# Bellflower Unified School District

## BENEFITS OVERVIEW GUIDE

## 2016 - 2017

MEDICAL DENTAL VISION LIFE/AD&D FLEXIBLE SPENDING ACCOUNTS

## CERTIFICATED
## (BTA Bargaining Unit Members)

!

## IMPORTANT – ACTION REQUIRED

**Certificated employees must log into SunGard (page 4) if they have changes to make. If you do not make any changes online during the Open Enrollment window, the coverages you had in 2015-2016 will be carried into 2016-2017. Only the employee's contribution rate will be changed as per information shown on page 6.**

**Open Enrollment for BTA Bargaining Unit Members: September 12th – October 7th, 2016**

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# CONTACT INFORMATION

## IMPORTANT INFORMATION FOR ALL BENEFITS:

Below is a list of all of your benefits plans along with your group policy number for the plan and the general customer service number and website. If you have any questions or concerns regarding your plans, you should first contact the One Source Insurance Help Desk for Bellflower at the following:

**Insurance Help Desk for Bellflower**
One Source – Char Lambert, Account Manager
Ph: 310-609-1917
Email: healthinsurance@busd.k12.ca.us

| Benefit | Group Number | Telephone | Web Address |
|---|---|---|---|
| **Medical - Certificated Teachers** | | | |
| CalPERS Plans | n/a | (888) 225-7377 | www.calpers.ca.gov |
| **Dental** | | | |
| Delta Care HMO Plan | 75604 | (800) 422-4234 | www.deltadentalca.org |
| Delta Dental PPO Plan | 6697-0003 | (800)422-4234 | www.deltadentalca.org |
| **Vision** | | | |
| VSP Signature | 818418 | (800) 877-7195 | www.vsp.com |
| **Life** | | | |
| Reliance Standard Life Insurance | 180449 | (800) 351-7500 | www.reliancestandard.com |
| **Disability** | | | |
| Pacific Educators Disability Plan | | (800) 722-3365 | www.peinsurance.com |

# ELIGIBILITY

## Eligibility Requirements - Employees

To participate as an "Employee" in the health plans of the District, individuals must be employed and paid for services by the Employer and meet the minimum requirements as negotiated by the District Collective Bargaining Units of District's applicable rules.

## Choice of Coverage & Annual Election

An Employee must enroll self and Dependents (if any are to be enrolled) in the same option(s) at the time of hire or at open enrollment.

Once each year, the District will hold an Annual Election. At that time, covered Employees and their covered Dependents may change between the coverage options. The newly-elected option will be come effective January 1, 2017.

## Effective Date - Employees

Effective the date the enrollment form is received (within 30 days of date of hire)

## Eligible Dependents

Employees requesting benefits for their spouse or domestic partner must provide one of the following documents at the time of their request:

- Marriage certificate
- Domestic partnership state registration

To enroll your child dependent, you must provide the following document at the time of request:

- Birth Certificate

The definition of eligible dependents is impacted by government regulations and plan provisions. At the time of the printing of this guide, eligible dependents are defined as:

- Legally married spouses
- Qualified domestic partners
- Children up to age 26
- Stepchildren
- Legally adopted children
- Disabled children (Social Security determination required after age 26/no age maximum)
- Children of qualified Domestic Partnerships
- Any child for whom a Qualified Medical Child Support order that complies with all applicable laws has been issued (effective August 10, 1993)

*Before enrolling anyone as your dependent, verify that he or she qualifies under the plan rules.*

Note: Government regulations and plan parameters that alter this section will prevail.

## Employee Certification of Dependent

Proof of dependent status for verification is required for all first time enrollees and when any addition is made. If you are unsure whether a person qualifies as your dependent, call Benefits for assistance. All employees are required to submit proof of eligibility certifying that the individuals enrolled as dependents meet the eligibility requirements.

# How and When to Enroll…

When it is time for you to enroll, you will need to have the following information available:

- Names, Social Security numbers, and dates of birth for eligible dependents you wish to enroll
- Name, Social Security number, and date of birth for life insurance beneficiary
- If you are adding a new dependent to your insurance, you must provide proof of dependent status (i.e. marriage certificate, birth certificate, court order)

## Making Changes During the Year

The choices you make when you first become eligible remain in effect for the entire plan year. Once you are enrolled, you must wait until the next open enrollment period to change your benefits or add coverage for dependents, unless you have a qualified change in family status as defined by the IRS.


- Change in marital status
- Change in number of dependents (birth, adoption, death)
- Change in spouse or dependent's eligibility under an employer's plan that results in an involuntary loss of coverage.
- Change in employment status that changes eligibility status
- Change in eligibility for a state program such as Medicaid

When you experience a family or employment status change, the benefit changes you request must be consistent with and due to your change in status. For example, if you have a newborn child, you may not also add other dependents that you did not previously add to the plan. If you need assistance determining what changes are allowed, contact Benefits.

Any benefit change needed due to a qualifying status change event must be made within 30 days of the event (or within 60 days of a loss of Medicaid/CHIP coverage, or within 60 days of gaining eligibility for a state's premium assistance program under Medicaid or CHIP).

You must submit appropriate documentation and complete any necessary change forms or you will not be able to make a change until the next annual open enrollment period.

## Opting out of Benefits:

"Opt Out" of medical insurance will continue to be an option for 2016/17. Those who choose this option will receive**: Medical only $250 tenthly or Medical, Dental and Vision $280 tenthly**. If you are currently enrolled in this program and would like to continue it for 2016, *you must re-enroll* and renewal will be required annually.

**In order to be enrolled, please complete the following steps:**

- ✓ Complete the District's "OPT OUT" form;
- ✓ Please return the Opt Out form to the Payroll Department at the District Office. These forms are not to be sent through District Mail.
- ✓ You must go online and select opt out option under medical in the new SunGard system. (See instructions on page 4)

# ONLINE ENROLLMENT

## SunGard Online Enrollment

Bellflower Unified School District has set up an online enrollment system through SunGard. Certificated employees must log into SunGard if they have changes to make. If you do not make any changes online during the Open Enrollment window, the coverages you had in 2015-2016 will be carried into 2016-2017, **except Opt Out, you must submit a new Opt Out form yearly!** Only the employer's contribution rate will be changed as per information shown on page 6.

**If you are adding, deleting or making a plan change to your MEDICAL benefits, in addition to your online enrollment, you must complete the PERS enrollment change form and return it to the Payroll Department at the District office.**

EMPLOYEE ONLINE (EOL) is the Bellflower Unified School District's intranet product that gives you the ability to change or view specific personal data. Keep the following intranet address in your favorites: (Please use Intranet Explorer)

https://online-bel.sungardk12saas.com/ifas7/emponline

Some advantages of EMPLOYEE ONLINE are:

- Add Emergency Contacts
- View Personal Information
- View and Print Your Check Stubs.
- Open Enrollment

To ensure your privacy we have selected a unique password for you to use when you first access Employee Online. When you access this site you will be required to enter both your EMPLOYEE ID number and your INITIAL PASSWORD . The system will force you to change your initial password immediately after you first log in.

Here is your information:
EMPLOYEE ID:
INITIAL PASSWORD : Your Full SSN (no dashes)

Your new password must include both alpha/numeric characters and be no longer than 6 to 12 places. Employee Online will not allow for spaces or special characters (!,/@#) . Once you have established a new password, you will be prompted to re-enter your employee id number and new password.
Remember to keep this in a safe place!

The system will only allow three attempts to match your password to your employee ID number . Otherwise it will lock you out and require you to email sungardsupport@busd. k12.ca.us to have your account re-set.
We are excited to offer this service to you!

We also encourage that you select to have a direct deposit. Please fill out the attached form and return to the payroll Department.

## Flexible Spending Account Enrollment

This year, Bellflower Unified School District has partnered with SHDR to offer you a Flex 125 plan. To enroll in this new plan, you must fill out the SHDR paper enrollment form and turn into the Payroll Department at the District Office. For additional information, please refer to page 18.

# CalPERS: 2016 OE & Health Benefits Information

## Benefits of the Online Health Plan Statement

A key change this year is the addition of customized online Health Plan Statements. Beginning August 22, 2016, employees should access their **my/CalPERS** account at **my.calpers.ca.gov** to view, download, and/or print their 2016 Health Plan Statement. This new feature provides secure 24/7 access to customized health enrollment in information with a variety of benefits.

For detailed instructions on how to register for a **my/CalPERS** account, or for employees who may have forgotten their username or password, refer to **How to Register For/How to Access my/CalPERS**

## New Pharmacy Benefits Manager

Beginning January 1, 2017, OptLimRx will administer the prescription drug benefits for Cal PERS members and their dependents enrolled in PERS Select, PERS Choice, and PERSCare, as well as those in Anthem Blue Cross, Health Net, Sharp, and UnitedHealthcare Health Maintenance Organization (HMO) plans. Kaiser and Blue Shield will not be impacted and will continue to administer their own prescription drug benefits.

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## Blue Shield NetValue

Blue Shield will not be offering their NetValue plan after December 31, 2016. If an employee or retiree enrolled in NetValue would like to be enrolled in Blue Shield Access+, no action is required. CalPERS will enroll the employee or retiree and their dependents in Blue Shield Access+, effective January 1,2017. Most providers currently participating in Blue Shield NetValue also participate in Blue Shield Access+. If the employee or retiree would like to select a health plan other than Blue Shield Access+, they may do so during Open Enrollment.

**All new Blue Shield NetValue enrollments will be frozen on September 1, 2016.**

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## Approved Health Plans

**Health Maintenance Organization (HMO) Basic Health Plans**

- Anthem Blue Cross
- Blue Shield of California
- Health Net of California
- Kaiser Permanente
- Sharp Health Plan
- UnitedHealthcare

**Preferred Provider Organization (PPO) Basic Health Plans**

- PERS Select
- PERS Choice
- PERSCare

# CalPERS Plans

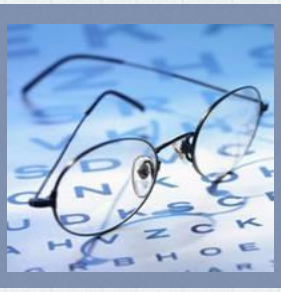
Nothing is more important than the health of you and your family. That is why Bellflower Unified School District offers you medical plan choices designed to help you get the care you need. Employees can find more information by logging onto the CalPERS website.

