelets/Immunoglobulins
- Experimental Treatment
- Hair Prosthesis/External Breast/Voice Box Prosthesis
- Supportive/Protective Care Drugs and Colony Stimulating Factors
- Bone Marrow Stem Cell Transplant
- Peripheral Stem Cell Transplant

Surgery Benefits

- Surgery Procedures (including skin cancer)
- Anesthesia (including skin cancer)
- Second Medical Opinion
- Reconstructive Surgery
- Prosthesis/Artificial Limb
- Outpatient Surgical Center

Transportation/Lodging Benefits

- Transportation
- Transportation for Companion
- Lodging

Extended Care Benefits

- Skilled Nursing Care Facility
- Hospice
- Home Health Care Service

Waiver of Premium

THIS IS A CANCER ONLY POLICY.

This policy has exclusions and limitations. For cost and complete details of the coverage, see your Colonial Life benefits counselor. Coverage may vary by state and may not be available in all states. Applicable to policy form GCAN-MP and certificate form GCAN-C (including state abbreviations where used, for example GCAN-C-TX.)

[1]ThinPrep is a registered trademark of Cytyc Corporation.

Colonial Life
1200 Colonial Life Boulevard
Columbia, South Carolina 29210
coloniallife.com

Group Cancer Insurance— Specified Disease Rider

Colonial Life
Making benefits count.

When you add this rider to your group cancer insurance coverage, you add valuable coverage related to the following specified diseases.

Specified Diseases

- Adrenal Hypofunction (Addison's Disease)
- Botulism
- Bubonic Plague
- Cerebral Palsy
- Cholera
- Cystic Fibrosis
- Diphtheria
- Encephalitis (including Encephalitis contracted from West Nile Virus)
- Huntington's Chorea
- Legionnaires' Disease
- Lou Gehrig's Disease (Amyotrophic Lateral Sclerosis)
- Lyme Disease
- Malaria
- Meningitis (bacterial)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Necrotizing Fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Reye's Syndrome
- Scleroderma
- Scarlet Fever
- Sickle Cell Anemia
- Systemic Lupus
- Tetanus
- Toxic Epidermal Necrolysis
- Toxic Shock Syndrome
- Tuberculosis (Mycobacterial)
- Tularemia
- Typhoid Fever
- Variant Creutzfeldt-Jakob Disease (Mad Cow Disease)
- Yellow Fever

Rider Benefits

- **Hospital Confinement** –We will pay this benefit if you incur charges for and are confined to a hospital for treatment of one of the specified diseases listed above.
- **Ambulance** – We will pay this benefit if you incur charges for and use a professional ambulance to transport you, on the advice of a doctor, to or from a hospital where you are confined as an inpatient for the treatment of a specified disease listed above. Limit 2 one way trips per confinement.
- **Attending Physician**– We will pay this benefit if you incur charges for and use the services of an attending physician while confined to a hospital for the treatment of a specified disease listed above.

Rider Features

- Covers the same family members as your cancer insurance coverage.
- Pays benefits regardless of any other insurance you have with other insurance companies.
- Pays benefits directly to you, unless you specify otherwise.

This rider has exclusions and limitations. For cost and complete details of the coverage, see your Colonial Life benefits counselor. Coverage may vary by state and may not be available in all states. Applicable to Rider form R-GCAN-SpDis (including state abbreviation where used - for example: R-GCAN-SpDis-TX).

Group Cancer 1000— Specified Disease Rider

Colonial Life
1200 Colonial Life Boulevard
Columbia, South Carolina 29210
coloniallife.com

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Group Cancer Insurance— Initial Diagnosis of Cancer Rider

Colonial Life®
Making benefits count.

The diagnosis of internal cancer can be an upsetting time. You do not need to add financial worry to what is already a very difficult situation. When you add an Initial Diagnosis of Cancer rider to your group cancer insurance coverage, you add a little more financial protection at the point you or an insured family member is diagnosed with internal cancer—a time before many medical costs are incurred.

Rider Benefits

This rider pays a lump sum benefit for the initial diagnosis of internal (not skin) cancer. Use the benefit any way you choose, such as to help pay for deductibles and coinsurance on your major medical insurance or settle any outstanding debts.