Effective January 1, 2017, the District's contribution to your Health Insurance shall be as follows:

| | District Contribution |
|---|---|
| **Employee Only** | $6,250 |
| **Employee + 1** | $11,250 |
| **Employee + Family** | $15,000 |

In addition, the District will continue to contribute one percent of the unit member's annual salary to health insurance premiums. For coverages from October 1 to December 31, 2016, you will see the same deductions, prior to July 1, 2016.

# VISION



You are automatically enrolled in Vision Service Plan with each medical plan. This plan provides a yearly examination and glasses if needed for a $10 deductible payment, and discounted prices for Laser Vision Correction.

## Your Vision Benefit Summary

Keep your eyes healthy with BELLFLOWER UNIFIED SCHOOL DISTRICT and VSP® Vision Care.

### Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider. To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

**That's it! We'll handle the rest**—there are no claim forms to complete when you see a VSP doctor.

### Personalized Care

A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

### Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. You'll have access to great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

### Plan Information

**VSP Doctor Network:** VSP Signature

| Benefit | Description | Copay |
|---|---|---|
| **Your Coverage with a VSP Doctor** | | |
| WellVision Exam | • Focuses on your eyes and overall wellness<br>• Every 12 months | $10 for exam and glasses |
| **Prescription Glasses** | | |
| Frame | • $120 allowance for a wide selection of frames<br>• 20% off amount over your allowance<br>• Every 12 months | Combined with exam |
| Lenses | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for dependent children<br>• Every 12 months | Combined with exam |
| Lens Options | • Tints/Photochromic lenses-Transitions<br>• Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average 35-40% off other lens options | $0<br>$50<br>$80 - $90<br>$120 - $160 |
| Contacts (instead of glasses) | • $120 allowance for contacts and contact lens exam (fitting and evaluation)<br>• 15% off contact lens exam (fitting and evaluation)<br>• Every 12 months | $0 |
| Additional Coverage | • Diabetic Eyecare Program | |
| Extra Savings and Discounts | **Glasses and Sunglasses**<br>• 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam.<br>**Retinal Screening**<br>• Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam.<br>**Laser Vision Correction**<br>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities<br>• After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor | |

**Your Coverage with Other Providers**

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

| | |
|---|---|
| Exam.....up to $45 | Lined Trifocal Lenses....up to $85 |
| Frame.....up to $47 | Progressive Lenses.....up to $85 |
| Single Vision Lenses.....up to $45 | Contacts.....up to $105 |
| Lined Bifocal Lenses.....up to $65 | Tints.....up to $5 |

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

# DENTAL PLAN OPTIONS

Good health includes healthy teeth and gums. As an employee of Bellflower Unified School District, you have the option between two dental plans with Delta Dental – Delta Care (DHMO), Delta Dental (PPO) . To check if your current provider is a Delta Dental dentist or for a list of dentists in your area, search the Delta Dental directories at www.deltadentalca.org.

Below is a brief description of how each program works and on the following page you will find a side-by-side comparison of the three programs and the benefits for each of the provider access levels.

### Delta Care (DHMO)

The Delta Care program is designed to encourage members to visit the dentist regularly to maintain their dental health. When you enroll, you select a contract dentist to provide services. The Delta Care network consists of private practice dental facilities that have been carefully screened for quality.

Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you. Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care, must be preauthorized by Delta Dental to be covered by your Delta Care program.

Under the Delta Care program, many services are covered at no cost, while others have copays. There are no deductibles, out-of-pocket costs are clearly defined, and there are no annual or lifetime dollar maximums (except for accidental injury). After you have enrolled, you will receive a Delta Dental membership packet that includes an identification card and an Evidence of Coverage with a "Description of Benefits and Copayments." Also included in this packet is the name, address and phone number of your selected contract dentist. Simply call the dental facility to make an appointment. Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer.

### Delta Preferred (PPO)

The Preferred (PPO) program is a preferred provider plan that allows you to save on out-of-pocket expenses when you visit a Delta Dental PPO network dentist. Your out-of-pocket costs will likely be higher when you visit a non-network dentist.

Under the Preferred plan, you can visit any licensed dentist of your choice, and your family members may select different dentists. You can change dentists at any time, go to a dental specialist of your choice and receive dental care anywhere in the world. To make the most of your benefits and pay the lowest out-of-pocket costs, you will want to utilize a Delta Dental PPO network dentist.
If you choose a dentist who is not in the PPO network, your next best choice is a Delta Dental Premier dentist. Although their fees are higher than PPO dentists and they are considered out-of-network dentists, Delta Dental Premier dentists cannot charge more than their Delta-allowed fees. You won't receive this cost protection and other conveniences when you visit a non-Delta dentist.
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# DELTACARE DHMO HIGHLIGHTS

**Eligibility for you and your family**
If you meet your group's eligibility requirements for dental coverage, you can enroll in the DeltaCare program. You may also enroll eligible dependents. Contact your benefits administrator if you have any questions.

**Easy enrollment**
Simply complete the enrollment process as directed by your benefits administrator. Be sure to indicate a dentist (from the list of contract dental facilities) for both yourself and your eligible dependents. Include the name of your group.

**How your DeltaCare program works**
Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you.
After you have enrolled, you will receive a PMI membership packet including an identification card and an Evidence of Coverage that fully describes the benefits of your dental program. Also included in this packet are the name, address and phone number of your contract dentist. Simply call the dental facility to make an appointment.
Under the DeltaCare program, many services are covered at no cost, while others have copayments (amount you pay your contract dentist) for certain benefits. See the Description of Benefits and Copayments for a list of your benefits.
Please note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care below, must be preauthorized by PMI to be covered by your DeltaCare program.

**Provisions for emergency care**
Under your DeltaCare program, you and your eligible dependents are covered for out-of-network dental emergencies. Your program pays up to
$100 for out-of-network emergency dental expenses per emergency for each enrollee.

**What is PMI?**
PMI administers DeltaCare dental programs and is an affiliate of Delta Dental of California. PMI has administered DeltaCare programs for more than 30 years. PMI contracts with DeltaCare dentists to ensure quality care for enrollees. Today, more than 1.25 million enrollees are covered by DeltaCare programs.

**My dentist is a Delta dentist but is not on the list of DeltaCare dentists. Can I still receive treatment from this dentist?**
You must receive treatment from your selected DeltaCare contract dentist. Please note that Delta dentists are not necessarily DeltaCare dentists. With more than 2,600 general and specialist dentists, the Delta Care network is one of the largest dental networks in California.

**Do my family members receive treatment from the same DeltaCare contract dentist?**
You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three individual contract dental facilities.

**Can I change my contract dentist?**
You may change contract dentists by notifying us either by phone or in writing, or by visiting our web site (www.deltadentalca.org/pmi). If you contact us by the 21st of the month, the change will become effective the first of the following month.

**How long does it take to get an appointment with a DeltaCare dentist?**
Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer. Most DeltaCare dentists are in private group practices, which means greater appointment availability and extended office hours.

**Are pre-existing dental conditions and work in progress covered?**
Treatment for pre-existing conditions such as extracted teeth is covered under the DeltaCare program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures).

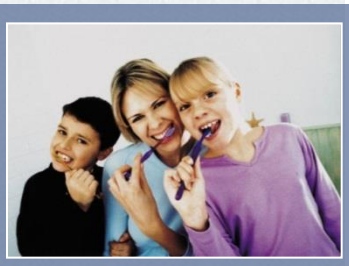
Orthodontic treatment in progress may be covered for new DeltaCare enrollees. See the Limitations and Exclusions of Benefits.

**How does the DeltaCare program encourage preventive care?**
Your DeltaCare program is designed to encourage regular visits to the dentist by having no copayments (fees you pay to the contract dentist) on most diagnostic and preventive benefits. See the enclosed Description of Benefits and Copayments.

**Does my DeltaCare program cover specialists' services?**
Your contract dentist will coordinate your specialty care needs for oral surgery, endodontics, periodontic s or pediatric dentistry with an approved contract specialist. If there is no contract specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable copayment. If you or your dependent is assigned to a dental school clinic for specialty services, those services may be provided by a dentist, a dental student, a clinician or a dental instructor.

**What if I have questions about my DeltaCare program?**
Call PMI Customer Service at (800) 422-4234. We have multilingual representatives available from 5 a.m. to 6 p.m. Pacific Time, Monday through Friday. Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

# DELTA DENTAL PPO HIGHLIGHTS



## ABOUT DELTA DENTAL PPO

Delta Dental PPO is a preferred provider plan that allows you to **save on out-of-pocket expenses** when you visit a Delta Dental PPO network dentist. Your out-of-pocket costs will likely be higher when you visit a non-network dentist.

Under the PPO plan, you can visit any licensed dentist of your choice, and your family members may select different dentists. You can change dentists at any time, go to a dental specialist of your choice and receive dental care anywhere in the world.

To make the *most* of your benefits and pay the *lowest* out-of-pocket costs under the Delta Dental PPO plan, we recommend you visit a Delta Dental PPO network dentist (84,000 dentist locations nationwide; more than 12,600 in California).

If you choose a dentist who is not in the PPO network, your best choice is a Delta Dental Premier dentist. Although their fees are higher than PPO dentists and they are considered out-of-network dentists, Delta Dental Premier dentists cannot charge more than their Delta-allowed fees. You won't receive this cost protection and other conveniences when you visit a non-Delta dentist.

| IN-NETWORK | OUT-OF-NETWORK | |
|---|---|---|
| DELTA DENTAL PPO DENTISTS | DELTA DENTAL PREMIER DENTISTS | NON-DELTA DENTIST |
| Your out-of-pocket expense will likely be less because PPO dentists have agreed to charge PPO patients reduced fees. | You will be charged no more than the fees allowed by Delta Dental (Premier dentist fees are general higher than PPO dentist fees). | You will be responsible for the difference if your dentist charges more than Delta Dental's allowed fees. |
| You may be charged only the patient share* at the time of treatment, not Delta's portion. | You may be charged only the patient share* at the time of treatment, not Delta's portion (patient share is likely to be higher compared to a PPO dentist). | You may have to pay the entire amount in advance and wait for reimbursement. |
| Claim forms will be completed and submitted for you at no charge. | Claim forms will be completed and submitted for you at no charge. | You may have to complete and submit your own claim forms or pay a service fee. |

## DELTA DENTAL PPO IS EASY TO USE

To use your PPO plan, just call the dental office of your choice and make an appointment. During your first appointment, give your dentist your group number, which is at the top of this page, and the primary enrollee's identification number. When you call a PPO dentist for an appointment, please confirm that the dentist participates in the Delta Dental PPO network.

To check if your current provider is a Delta Dental PPO dentist or for a list of PPO dentists in your area, search the dentist directory on our web site at www.deltadentalca.org. You can also check with your benefits administrator, who has a complete list of PPO dentists.

Visit our web site to view your eligibility and benefits or print your own ID card. (Note: You do not need an ID card to verify coverage, make an appointment or receive treatment.) You also can have eligibility information faxed to you by calling toll-free to speak with a team specialist especially trained to serve school district employees: (866) 499-3001.

Delta Dental of California offers you what no other dental plan can — The Delta Difference®. Here's what makes us unique:

*Determination of fees.* PPO and Premier dentists agree to our determination of fees.

*Copayments are guaranteed.* PPO and Premier dentists may charge you only what Delta Dental determines to be your share of the treatment cost. Your copayments will most likely be lowest when you visit a PPO dentist.

*We require professional treatment standards.* PPO and Premier dentists must meet professional standards for hygiene, radiation safety and other areas related to quality care.

These are just a few of the reasons that *one in three Californians* count on Delta Dental for dental care benefits.

** "Patient share" is the copayment, applicable deductible and any amount over the annual maximum. Some services may not be covered; please refer to your Evidence of Coverage. Some examples of services not covered are cosmetic dentistry, experimental procedures and services to correct congenital malformations.*

# DELTA DENTAL PPO HIGHLIGHTS CONT…

**PRINCIPAL BENEFITS AND COVERED SERVICES***

Under this plan, Delta Dental pays 70% of the allowed fees for covered diagnostic, preventive, basic, cast and crown benefits during the first year you are eligible. This percentage will increase 10% each year (to a maximum of 100%) for each enrollee, provided that person visits the dentist at least once during the year. If an enrollee does not use the plan during a calendar year, the percentage remains at the level reached the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

| WHEN TREATMENT IS PROVIDED BY… | A DELTA DENTAL PPO IN-NETWORK DENTIST | AN OUT-OF-NETWORK DENTIST (if you go out-of-network, visit a Delta Dental Premier dentist for lower costs) |
|---|---|---|
| WHO'S COVERED | Primary enrollee and spouse as well as eligible dependent children to age 19 and full-time students to age 23 | Primary enrollee and spouse as well as eligible dependent children to age 19 and full-time students to age 23 |
| BENEFITS MAXIMUM | The maximum benefit paid per calendar year is $2,000 per person. | The maximum benefit paid per calendar year is $1,500 per person. |
| DIAGNOSTIC AND PREVENTIVE BENEFITS* — oral examinations, cleanings, x-rays, examinations of tissue biopsy, fluoride treatment, space maintainers, specialist consultation | 70% - 100% of PPO dentist's allowed fee | 70% - 100% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists |
| BASIC BENEFITS* — oral surgery (extractions), fillings, root canals, periodontic (gum) treatment, tissue removal (biopsy), sealants | 70% - 100% of PPO dentist's allowed fee | 70% - 100% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists |
| CROWNS AND OTHER CAST RESTORATIONS* | 70% - 100% of PPO dentist's allowed fee | 70% - 100% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists |
| PROSTHODONTIC BENEFITS* — bridges, partial dentures, full dentures | 50% of PPO dentist's allowed fee | 50% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists |
| DENTAL ACCIDENT BENEFITS* | 100% of PPO dentist's allowed fee (separate $1,000 maximum per person per calendar year) | 100% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists (separate $1,000 maximum per person per calendar year) |

Although your plan covers many of the most commonly needed services, some services are not covered. If you are unsure whether a particular procedure is covered, or how much of it is paid for by your plan, check with us before proceeding.

The following are *not* covered by the plan:

- Services for injuries or conditions that are covered under Workers' Compensation or Employer's Liability Laws
- Cosmetic surgery or dentistry or services to correct congenital malformation
- Experimental procedures
- Therapeutic drugs, premedication or pain relievers
- Hospital costs or extra charges for hospital treatment
- Anesthesia (except for general anesthesia for oral surgery)
- Extra-oral grafts, implants and implant removal
- Treatment related to the temporomandibular joint (TMJ)
- Orthodontic treatment

**The preceding information is not intended for use as a summary plan description, nor is it designed to serve as an Evidence of Coverage for the plan.**

**This Delta Dental PPO plan is administered by Delta Dental of California. If you have specific questions regarding benefit structure, limitations or exclusions, consult the Evidence of Coverage or contact our Customer Service department.**

# VOLUNTARY LIFE INSURANCE

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

## Voluntary Life Insurance

Providing economic security for your family if you die, become disabled, or experience an injury or illness is a major consideration in personal financial planning. Bellflower Unified School District provides you with an option of Voluntary Life Insurance. Employee will pay the premiums through payroll deductions. Below are details of your options:

All Employees have the option of Voluntary Life Insurance through **Reliance Standard** with the following benefits and rates:

### Schedule of Benefits

**Employee and Spouse:**
Increments of $10,000 to a maximum of $500,000
**Children:**
14 days but less than 6 months: $1,000
6 mos. to Age 20*: Options of $5,000, $10,000, $15,000 or $20,000
*Child coverage is to age 23 if FT Student

### Guarantee Issues:

**Employee under age 60:** $100,000
**Employees age 60 to 70:** $10,000
**Spouse under age 60:** $50,000
**Children:** Any amount is guaranteed provided the Employee and/or spouse is approved for coverage

- **Evidence of Insurability Requirements**:
  Amounts over Guarantee Issue
- Any amount for a late entrant

### Exclusions and Limitations

Death by suicide is not covered during the first two years of coverage. The policy becomes incontestable after two years except for non-payment of premium

Employee and Spouse Tenthly Rates per $10,000

| Age | Voluntary Life Rate |
|---|---|
| Under 30 | $.60 |
| 30 – 34 | $1.00 |
| 35 – 39 | $1.10 |
| 40 – 44 | $1.30 |
| 45 – 49 | $1.80 |
| 50 – 54 | $3.10 |
| 55 – 59 | $5.20 |
| 60 – 64 | $8.10 |
| 65 – 69 | $15.50 |
| 70 + | $25.00 |

Dependent Rates Per Dependent Unit

| Coverage | Rate per Dependent Unit |
|---|---|
| $5,000 | $1.00 |
| $10,000 | $2.00 |
| $15,000 | $3.00 |
| $20,000 | $4.00 |

| Example of Cost | Election | Cost per Month |
|---|---|---|
| Employee age 30 | $ 100,000 | $ 10.00 |
| Spouse age 30 | $ 50,000 | $ 5.00 |
| Children (2) | $ 20,000 | $ 4.00 |

# VOLUNTARY LIFE INSURANCE cont…

Certificated Employees also have the option of Voluntary Term Life, Disability and Cancer Insurance through Pacific Educators. Pacific Educators is one of California's oldest and largest providers of employee benefits to education/school personnel and their families. Pacific Educators focuses on providing the highest quality Disability Insurance, Life Insurance, and Cancer Insurance available to California Teachers, California School Employees (Classified) and California Administrators/Management. All of their products are from reputable, top-rated insurance companies.

### *Term Life Insurance: Option 1 (FSL)*

- 6 plans to choose from to meet any budget.
- Premiums start at just $4.50 a month.
- Spouses may be covered without the employee.
- Family coverage is available and provides $5,000 in coverage to all dependent children (6 months to 23 years) and spouse for only $1 a month.
- Accelerated life insurance benefits provide early payments for critical illness.
- Coverage may be continued even if you leave the District.

### *Term Life Insurance: Option 2 (FSL)*

You tailor the coverage to fit your needs.

- Buy from 1 to 14 units starting at just $2 per unit.
- New employees can receive 1 unit of coverage Guarantee Issue (no health questions) if applied for within the first 120 days of employment.
- All Unmarried dependent children (6 months to 25 years) are eligible for $2,500.00 to $10,000.00 of coverage.
- May be continued even if you leave employment with the District

### *California Teacher/Classified Administrator Disability (FSL)*

Fidelity Security Life Insurance Company

The California Teacher, Classified Employee, and Administrator Disability Plans are designed to help provide replacement income when employees are sick or injured away from the job. Most school districts employees do not pay for the State Disability Plan (SDI). This can leave an employee in a serious financial crisis if disabled and unable to work. These plans help solve this problem by offering substantial financial assistance when disability strikes. Some features are:

- The plans pay 100% full benefits in addition to sick leave, differential pay, S.T.R.S., and P.E.R.S. benefits. Many other plans subtract or integrate benefits with other income.
- The plans pay benefits 12 months a year including off-track, summer, vacation periods. Many other plans pay only for scheduled work days.
- Maternity Benefits are available at the option of the employee.

Along with the benefits above, these plans are affordable. You tailor the coverage to meet your specific needs through different waiting periods, benefit amounts, maternity or not, and benefit length.

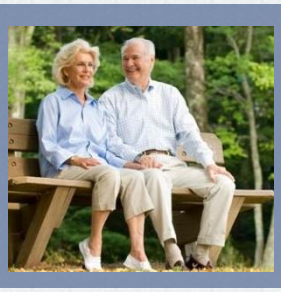
### *Cancer Insurance (FSL)*

Guaranteed acceptance for persons who have not had any forms of cancer in the past 10 years. Plus additional features, i.e. mammograms and cervical cancer screening benefits without diagnosis of cancer. Costs as little as $7.26 a month!

***Other Life Insurance Policies:*** Pacific Educators has the ability to quote any amount of life insurance on a specialized one-on-one basis. Their database scans thousands of "A" rated insurance companies' policies to find the best premiums based on your criteria. Whether you're looking for $50,000.00 or $1,000,000.00 in Level Term, Universal or Whole Life, we have the capability to meet almost any need.

**SEE BROCHURES FOR COMPLETE PLAN BENEFITS, EXCLUSIONS AND LIMITATIONS AND RATES.** For more information or if you have any questions, please call (800) 722-3365 or go to **www.peinsurance.com**

# VOLUNTARY DISABILITY INSURANCE



Bellflower Unified School District offers all employees Voluntary Disability Life Insurance written through Fidelity Life Insurance Company. The plan pays 100% of full benefits in addition to sick leave, differential pay, S.T.R.S. and P.E.R.S. benefits. The plan pays benefits 12 months a year including off track summary and vacation periods. You select your waiting period, benefit amount and payout duration.