Rider Features

- Guaranteed renewable as long as your cancer insurance policy is in force.
- Covers the same family members as your cancer insurance policy.
- Pays benefits regardless of any other insurance you have with other insurance companies.
- Pays benefits directly to you, unless you specify otherwise.

This rider has exclusions and limitations. For cost and complete details of the coverage, see your Colonial Life benefits counselor. Coverage may vary by state and may not be available in all states. Applicable to rider form R-GCAN-Indx (including state abbreviations where used - for example: R-GCAN-Indx-TX).

Group Cancer 1000— Initial Diagnosis of Cancer Rider

Colonial Life
1200 Colonial Life Boulevard
Columbia, South Carolina 29210
coloniallife.com

Advantages of a Flexible Spending Account (FSA)

A valuable pre-tax benefit with innovative services!

FlexSystem Healthcare FSA
FlexSystem Dependent Care FSA

FlexSystem FSA increases your take-home pay by reducing your taxable income. A Flexible Spending Account (FSA) allows you to save up to 30% on your eligible healthcare and/or dependent care expenses every year by using pre-tax dollars.

Consider how much you spend on healthcare and/or dependent care expenses for you and your qualified dependents in one year:

- prescription drugs/medications
- medical/dental office visit co-pays
- eye exams and prescription glasses/lenses
- vaccinations
- daycare tuition

Why not reduce these expenses by using pre-tax dollars instead of after-tax dollars? With rising healthcare costs, ***every penny counts!*** By using pre-tax dollars, you are taxed on a lower gross salary, thereby saving money that would otherwise be spent on federal, state and FICA taxes, and thereby you ***increase your take home pay!***

Employee salary reductions to a medical Flexible Spending Account (FSA) are limited to $2,550 per Plan Year, indexed for inflation. Check with your employer for your Plan's maximum annual election amount.

Putting money in an FSA can be smart and safe! However, if you have medical FSA funds leftover at the end of the year you may lose those funds, plan carefully.

Pre-Tax Savings Example

	Without FSA	*With FSA*
Gross Monthly Pay:	$3,500	$3,500
Pre-Tax Contributions		
Medical/Dental Premiums	$0	-$125
Medical Expenses	$0	-$75
Dependent Care Expenses	$0	-$400
TOTAL:	$0	-$600
Taxable Monthly Income	**$3,500**	**$2,900**
Taxes (federal, state, FICA):	-$968	-$802
Out-of-pocket Expenses:	-$600	$0
Monthly Take-home Pay:	**$1,932**	**$2,098**

Net Increase in Take-Home Pay = $166/mo!

For illustration only. Actual dollar amounts may vary.

How FlexSystem Works

FlexSystem FSA is offered through your employer and is adminstered by TASC. When you choose to enroll in a FlexSystem FSA Healthcare and/or Dependent Care, you choose the dollar amount you want to contribute to each account based on your estimated expenses for the upcoming Plan Year. Your contributions will be deducted in equal amounts from each paycheck, **pre-tax**, throughout the Plan Year. ***The more you contribute to these accounts, the more you save by paying less in taxes!***

Your total Healthcare FSA annual contribution amount is available immediately at the start of the Plan Year; Dependent Care FSA funds are available up to the current account balance only.

Reimbursements and the TASC Card

As you incur eligible expenses, simply swipe your TASC Card. The card automatically pays for and substantiates most eligible expenses at the point of purchase. If you do not use the TASC Card to pay for an eligible expense, simply submit a request for reimbursement via the MyTASC Mobile App, online Request for Reimbursement Wizard in MyTASC, text message, fax, or mail.

Your reimbursement is deposited in your MyCash account. You can access your MyCash funds in three ways: (1) swipe your TASC Card at any merchant that accepts major credit cards, (2) withdraw at an ATM using your TASC Card (with PIN), or (3) transfer to a personal bank account from MyCash Manager within MyTASC.