### How Much Will It Cost?

*Sample 1*: A 45 year old with a $2,500.00 a month benefit, kicking in after 15 calendar days and a 1 year payout would cost just $33.33 a month.

*Sample 2*: A 38 year old with a $3,500.00 a month benefit kicking in after 30 calendar days and a 1 year payout would cost just $25.08 a month.

You must complete the enrollment form and turn it in at the District office. Be sure you ask for a copy of the date stamped application for your records. Employee will pay the premiums through payroll deductions.

When your paychecks stop, your bills keep going. Your income is a very important asset. It helps you cover all your routine living expenses. If you should become sick or injured and unable to earn your salary, how would you continue to meet your financial obligations? Disability Income Insurance provides you with benefits when you're unable to work due to a covered sickness or injury.

**APPLY NOW, BECAUSE THE TIME TO PLAN FOR A DISABILITY IS BEFORE YOU REALLY NEED IT!**

**YOU CHOOSE YOUR BENEFIT**
Because everyone's need for disability income insurance differs, you have a choice of monthly benefits and how long you want your benefits to continue. You may also choose between maternity and non-maternity coverage. Naturally, your premium varies with the plan and monthly benefit you choose.

The benefits you select for this coverage, combined with any other disability income insurance policy benefits for which you are currently insured or have an application pending must not exceed sixty percent of your monthly wage or salary. Select a plan and monthly benefit which best fits your needs!

***THESE PLANS PAY YOU FULL BENEFITS IN ADDITION TO YOUR SICK LEAVE, SUBSTITUTE DIFFERENTIAL PAY, EXTENDED SICK LEAVE, S.T.R.S. AND P.E.R.S. DISABILITY, AND ANY OTHER DISABILITY PLANS FOR WHICH YOU MAY BECOME ELIGIBLE AFTER THE EFFECTIVE DATE OF YOUR CERTIFICATE.***

In other words, these benefits do NOT reduce, coordinate, integrate or subtract from the above income or any disability plan for which you become eligible after the effective date of your certificate

**PAYS BENEFITS**
**12 MONTHS OF THE YEAR (Including summer vacation, off track & holidays)**

**MONTHLY BENEFIT**
Find your annual salary in the salary chart below to deter- mine your maximum eligible monthly disability benefit. You may choose the maximum, or any amount less than that. (Please note the benefit selected cannot be greater than 60% of your monthly income when combined withother disability insurance.)

| If Your Gross Annual Salary Is At Least... | Maximum Monthly Disability Benefit |
|---|---|
| $ 24,000.00 | $ 1,200.00 |
| $ 26,000.00 | $ 1,300.00 |
| $ 28,000.00 | $ 1,400.00 |
| $ 30,000.00 | $ 1,500.00 |
| $ 32,000.00 | $ 1,600.00 |
| $ 34,000.00 | $ 1,700.00 |
| $ 36,000.00 | $ 1,800.00 |
| $ 38,000.00 | $ 1,900.00 |
| $ 40,000.00 | $ 2,000.00 |
| $ 42,000.00 | $ 2,100.00 |
| $ 44,000.00 | $ 2,200.00 |
| $ 46,000.00 | $ 2,300.00 |
| $ 48,000.00 | $ 2,400.00 |
| $ 50,000.00 | $ 2,500.00 |
| $ 52,000.00 | $ 2,600.00 |
| $ 54,000.00 | $ 2,700.00 |
| $ 56,000.00 | $ 2,800.00 |
| $ 58,000.00 | $ 2,900.00 |
| $ 60,000.00 | $ 3,000.00 |
| $ 62,000.00 | $ 3,100.00 |
| $ 64,000.00 | $ 3,200.00 |
| $ 66,000.00 | $ 3,300.00 |
| $ 68,000.00 | $ 3,400.00 |
| $ 70,000.00 | $ 3,500.00 |
| $ 72,000.00 | $ 3,600.00 |
| $ 74,000.00 | $ 3,700.00 |
| $ 76,000.00 | $ 3,800.00 |
| $ 78,000.00 | $ 3,900.00 |
| $ 80,000.00+ | $ 4,000.00 |

# FLEXIBLE SPENDING ACCOUNTS (FSA)

SHDR
STANLEY, HUNT, DUPREE, & RHINE
Benefit Consultants
A Division of BB&T Insurance Services, Inc.

Bellflower Unified School District, partnered with SHDR, offers you the opportunity to participate in tax-savings accounts through payroll deduction. With these plans, money is taken out of your paycheck before taxes and set aside—so you don't pay taxes on the contributions. Then, the money is used to reimburse you for your eligible health care and dependent care expenses. However, health insurance premiums that are automatically deducted by your employer from your paycheck are not eligible for reimbursement. Under the cafeteria plan, deductions for your medical, dental and vision insurance premiums are also made before taxes. The FSA plan, administered by SHDR, operates on a plan year basis from October 1, 2016 through September 30, 2017 and offers the two following accounts for you to participate in (one or both):

1. A **Health Care FSA** can reimburse for health care expenses that are not covered, or are only partially covered, by your medical, dental and vision insurance plans including other eligible expenses. You will have immediate access to the entire annual contribution amount from the first day of the benefit year, before all scheduled contributions have been made. The maximum contribution for your Health Care FSA is $2,500.

2. The **Dependent Care FSA** can be used to pay for qualified child care and/or caregivers for a disabled family member living in the household who is unable to care for themselves. Unlike the Health Care FSA, you can only access the money that is currently in the account. The maximum contribution for your Dependent Care FSA is $5,000.

**Enrollment form is included in the open enrollment packet.**

## Enrolling in an FSA

To participate in the FSA program, enrollment must be completed each year during the Open Enrollment period for both new and active employees up to a maximum amounts allowed. An annual contribution amount must be determined at the time of enrollment.

Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status and more at www.shdr.com/flex.

# REQUIRED NOTICES:
## MEDICARE PART D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **BELLFLOWER UNIFIED SCHOOL DISTRICT** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **The prescription drug coverage offered by Health Net is expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 31.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage under the group health plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

**For More Information about This Notice or Your Current Prescription Drug Coverage**

Contact Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through IMS changes. You also may request a copy of this notice at any time.

**For More Information about Your Options under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

**For More Information about Medicare Prescription Drug Coverage:**

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

# REQUIRED NOTICES:
## HIPAA PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Our Pledge to You**

This notice is intended to inform you of the privacy practices followed by the **BELLFLOWER UNIFIED SCHOOL DISTRICT** Benefit Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It became effective on July 1, 2009.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. **BELLFLOWER UNIFIED SCHOOL DISTRICT** requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

**Protected Health Information**

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

**How We May Use Your Protected Health Information**

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

- ***Payment.*** We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.
- ***Health Care Operations.*** We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.
- ***Treatment.*** Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.
- ***As permitted or required by law.*** We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.
- ***Pursuant to your Authorization.*** When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.
- ***To Business Associates***. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

- ***To the Plan Sponsor.*** We may disclose protected health information to certain employees of **BELLFLOWER UNIFIED SCHOOL DISTRICT** for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

**Your Rights**

- ***Right to Inspect and Copy.*** In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.
- ***Right to Amend.*** If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the Risk Management Department. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.
- ***Right to an Accounting of Disclosures.*** You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

  Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.
- ***Right to Request Restrictions.*** You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

  Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.
- ***Right to Request Confidential Communications.*** You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to Risk Management Department. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.
- ***Right to be Notified of a Breach.*** You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.
- ***Right to Receive a Paper Copy of this Notice.*** If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact Human Resources.

**Our Legal Responsibilities**

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below. If you have any questions or complaints, please contact Human Resources.

**Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

# OTHER REQUIRED NOTICES

## Health Insurance Marketplace Coverage Options and Your Health Coverage

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

**What is the Health Insurance Marketplace?**
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began October 2013 with coverage starting as early as January 1, 2014.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or call your plan administrator.
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

## COBRA Continuation Coverage

COBRA, which stands for “Consolidated Omnibus Budget Reconciliation Act,” gives you and your dependents the right to continue health care coverage for a specific time if your employer-sponsored coverage ends. In accordance with COBRA, you (and/or your covered dependents) have a right to continue your health care coverage in the event you (or your dependents) are no longer eligible for coverage through the employee benefits program. There are several instances in which COBRA continuation is available; these instances are referred to as “qualifying events.”

Examples of qualifying events include:

- You end your employment
- You are no longer eligible for benefits due to a reduction of work hours
- You and your spouse divorce or become legally separated
- Your dependent child reaches the maximum age for coverage

Generally, COBRA coverage is available to your for up to 18 months (an additional 18 months may be available in certain circumstances). To receive this coverage, you must enroll for benefits in a timely manner and pay the required premium. The amount charged can be equal to the full premium plus a 2% administration fee. If a qualifying event occurs and your employer is aware of it or notified, the COBRA administrator will send you the required COBRA enrollment materials. For qualifying events that your employer may not be aware of, such as a divorce or birth of a child, it is your responsibility to report the event within 60 days.

# OTHER REQUIRED NOTICES

## Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

## Children's Health Insurance Program Act (CHIP)

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that offers assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available for you.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance. Many states offer assistance. A detailed contact list with phone numbers and websites is available and is updated periodically by the U.S. Department of Labor and the U.S. Department of Health and Human Services. This detailed notice is available during open enrollment or upon request at any time during the year.**

## Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Effective April 1, 2009, employees and dependents who are eligible for coverage under the medical plan, but are not enrolled, will be permitted to enroll in the plan if they lose eligibility for Medicaid or CHIP coverage or become eligible for a premium assistance subsidy under Medicaid or CHIP.

Individuals must request coverage under the plan within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. CHIPRA allows states to offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. Some states offer a premium assistance subsidy. Included with this notice is a list of potential opportunities available for premium assistance. You should contact your State for further information on eligibility.

## Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prepared by:

BB&T Insurance Services OF CALIFORNIA

*The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer and the insurance companies. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.*

# BTA-Contribution Schedule for 2017 CalPERS Health Benefits

| EE Only Coverage | | | | | |
|---|---|---|---|---|---|
| Plan | EE Only (rates billed 12thly) | EE Only (annual premium) | District Annual Contribution | EE Annual Contribution | EE 10thly Contribution |
| Anthem HMO Select | $592.78 | $7,113.36 | $6,250.00 | $863.36 | $86.34 |
| Anthem HMO Traditional | $713.69 | $8,564.28 | $6,250.00 | $2,314.28 | $231.43 |
| BSC Access + | $675.98 | $8,111.76 | $6,250.00 | $1,861.76 | $186.18 |
| HealthNet SmartCare | $526.73 | $6,320.76 | $6,250.00 | $70.76 | $7.08 |
| Kaiser Permanente | $573.89 | $6,886.68 | $6,250.00 | $636.68 | $63.67 |
| PERS Choice | $637.53 | $7,650.36 | $6,250.00 | $1,400.36 | $140.04 |
| PERS Select | $565.33 | $6,783.96 | $6,250.00 | $533.96 | $53.40 |
| PERS Care | $715.88 | $8,590.56 | $6,250.00 | $2,340.56 | $234.06 |
| United HealthCare | $545.71 | $6,548.52 | $6,250.00 | $298.52 | $29.85 |

| EE + 1 Coverage | | | | | |
|---|---|---|---|---|---|
| Plan | EE + 1 (rates billed 12thly) | EE + 1 (annual premium) | District Annual Contribution | EE Annual Contribution | EE 10thly Contribution |
| Anthem HMO Select | $1,185.56 | $14,226.72 | $11,250.00 | $2,976.72 | $297.67 |
| Anthem HMO Traditional | $1,427.38 | $17,128.56 | $11,250.00 | $5,878.56 | $587.86 |
| BSC Access + | $1,351.96 | $16,223.52 | $11,250.00 | $4,973.52 | $497.35 |
| HealthNet SmartCare | $1,053.46 | $12,641.52 | $11,250.00 | $1,391.52 | $139.15 |
| Kaiser Permanente | $1,147.78 | $13,773.36 | $11,250.00 | $2,523.36 | $252.34 |
| PERS Choice | $1,275.06 | $15,300.72 | $11,250.00 | $4,050.72 | $405.07 |
| PERS Select | $1,130.66 | $13,567.92 | $11,250.00 | $2,317.92 | $231.79 |
| PERS Care | $1,431.76 | $17,181.12 | $11,250.00 | $5,931.12 | $593.11 |
| United HealthCare | $1,091.42 | $13,097.04 | $11,250.00 | $1,847.04 | $184.70 |

| EE + Family Coverage | | | | | |
|---|---|---|---|---|---|
| Plan | EE+FAM (rates billed 12thly) | EE+FAM (annual premium) | District Annual Contribution | EE Annual Contribution | EE 10thly Contribution |
| Anthem HMO Select | $1,541.23 | $18,494.76 | $15,000.00 | $3,494.76 | $349.48 |
| Anthem HMO Traditional | $1,855.59 | $22,267.08 | $15,000.00 | $7,267.08 | $726.71 |
| BSC Access + | $1,757.55 | $21,090.60 | $15,000.00 | $6,090.60 | $609.06 |
| HealthNet SmartCare | $1,369.50 | $16,434.00 | $15,000.00 | $1,434.00 | $143.40 |
| Kaiser Permanente | $1,492.11 | $17,905.32 | $15,000.00 | $2,905.32 | $290.53 |
| PERS Choice | $1,657.58 | $19,890.96 | $15,000.00 | $4,890.96 | $489.10 |
| PERS Select | $1,469.86 | $17,638.32 | $15,000.00 | $2,638.32 | $263.83 |
| PERS Care | $1,861.29 | $22,335.48 | $15,000.00 | $7,335.48 | $733.55 |
| United HealthCare | $1,418.85 | $17,026.20 | $15,000.00 | $2,026.20 | $202.62 |

CalPERS

California Public Employees' Retirement System
P.O. Box 942715
Sacramento, CA 94229-2715

HEALTH BENEFIT PLAN ENROLLMENT FORM
PERS-HBD-12 (Rev. 6/13)

**DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS**

CalPERS **USE ONLY - DOCUMENT REFERENCE NUMBER**

**PLEASE TYPE**

1. TYPE OF ACTION (Check One)
- ☐ a. NEW enrollment
- ☐ b. CHANGE of coverage
- ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER ___ ___

3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER ___ ___

4A. Name

Mailing Address (FIRST) (MI) (LAST)

City, State, ZIP | Daytime Phone | Evening Phone

4B. RESIDENCE ZIP CODE (If different from 4A)

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. GENDER ☐ Male ☐ Female

7. MARRIED ☐ Yes ☐ No

8. PLAN CODE

9. NAME OF HEALTH PLAN

10. GROSS PREMIUM $

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Reason Code

15. Permitting Event Date Mo. Day Yr.

16. EFFECTIVE DATE Mo. Day 01 Yr.

| ACTION CODE | LIST ALL PERSONS (including self) TO BE ENROLLED IN: | DATE OF BIRTH Mo. Day Yr. | Family Relationship | GENDER M F | CODE |
|---|---|---|---|---|---|
| | 17. BASIC PLAN (FIRST) (MI) (LAST) | | SELF | | |
| | SSN (FIRST) (MI) (LAST) | | | | |
| | SSN (FIRST) (MI) (LAST) | | | | |
| | SSN | | | | |
| | | | | | |
| ACTION CODE | 18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST) | DATE OF BIRTH Mo. Day Yr. | Relationship | | CODE |
| | | | | | |
| | | | | | |

19. CHECK ONE
- ☐ I **DO NOT** elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy)

TELEPHONE NUMBER ( )

21. DATE SIGNED Mo. Day Year

**PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27**

22. DEDUCTION PLAN CODE

23. Type of action (Check One) 1. ☐ New 2. ☐ Cancel 3. ☐ Change

24. PAY PERIOD Month Year

25. PARTY CODE

26. EMPLOYEE DESIGNATION

27. BARGAINING UNIT

28. AGENCY NAME (or Retirement System)

29. PAYROLL OFFICE CODE

30. AGENCY CODE

31. UNIT CODE

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act.

SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in employing office Mo. Day Year

34. PHONE NUMBER

35. REMARKS

_____ of _____ Forms

WHITE – HB PINK – Agency BLUE - Employee

## PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and state benefits. Furthermore, Health Account Services requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits. Specifically, the California Public Employees' Retirement System uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Payroll deduction and state contribution for state employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to the Public Employees' Retirement System and other state agencies.
5. Coordination of benefits among carriers.

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## BINDING ARBITRATION

Enrollment in certain plans constitutes an agreement to have any issue of medical malpractice decided by neutral arbitration and waiver of any right to a jury or court trial. Refer to the health plan Evidence of Coverage booklet to determine if this provision is applicable to your plan.

# Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

### Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

### Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

### Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

### Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).

BUSINESS REPLY

POSTAGE WILL BE PAID BY ADDRESSEE

PACIFIC EDUCATORS INC
POST OFFICE BOX 1526
ORANGE CA 92856-9975

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

# CSP

California Schools Personnel

## GROUP DISABILITY INCOME INSURANCE PLAN

Underwritten by:

**Fidelity Security Life Insurance Company**
Kansas City, Missouri 64111

Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance by A. M. Best Company, an independent analyst of the insurance industry. For the latest rating, access www.ambest.com

Administered by:

Pacific Educators Insurance Services

2808 E. Katella Ave., Suite 101 • Orange, CA 92867
**(800) 722-3365 • (714) 639-0962**
www.PEinsurance.com Lic.#0429928

Policy Form No. M-4018

Policy No.SD-20/SD-20A
(04/13)

**CSP** California Schools Personnel

IT CAN HAPPEN TO ANYONE

# SICKNESS & ACCIDENT DISABILITY INCOME INSURANCE PLAN

**PAYS FULL BENEFITS**
In addition to Sick Leave
Sub Differential Pay,
S.T.R.S. & P.E.R.S.

# IT CAN HAPPEN TO ANYONE

## CONSIDER THESE FACTS

When your paychecks stop, your bills keep going. Your income is a very important asset. It helps you cover all your routine living expenses. If you should become sick or injured and unable to earn your salary, how would you continue to meet your financial obligations? Disability Income Insurance provides you with benefits when you're unable to work due to a covered sickness or injury.

**APPLY NOW, BECAUSE THE TIME TO PLAN FOR A DISABILITY IS BEFORE YOU REALLY NEED IT!**

## YOU CHOOSE YOUR BENEFIT

Because everyone's need for disability income insurance differs, you have a choice of monthly benefits and how long you want your benefits to continue. You may also choose between maternity and non-maternity coverage. Naturally, your premium varies with the plan and monthly benefit you choose.

The benefits you select for this coverage, combined with any other disability income insurance policy benefits for which you are currently insured or have an application pending must not exceed sixty percent of your monthly wage or salary. Select a plan and monthly benefit which best fits your needs!

***THESE PLANS PAY YOU FULL BENEFITS IN ADDITION TO YOUR SICK LEAVE, SUBSTITUTE DIFFERENTIAL PAY, EXTENDED SICK LEAVE, S.T.R.S. AND P.E.R.S. DISABILITY, AND ANY OTHER DISABILITY PLANS FOR WHICH YOU MAY BECOME ELIGIBLE AFTER THE EFFECTIVE DATE OF YOUR CERTIFICATE.***

In other words, these benefits do NOT reduce, coordinate, integrate or subtract from the above income or any disability plan for which you become eligible after the effective date of your certificate.

## PAYS BENEFITS

**12 MONTHS OF THE YEAR (Including summer vacation, off track and holidays)**

## MONTHLY BENEFIT

Find your annual salary in the salary chart below to determine your maximum eligible monthly disability benefit. You may choose the maximum, or any amount less than that. (Please note the benefit selected cannot be greater than 60% of your monthly income when combined with other disability insurance.)

## SALARY CHART

| If Your Gross Annual Salary Is At Least... | Maximum Monthly Disability Benefit |
|---|---|
| $ 24,000.00 | $ 1,200.00 |
| $ 26,000.00 | $ 1,300.00 |
| $ 28,000.00 | $ 1,400.00 |
| $ 30,000.00 | $ 1,500.00 |
| $ 32,000.00 | $ 1,600.00 |
| $ 34,000.00 | $ 1,700.00 |
| $ 36,000.00 | $ 1,800.00 |
| $ 38,000.00 | $ 1,900.00 |
| $ 40,000.00 | $ 2,000.00 |
| $ 42,000.00 | $ 2,100.00 |
| $ 44,000.00 | $ 2,200.00 |
| $ 46,000.00 | $ 2,300.00 |
| $ 48,000.00 | $ 2,400.00 |
| $ 50,000.00 | $ 2,500.00 |
| $ 52,000.00 | $ 2,600.00 |
| $ 54,000.00 | $ 2,700.00 |
| $ 56,000.00 | $ 2,800.00 |
| $ 58,000.00 | $ 2,900.00 |
| $ 60,000.00 | $ 3,000.00 |
| $ 62,000.00 | $ 3,100.00 |
| $ 64,000.00 | $ 3,200.00 |
| $ 66,000.00 | $ 3,300.00 |
| $ 68,000.00 | $ 3,400.00 |
| $ 70,000.00 | $ 3,500.00 |
| $ 72,000.00 | $ 3,600.00 |
| $ 74,000.00 | $ 3,700.00 |
| $ 76,000.00 | $ 3,800.00 |
| $ 78,000.00 | $ 3,900.00 |
| $ 80,000.00 + | $ 4,000.00 |

Larger amounts are available for Administrators and Management. Please call (800) 722-3365 for details...