FSA Eligible Expenses

FlexSystem FSA funds may only be used for eligible expenses under your healthcare FSA and/or dependent care FSA. Some eligible expenses include:

- Medical care services
- Dental care services
- Vision care expenses
- Prescriptions
- Certain over-the-counter medications
- Daycare tuition

More detailed lists can be found at www.irs.gov in IRS Publications 502 & 503.
Please note insurance premiums are NOT eligible for reimbursement.

Multiple Methods for Account Management

You may use any of the following self-service options to access your FlexSystem accounts and TASC Card transactions:

- **MyTASC Online**: www.tasconline.com
- **MyCash Manager:** within MyTASC at www.tasconline.com
- **MyTASC Mobile App:** free download at www.tasconline.com/mobile
- **MyTASC Text Messaging:** elect through your MyTASC account online

Online enrollment and account management.

Online tax-savings calculator to help determine how much to contribute.

Convenient pre-tax payroll deductions.

Benefits debit card for eligible purchases.

Mobile app for account access on the go.

Multiple self-service tools.

Fast reimbursements.

Important Considerations

FSA Funds do not Rollover:

It is important to be conservative in making elections because any unused funds left in your FSA at the close of the Plan Year are not refundable to you. You are urged to take precautionary steps, such as tracking account balances on the FlexSystem website and/or using the Interactive Voice Response System, to avoid having funds remaining in your account at year-end.

Changing Elections During the Plan Year:

You may change your FSA elections during the Plan year only if you experience a change of status such as:

- a marriage or divorce
- birth or adoption of a child, or
- a change in employment status

Refer to the Change of Election Form (available from your employer) for a complete list of circumstances acceptable for changing elections mid-year.

Sign up for FlexSystem and keep more money in your pocket!

TASC FlexSystem

DENTON INDEPENDENT SCHOOL DISTRICT

Employee Assistance Program

Pointing You In The Right Direction

Benefits/Insurance Department
940.369.0028

We all experience times when we need a little help managing our personal lives. Your employer understands this and is providing the Employee Assistance Program (EAP) to covered employees in connection with your group insurance from The Standard‡, to offer support, guidance and resources to help you and your family find the right balance between your work and home life.

What Can The EAP Do For Me?

Experienced master's-degreed clinicians will confidentially consult with you over the telephone and direct you to the solutions and resources you need. You may also receive referrals to support groups, community resources, a network counselor or your health plan. These services are available for covered employees, their dependents, including children to age 26, and all household members.

The EAP Services Can Help With:

- Child care and elder care
- Alcohol and drug abuse
- Life improvement
- Difficulties in relationships
- Stress and anxiety with work or family
- Depression
- Goal-setting
- Emotional well-being
- Financial and legal concerns
- Grief and loss
- Identity theft and fraud resolution
- Online will preparation

How Do I Access EAP Services?

Follow the directions on the wallet card on this page.

Is It Confidential?

Your calls and all counseling services are confidential. Information will be released only with your permission or as required by law.

continued on reverse

This EAP service is not affiliated with The Standard. The EAP service is not an insurance product.

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Ore., in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 360 Hamilton Avenue, Suite 210, White Plains, NY. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

TheStandard®

Call 877.851.1631 or visit www.eapbda.com. The EAP is always ready to assist you. We've also provided a handy reference card for your wallet.

How To Access EAP Online

1. Enter this address in your Web browser: **www.eapbda.com**
2. Enter **standard6** as the login ID (in all lowercase letters) when prompted.
3. Enter **eap4u6** as the password (in all lowercase letters) when prompted.

Note: It is a violation of your company's contract to share this information with individuals who are not eligible for this service.

Fold

EAP For Policyholders of The Standard

Call this toll-free number for access to EAP services.

877.851.1631
TDD 800.327.1833

Available 24 hours a day, 365 days a year.

Standard Insurance Company

The Standard Life Insurance Company of New York

www.standard.com

Employee Assistance Program-6
17200-751174 (8/14) SI/SNY EE

When Is The EAP Available?

Over-the-phone consultation and online access to EAP services are always available. Simply call the toll-free number or log on to **www.eapbda.com**. In emergency situations, you may call the toll-free number to speak with a master's-degreed clinician who can also connect you to emergency services.

Your program also includes up to six face-to-face assessment and consultative sessions per issue. A clinician will work with you to schedule appointments according to your needs.