**Based on your monthly benefit amount, calculate your premium (cost) on the next page.**

# QUESTION & ANSWERS

### WHO MAY APPLY?
All members, actively employed in the full-time duties (20 hours a week) of their occupation, may apply!

### HOW ARE BENEFITS PAID?
Benefits are paid directly to you. All benefits you receive are yours to use as you please. Pay hospital, doctor or other miscellaneous medical expenses. Pay at-home expenses or continuing monthly bills. The choice is yours!

### ARE MY BENEFITS TAXABLE?
No tax is payable on your monthly benefits as long as you, not your employer, pay the entire premium. If you use the premium under a pre-taxed section 125 plan, your benefits are taxable. Please consult your tax advisor.

### WHAT IS MEANT BY SICKNESS?
Sickness means a bodily disorder; a disease; or Complications of Pregnancy. The Sickness must first begin while the coverage for the Insured is in force under the Policy. Sickness includes pregnancy and resulting childbirth if that option is selected and the pregnancy commences after the Insured's Effective Date. Sickness includes a nervous or mental disorder.

### DO I STILL PAY PREMIUMS WHEN I'M DISABLED?
No! After 6 months of total disability (and after your elimination period), your premium is waived for as long as you're totally disabled and benefits are payable.

### WHAT ABOUT RECURRING CONDITIONS?
Maximum benefits are available, subject to a new elimination period, for the same recurring disability after 180 consecutive days of normal, active work.

### HOW LONG CAN I KEEP MY COVERAGE?
Renew your coverage until retirement - provided you pay your premiums, remain a member, are gainfully employed and the group policy remains in force. This policy is renewable at the option of the company.

### WHAT ISN'T COVERED?
Benefits are not payable for any injury, sickness or condition caused by or due to: war or acts of war declared or undeclared; military service of any country or international organization; pregnancy or childbirth (unless applying for maternity coverage); abortion, except to save the life of the mother; illegal blood alcohol content; being under the influence of any narcotic, barbiturate or hallucinatory drug, unless administered under advice of a physician and taken in the prescribed dosage; suicide or any attempt at suicide while sane or insane; travel or flight in any kind of aircraft while participating in aviation training, or as a pilot, officer or other member of the crew; injury or sickness arising out of and in the course of any occupation for wage or profit.

Calculate your premium

# CSP GROUP RATES

## EXTEND YOUR INCOME WHEN DISABILITY STRIKES

### PREMIUM

To determine your premium, choose the plan that has the waiting (elimination) period, the length of payment (1 or 2 years), and whether applying for maternity or non-maternity coverage. Based on the plan you select and your current age, multiply the rate in the table below by the monthly benefit amount in $100 increments (see example). Premiums are based on your attained age on your effective date.

**EXAMPLE: If applying for $2100/month benefit, multiply 21 x the rate shown in the table below.**

### NEED HELP CALCULATING YOUR PREMIUM?

**Call Us at (800) 722-3365 or go to WWW.PEINSURANCE.COM and click on**
Products, California School Personnel, and Disability Insurance to use our rate calculator.

### NO MATERNITY BENEFITS

| All Premiums are 10 Times per Year | DISABILITY BENEFITS PAID UP TO ONE YEAR Rates Per $100 Monthly Benefit | | | | DISABILITY BENEFITS PAID UP TO TWO YEARS Rates Per $100 Monthly Benefit | | | |
|---|---|---|---|---|---|---|---|---|
| **Your Age** | **Under 40** Tenthly | **40 - 49** Tenthly | **50 - 59** Tenthly | **60 - 69*** Tenthly | **Under 40** Tenthly | **40 - 49** Tenthly | **50 - 59** Tenthly | **60 - 69*** Tenthly |
| Waiting Period - **15 Calendar Days** | $1.16 | $1.60 | $2.46 | $3.96 | $1.56 | $2.22 | $3.50 | $5.84 |
| Waiting Period - **30 Calendar Days** | $0.86 | $1.24 | $1.98 | $3.38 | $1.26 | $1.86 | $3.04 | $5.26 |
| Waiting Period - **60 Calendar Days** | $0.61 | $0.95 | $1.58 | $2.82 | $1.04 | $1.54 | $2.60 | $4.66 |

### WITH MATERNITY BENEFITS

| All Premiums are 10 Times per Year | DISABILITY BENEFITS PAID UP TO ONE YEAR Rates Per $100 Monthly Benefit | | | | | | DISABILITY BENEFITS PAID UP TO TWO YEARS Rates Per $100 Monthly Benefit | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Your Age** | **Under 30** Tenthly | **30 - 34** Tenthly | **35 - 39** Tenthly | **40 - 49** Tenthly | **50 - 59** Tenthly | **60 - 69*** Tenthly | **Under 30** Tenthly | **30 - 34** Tenthly | **35 - 39** Tenthly | **40 - 49** Tenthly | **50 - 59** Tenthly | **60 - 69*** Tenthly |
| Waiting Period - **15 Calendar Days** | $3.88 | $2.36 | $1.80 | $1.60 | $2.46 | $3.96 | $4.22 | $2.73 | $2.22 | $2.22 | $3.50 | $5.84 |
| Waiting Period - **30 Calendar Days** | $2.68 | $1.65 | $1.29 | $1.24 | $1.98 | $3.38 | $3.03 | $2.03 | $1.75 | $1.86 | $3.04 | $5.26 |
| Waiting Period - **60 Calendar Days** | $1.00 | $0.81 | $0.78 | $0.95 | $1.58 | $2.82 | $1.30 | $1.10 | $1.20 | $1.54 | $2.60 | $4.66 |

* At age 70, the benefit period will reduce to 6 months. **Tenthly premiums for age 70 and over are as follows:** 15 Day Plan - $3.41 per $100 unit. 30 Day Plan - $2.89 per $100 unit. 60 Day Plan - $2.31 per $100 unit.

### DEFINITION OF TOTAL DISABILITY

Total Disability or Totally Disabled means that because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation; and must be under the care of a physician unless the physician certifies you do not need the regular care of a physician for such disabling condition. Loss of a professional or occupational license for any reason does not, in itself, constitute total disability.

### PRE-NOTICE

Although your application is our main source of information, we at Fidelity Security Life Insurance Company (FSL) may also collect or verify information pertaining to age, occupation, physical condition, health history and avocations by contacting various individuals or organizations by correspondence, telephone or personal contact. It may be necessary for us to share information we obtain with an individual or organization related to the medical or insurance industry or with an individual performing a function for us without your express written authorization.

Information regarding your insurability will be treated as confidential. FSL or its reinsurers may, however, make a brief report thereon to the MIB, formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

FSL or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

### HOW TO APPLY

Fill out the application, detach, fold and mail today. Your answers to the general health questions will help determine your insurability. Please be sure the answers are correct and complete.

If this coverage replaces a similar plan, do not cancel current coverage until you have been approved for this plan.

Coverage becomes effective upon approval of your application by the Insurance Company and the first payroll deduction, provided you are actively at work on that day.

To file a claim, contact Pacific Educators, Inc. for a form which you and your doctor fill out. Return the form to the Insurance Company for prompt processing.

**COMPLETE APPLICATION & MAIL**
**Postage is Paid!**

**APPLICATION TO FIDELITY SECURITY LIFE INSURANCE COMPANY** **For California Schools Personnel Group Disability Income Insurance Plan**

Policy No. SD-20

Please indicate your choice of plan options.

Elimination Period: ☐ 15 Day ☐ 30 Day ☐ 60 Day Benefit Period: ☐ 1 Year ☐ 2 Years Maternity Benefits: ☐ Yes ☐ No

Monthly Benefit Desired: $_____; Number of $100 units _____ X _____ = _____

*Please Print or Type in Black Ink* (6 to 40) ( Rate per $100) (Premium)

NAME _____ SOCIAL SECURITY NO. _____

FIRST MIDDLE LAST

ADDRESS _____

STREET CITY STATE ZIP

BIRTHDATE_____ AGE _____ SEX _____ HEIGHT _____ ft._____ in. WEIGHT _____lbs. GROSS ANNUAL SALARY_____

1. Duties: _____ Are you actively performing the full-time duties of your occupation? ..... ☐ Yes ☐ No
2. Have you ever been advised that you've had: brain disorder, stroke, heart or circulatory disorder, pulmonary or lung disorder, internal cancer or malignancy (other than basal or squamous cell skin cancer), leukemia, diabetes, bladder or kidney disease, liver disease, or arthritis? ..... ☐ Yes ☐ No
3. During the past five years, have you had any condition requiring the use of medication other than for flu or cold? ..... ☐ Yes ☐ No
4. During the past five years, have you had any condition requiring diet, physical therapy, chiropractic therapy, braces, crutches, or other corrective devices? ..... ☐ Yes ☐ No
5. During the past five years, have you been treated for any physical or mental condition, including anxiety, depression or excessive use of alcohol or drugs? ..... ☐ Yes ☐ No
6. (Females only) Have you ever been diagnosed with, treated for or taken medication for: reproductive organ disease or disorder, C-Section, pregnancy complications, or are you currently pregnant? ..... ☐ Yes ☐ No
7. If the answer to any question 2 thru 7 is "yes" please provide the information below. If needed, use a signed and dated separate sheet

| DIAGNOSIS/MEDICATION | DATE | DURATION | DEGREE OF RECOVERY | NAME & ADDRESS OF DOCTOR / HOSPITAL |
|---|---|---|---|---|
| | | | | |
| | | | | |

8. Do you carry any other individual or group disability insurance? ☐ Yes ☐ No If yes, will this policy replace any existing disability insurance? ☐ Yes ☐ No
   Company _____ Amount _____
9. Do you understand and agree that the monthly benefit herein applied for, together with all other individual and/or group disability income policies you have or are applying for, cannot exceed 60% of your wage or salary? ☐ I agree
10. Do you understand and agree that the insurance shall not become effective unless you are actively at work at your regular place of employment on the date it would otherwise become effective? ☐ I agree. Do you understand and agree that no indemnity for loss of time is payable during the elimination period applicable to the plan you select? ☐ I agree.

I understand that by applying for this group insurance that I am becoming a member of the Combined Association & Organization Group Insurance Trust. I understand that the insurance applied for shall become effective on the date specified by the Company only if this application is accepted by the Company and the first premium is paid prior to the death of any proposed insured. I represent that all statements and answers recorded on this application are true and complete as of the date I signed this application and made to obtain the insurance applied for. I understand any misstatements or omissions may be used as a basis for rescinding my coverage. This means all claims will be denied and the Company's liability will be limited to full refund of premium less any claims previously paid. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. I have received and read a copy of the Pre-Notice which describes how information is obtained and used by the Company. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB,Inc. (MIB) or other organization or institution that has any records or knowledge of my physical or mental health, including significant history, findings, diagnoses and treatment or nonmedical information, such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications of insurance, to give to the Compay, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. The Company or its authorized representatives may release to its plan administrators, business associates, other insurance companies, MIB, or others whom I authorize in writing, information covered by this authorization. I authorise the company to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date shown below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64111-8131, Attention: Privacy Officer. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand I will receive a copy of this authorization.

_____

DATE SIGNATURE OF APPLICANT HOME PHONE (Area Code and Number)

A-00999CA (01/02) Policy Form No. M-4018

**Payroll Deduction Authorization:** I hereby authorize the Payroll Department to deduct from my salary or wages the amount necessary to pay the required premium and forward the amount to Fidelity Security Life Insurance Company or its authorized representative. I also reserve the right to revoke this authorization by giving written notice prior to the next premium date.

I am now actively employed by the _____District.

_____

DATE SIGNATURE OF APPLICANT HOME E-MAIL ADDRESS

Print Form

Rev. 04/13

**BUSINESS REPLY MAIL**
FIRST CLASS MAIL PERMIT NO. 335 ORANGE, CA

POSTAGE WILL BE PAID BY ADDRESSEE

**PACIFIC EDUCATORS INC**
POST OFFICE BOX 1526
ORANGE CA 92856-9975

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

# CSP
California Schools Personnel

## CANCER INSURANCE PLAN

Underwritten by:

**Fidelity Security Life Insurance Company**
Kansas City, Missouri 64111

Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance by A. M. Best Company, an independent analyst of the insurance industry. For the latest rating access www.ambest.com

Administered by:

Pacific Educators Insurance Services

2808 E. Katella Ave., Suite 101 • Orange, CA 92867
**(800) 722-3365 • (714) 639-0962**
www.PEinsurance.com Lic.#0429928

Policy Form No.IC0010
(4/12)

Policy No. CA15
Policy No. CA15A
Policy No. CA15B

**CSP** California Schools Personnel

EARLY DETECTION IS THE BEST MEDICINE!

# CANCER INSURANCE PLAN

**AFFORDABLE PROTECTION**
**MAMMOGRAM COVERAGE AVAILABLE WITHOUT DIAGNOSIS OF CANCER.**

# EXCELLENT PROTECTION
## AT RATES YOU CAN AFFORD

This Cancer Protection Insurance Plan provides you with important **Additional Extra Benefits** for your increased protection. You, your spouse and unmarried dependent children (under age 25), are eligible to apply. Acceptance is guaranteed to each family member who hasn't been medically treated or advised of cancer within 10 years. If you choose family coverage, all children born after your effective date will be automatically insured.

## QUESTIONS & ANSWERS

**Q: Why buy insurance just for cancer?**
**A:** About 1,638,910 new cancer cases are expected to be diagnosed in 2012. This estimate does not include carcinoma in situ (noninvasive cancer) of any site except urinary bladder, and does not include basal and squamous cell skin cancers* The National Cancer Institute estimates that the national expenditures for cancer care in 2010 to be 124.57 Billion Dollars** This may be more than your health insurance will cover. An affordable cancer plan can help with the extraordinarily high cost of cancer treatment.

* Source: American Cancer Society Facts & Figures 2012. www.cancer.org
** http://costprojections.cancer.gov/expenditures.html

**Q: I've had cancer. Can I still apply?**
**A:** Yes, as long as you've been cancer-free for the last ten years.

**Q: Does this plan pay in addition to any other insurance?**
**A:** Yes. We pay in addition to any other insurance you may have... including the Kaiser Plan, Blue Cross, Blue Shield and Medicare. Whenever cancer strikes you, or any insured family member, all of the benefits of your Cancer Protection Plan will be available for you (and paid directly to you) in this time of great need.

**Q: If I have a mammogram or a cervical cancer screening and there is no diagnosis of cancer, what is the benefit?**
**A:** We will pay in addition to any other coverage up to $50 per the policy schedule for a mammogram and up to $30 per year for a Pap smear, even if there is NO diagnosis of cancer. If you have no other coverage, actual charges will be paid per the policy schedule.

## DEFINITIONS

**Hospital Definition**

"Hospital" means an establishment which is a legally constituted institution; operates mainly for the care of sick or injured persons as inpatients; provides 24-hour nursing service by registered or graduate nurses; has a staff of one or more licensed physicians; provides facilities for diagnosis and surgery; is not mainly a clinic, nursing home or similar establishment; is not other than incidentally, a place for alcoholics or drug addicts. If confined in a special unit of a hospital used mainly as an extended care or similar facility, the company will not consider this as hospital confinement.

**Cancer Definition**

"Cancer" means a disease manifested by the presence of a malignant tumor. This tumor must be characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, or leukemia. Such cancer must be diagnosed by a licensed doctor. Diagnosis must be a result of a microscopic study of fixed tissue or preparations from the hemic system. Judgment will be based solely on the criteria of malignancy as accepted by the American or Osteopathic Boards of Pathology.

**What the Policy Does Not Cover**
This policy does not cover bodily injury or sickness other than cancer; expenses for diagnostic procedures; confinement or treatment in a Veteran's Administration or other government hospital unless you are legally required to pay in the absence of insurance; or any loss while serving in the armed forces of any country.

## RENEWABLE

Renew your coverage for your lifetime. It terminates only if you do not pay your premium or if the Company non-renews all policies with this form number in California.

Dependent coverage terminates when your coverage terminates, or when the dependent is no longer eligible.

## NO MEDICAL EXAM NEEDED!

You must tell us if you have been diagnosed with cancer within the last 10 years. If you haven't been - you are eligible for coverage.

**More details**

# OUTLINE OF YOUR COVERAGE

## This is a cancer-only Plan Of Insurance

When you or your covered dependents have cancer, you will be paid benefits as outlined below. Cancer means pathologically diagnosed cancer including metastatic tumors or leukemia.

**The following preventive benefits are paid in addition to any other coverage.**

**Mammography Screening*** .....Up to $50.00 maximum paid according to policy schedule
**Cervical Cancer Screening*** .....$30.00 maximum 12-month period

| Your Choice of Three Plans! | | | |
|---|---|---|---|
| During the first 90 days of a covered cancer hospitalization for any one illness period your plan will pay: | **High Benefit Plan*** | **Mid Benefit Plan*** | **Economy Plan*** |
| • Beginning with the first day of hospitalization | $200.00 a day | $100.00 a day | $50.00 a day |
| • Miscellaneous hospital expenses including operating room, medical supplies, drugs, oxygen and other necessary supplies and services provided by the hospital* | $4,000.00 | $2,000.00 | $1,000.00 |
| • Attending Physician benefit* | $40.00 a day $2,400.00 maximum | $20.00 a day $1,200.00 maximum | $10.00 a day $600.00 maximum |
| The following payments for a covered cancer will be made during an illness period whether or not you are hospital confined. Maximums are per illness period: | | | |
| • For surgery by a licensed physician or surgeon — paid according to policy schedule* | $4,000.00 maximum | $2,000.00 maximum | $1,000.00 maximum |
| • For blood and blood plasma* (no maximum for leukemia) | $800.00 | $600.00 | $500.00 |
| • For private-duty Registered Nurse or Licensed Practical Nurse* | $30.00 a day $750.00 maximum | $30.00 a day $750.00 maximum | $30.00 a day $750.00 maximum |
| • For anesthetist not employed by hospital ($40 maximum for skin cancer operations)* | $400.00 | $200.00 | $100.00 |
| • For ambulance to and from the hospital* | $50.00 per confinement $500.00 maximum | $50.00 per confinement $500.00 maximum | $50.00 per confinement $500.00 maximum |
| • For x-ray, radium, cobalt treatment and chemotherapy not including diagnostic procedures* | $3,000.00 | $2,000.00 | $1,500.00 |
| • Professional consultation when requested by your Physician* | $100.00 | $100.00 | $100.00 |

* All these $ figures are maximums based on actual expenses. All benefits reduce 50% at age 65.

# Additional Benifits

**THESE GENEROUS BENEFITS ARE THE SAME WHETHER YOU CHOOSE THE HIGH, MID OR ECONOMY PLAN.**

***First Diagnosis** Pays a one-time $1,500.00 benefit for the first diagnosis of any cancer (except skin cancer).

***Intensive Care** Pays $200.00 a day for the first 90 days in I.C.U.

***Extended Care** Pays $40.00 a day for up to a lifetime maximum of 120 days after a hospital stay of at least 3 days.

***Hospice Care** Pays $30.00 a day to a maximum of 90 cumulative days. (Physician must certify that the insured has a life expectancy of less than six months.

# Extended Benefits

Beginning with the 91st day of cumulative hospital confinement during any one illness period, Cancer Protection Plan will pay 100% of all reasonable expenses incurred for medical services and supplies furnished by the hospital.

***Highest Benefit Plan** Up to $8,000.00 a month for as long as you're confined.

***Mid Benefit Plan** Up to $6,000.00 a month for as long as you're confined.

***Economy Plan** Up to $5,000.00 a month for as long as you're confined.

## ILLNESS PERIOD DEFINED

An Illness Period begins when you incur expenses which are payable under the policy. If you go 45 days without incurring any expenses that are eligible for benefits, any further treatment is considered as resulting from a new illness period and eligible for new benefits.