What Can WorkLife Services Do For Me?

WorkLife services can save you countless hours by researching and providing referrals for important needs like:

- Child care and elder care
- Education
- Adoption
- Pet care
- Daily living
- Travel

A broad range of educational materials and guide books on dependent care topics are also available.

How Much Does It Cost?

The EAP and WorkLife services are provided to you in connection with your employer-sponsored group insurance from The Standard. If you accept a referral to services that are not a part of your EAP program, you may be responsible for the costs associated with those services.

All The Help You Need Online

The EAP provides the following online services:

- Informative guides and articles
- Monthly webinars and bulletins
- Options to search on your own for:
  - Child care or elder care services
  - Pet care
  - Adoption resources
- Detailed maps for every search
- Self-assessments
- Healthy lifestyle guidance, from tools for diet and fitness to smoking cessation
- Videos and articles on topics like understanding depression, nutrition advice and preparing for childbirth
- Financial and legal information, including a program for completing a simple will and identity theft consultation recovery and prevention services
- Detailed calculators used to help solve common financial concerns, such as computing college finances

Frequently Asked Questions

What is a plan year?

The period between the date your benefit plans begin and end. The Denton ISD plan year is from September 1st through August 31st. This plan year applies to all insurance benefits, as well as the Flexible Spending Account plan options. The deductible on the medical and dental plans also start and end on the same dates as the plan year does.

Who is my Insurance carrier?

Health/Medical – TRS ActiveCare
Prescription – Caremark
Dental – Standard Dental
Vision – Superior Vision
Flexible Spending Accounts – TASC
Disability – Standard Insurance Co.
Supplemental Cancer – Colonial
Basic & Supplemental Life Ins. – Lincoln Life
Employee Assistance Plan (EAP) – Standard Insurance Co.

Where can I find phone numbers for the Insurance carriers?

You can find contact information on the insurance dept. webpage or the contact page in this guide. In the left-hand column, click on the "Insurance" link, then click on the "Providers Contact Information" link.

I did not receive my insurance card, or I need a new one. How can I get one?

You will need to call the insurance carrier directly, they issue the cards. You can find their contact information on the insurance dept. webpage.

Do deductibles, coinsurance and copays apply to my out of pocket maximum?

Yes, effective 9/1/2015 deductibles, coinsurance and copays apply to the plan year out of pocket maximum.

Am I required to use in network providers?

*On the TRS medical plans *ActiveCare 1HD and ActiveCare 2*, you do have out of network benefits if you decide to use out of network providers. However, they are a reduced benefit amount and are based on out of network allowable amount for the charges. This can increase your portion of the costs.

*On the TRS medical plan *ActiveCare Select* there are no benefits if you decide to use out of network providers. Also, if you reside in one of the specified counties (Bexar, Collin, Comal, Dallas, Denton, Ellis, Ft. Bend, Guadalupe, Harris, Hays, Kendall, Montgomery, Parker, Rockwall, Tarrant, Travis, Williamson) *you must use only the providers listed under the network identified for that county*.

Where do I find network providers on the medical plans?

To locate an in network provider for a TRS ActiveCare medical plan go to: www.trsactivecareaetna.com or call Aetna at 1-800-222-9205.

To locate an in network provider for the Scott & White HMO medical plan go to: www.trs.swhp.org or call 1-800-321-7947.

Can I sign up for or drop insurance at any time?

No. There are only certain times you can add or drop insurance plans:

- During the annual Open Enrollment
- Within 31 calendar days of your official Start Date with DISD
- Within 31 calendar days of the loss of other eligible insurance coverage(s)
- Within 31 calendar days of a life changing event (marriage, divorce, child birth, death)

Documentation of the event is required. Please contact the Insurance Dept. or visit our website for information.

Where can I see what benefits I'm signed up for?

You can log onto the online enrollment system and view the benefits you signed up for at any time. www.inrollplus.com/dentonisd
You will log in with the username and password you initially set up on this site. If you have not registered, you must do so at that time.

Who do I contact for assistance in filing a disability claim?

The Denton ISD insurance department. 940-369-0028 or DISDinsurance@dentonisd.org