# Additional Features

Your Cancer Plan pays 100% of the actual charges made by the hospital up to $8,000.00 (High Benefit Plan), $6,000.00 (Mid Benefit Plan) or $5,000.00 (Economy Plan) per month beginning with the 91st day of cumulative hospital confinement. Other cancer plans may begin to pay similar benefits only after a period of 90 consecutive days in the hospital. This significant benefit of your Cancer Plan can mean a real difference to your peace of mind.

# Surprised at the Cost?

Being one of many school personnel adds up to substantial buying power.

| | High Benefit Plan | | Mid Benefit Plan | | Economy Plan | |
|---|---|---|---|---|---|---|
| | Tenthly | Monthly | Tenthly | Monthly | Tenthly | Monthly |
| Yourself | $25.16 | $20.96 | $13.32 | $11.10 | $8.72 | $7.26 |
| Full Family | $38.44 | $32.02 | $19.86 | $16.54 | $12.46 | $10.38 |

**NOTE:** Premiums **DO NOT** increase as you get older, however premiums may be changed by the Company for all insureds.

# Easy to Apply

Just complete the enrollment form and payroll deduction authorization to the right. Detach, fold and mail the postage-paid form. Your coverage will become effective on approval of your enrollment form and the first payroll deduction (if available).

**QUESTIONS? Call 1-800-722-3365**
**COMPLETE APPLICATION & MAIL**
**Postage is Paid!**

## CALIFORNIA SCHOOLS PERSONNEL CANCER INSURANCE PLAN APPLICATION

***Check your choice of plans. Choose one:***

CA15 (075-0602)
CA15A (075-0603)
CA15B (075-0604)

**High Benefit Plan**

| | Tenthly | Monthly |
|---|---|---|
| Yourself | ☐ $25.16 | ☐ $20.96 |
| Family | ☐ $38.44 | ☐ $32.02 |

**Mid Benefit Plan**

| | Tenthly | Monthly |
|---|---|---|
| Yourself | ☐ $13.32 | ☐ $11.10 |
| Family | ☐ $19.86 | ☐ $16.54 |

**Economy Plan**

| | Tenthly | Monthly |
|---|---|---|
| Yourself | ☐ $ 8.72 | ☐ $ 7.26 |
| Family | ☐ $12.46 | ☐ $10.38 |

*PLEASE PRINT OR TYPE IN BLACK INK*

**1.** Name _____
Last First Middle

**2.** Address _____
Street City State Zip

**3.** Soc. Sec. # _____ Birthdate _____ Age _____ Sex _____

**4.** Fill in below if you wish to include your spouse and/or dependent children (attach separate sheet if necessary)

| | NAME | SOCIAL SECURITY # | SEX | AGE | BIRTH DATE |
|---|---|---|---|---|---|
| SPOUSE | | | | | |
| CHILD | | | | | |
| CHILD | | | | | |
| CHILD | | | | | |

I hereby represent that as of the date I signed this application no person to be insured under this Cancer Plan has had any type of cancer during the past 10 years except _____ who is/are to be excluded from coverage under this plan (California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage). I understand any material misstatements or omissions may be used as a basis for rescinding my coverage. This means all claims will be denied and the Company's liability will be limited to full refund of premium less any claims previously paid.

Date _____ Signature of Employee _____

*This plan is underwritten by: Fidelity Security Life Insurance Co., Kansas City, MO and administered by: Pacific Educators, Inc., Orange, CA*
A-00747 Policy Form No. IC-00010

Occupation _____ Employed By _____ District

**PAYROLL DEDUCTION AUTHORIZATION**

I hereby authorize the Payroll Department to deduct monthly from my salary the amount necessary to pay my insurance Premium and to pay same to Fidelity Security Life Insurance Company or its authorized administrator for me. This authorization will continue in effect until my employment is terminated or until I submit timely written notice of cancellation to the Payroll Department on the prescribed form.

_____ _____ _____ _____
Date Signature Home Phone (area code and number) Home E-mail Address

Print Form

**BUSINESS REPLY MAIL**
FIRST CLASS MAIL PERMIT NO. 335 ORANGE, CA

POSTAGE WILL BE PAID BY ADDRESSEE

**PACIFIC EDUCATORS INC**
POST OFFICE BOX 1526
ORANGE CA 92856-9975

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

# GROUP TERM LIFE INSURANCE PLAN

Policyholder:
United Associations of America
Group Insurance Trust

Underwritten by:
**Fidelity Security Life Insurance Company**
Kansas City, MO 64111

This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Fidelity Security Life Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. Not available in all states. Some benefits, exclusions or limitations may vary by state.

**Policy No. TL-141; Policy Form No. M-1006**

Administered by:

Pacific Educators Insurance Services

Pacific Educators is the Plan Administrator and Insurance broker that administers the insurance plan on behalf of Fidelity Security Life Insurance Company. Pacific Educators is compensated for the placement of insurance and for the services it provides to customers on behalf of the insurance company, in addition to other compensation it may receive.

2808 E. Katella Ave., Suite 101 • Orange, CA 92867
**(800) 722-3365 • (714) 639-0962**
www.PEinsurance.com Lic.#0429928

PE-Group-1 (10/15)

# GROUP TERM LIFE INSURANCE PLAN

## FAMILY PROTECTION

**AVAILABLE ONLY TO SCHOOL PERSONNEL AND THEIR FAMILIES**

- With Premiums starting at **$4.50 Per Month**
- **NEW PLAN** With Coverage up to **$402,000.00**

# PROTECTION

## Help to Ensure Your Family's Future

### If something happened to you, would your family be financially secure?

### Term Life insurance can help give your family the protection they need … and deserve.

But how much life insurance is enough? To find out, begin by estimating your monthly expenses. Include mortgage or rent payments, car loan, medical expenses, utility bills, charge account bills and grocery bills — and don't forget the amount you save regularly for vacations and the children's college education. Then divide the amount of your present life insurance by your monthly expenditure. Please consult a professional financial advisor, as individual needs may vary.

You may find that your present life insurance would not cover all of these expenses. Three in ten American households (35 million) are uninsured and half say they need more life insurance.*

Now, there's an insurance plan that helps give you the protection you may need at a price that's more affordable: the Life/Accidental Death and Dismemberment insurance plan. It's an economical combination of coverage that helps give you extra protection. Best of all, its reasonable rates can work for most budgets!

This plan lets you buy what you may need. Term life insurance with accidental death and dismemberment coverage built in to help strengthen your overall insurance protection. And with six coverage amounts to choose from,there's sure to be one that helps fit your needs — and your pocket book!

### Eligibility

All active employees/members who are Actively-at-Work Members of California School Districts Teachers, School Staff, District Staff; and their legal spouse and dependent children are eligible to apply. **Your spouse may be insured for the same plan as you.** For an additional cost, you can provide additional spouse and children coverage by selecting the dependent plan: $5,000 for your spouse under age 70 and each of your dependent, unmarried children age 6 months to 23 years ($500 for those age 15 days to 6 months).

### Eligibility Restrictions:

When a husband and wife are both insured:

a) coverage may not be duplicated by applying as dependents of each other; and
b) coverage for Dependent Child may be requested by either the wife or the husband, but not both.

No Dependent Child will be covered unless either the Insured or Spouse is covered.

# FEATURES

## Of Our Life Insurance Program

### Six plans to choose from

The plan amounts you may select are determined by your age. Select your own plan of coverage beginning at $402,000, $281,400, $201,000, $120,600, $80,400 or $40,200 under age 25, and decreasing as you get older, according to the Benefit Schedule.

### Accidental Death and Dismemberment coverage

The program provides an additional amount of insurance for accidental losses listed in the policy. The amount of Accidental Death and Dismemberment coverage you may receive is based on your age, the plan you select, and the type and/or severity or your loss. Check the benefit schedule for exact amounts. Accidental losses must occur within 365 days of the covered accident to be eligible for benefits. Accidental Death and Dismemberment Benefits are not payable for dependents of active members or retired member's coverage.

*Facts from LIMRA, Facts Of Life 2012

### Terminations

Your coverage remains in effect as long as you pay the required premiums, and the group master policy remains in force. Spouse and family coverage ends when yours does, unless your spouse is no longer married to you and your dependent children no longer meet the eligibility requirements, or the date the Insured Person's plan of benefits or class is terminated, or the death of the Insured.

### Premiums

Premiums are subject to change on a class wide basis.

### Reductions

Benefits reduce as you enter new age category.

### Affordable Group Rates

Premiums for this important program are economical because of the mass purchasing power of your group and the savings of standardized administration.

### Definitions

**Loss means:** for a hand or foot, total, complete and permanent severance of all four fingers or entire hand above the wrist joint or the entire foot at or above the ankle joint; for thumb and index finger through or above the metacarpophalangeal joints; for loss of use, movement or total feeling in the arm including the hand, or in the leg, including the foot, and the loss is determined by a physician to be total and irrecoverable; for an eye, total and irrecoverable loss of sight; for speech and/or hearing total and irrecoverable loss of speech and/or hearing; for death, the direct result of a covered accidental bodily injury.

**Injury** means bodily Injury caused by an accident. The accident must happen while the Insured Person is covered by the Policy and must be the direct cause of loss, independent of sickness or other causes. All injuries to an Insured Person in a single accident are treated as one Injury.

### Suicide Limitation

Death by suicide, while sane or insane is not covered for 24 months from the Insured's effective date. In such event the Company will only refund the premiums paid.

This provision will also apply if the Insured Person commits suicide during the two years immediately following an increase in coverage under the Policy. In that event, the amount of insurance payable will equal the amount of insurance inforce prior to the increase, plus an amount equal to the premium paid for the increase to the date of death.

### Exclusions

Accidental Death and Dismemberment benefits are not payable for any loss caused directly by: intentional self-inflicted Injury or suicide while sane or insane; sickness including any medical or surgical treatment of sickness; infections, except pyogenic infection resulting from an accidental bodily Injury or from accidental ingestion of a contaminated substance; participation in a riot or insurrection; active duty as a member of any military, naval or air force; war or any act of war, declared or not; commission or attempted commission of a felony, assault or illegal action; voluntary use of any alcohol, drug or narcotic unless prescribed by a Physician and taken as prescribed; voluntary inhalation of any kind of gas including carbon monoxide; travel or flight in any aircraft except as a fare paying passenger of a commercial airline flying on regularly scheduled routes between definitely established airports; driving a vehicle while legally intoxicated according to the laws of the area where the accident occurred; an on-the-job Injury covered by Workers Compensation.

### Prompt Claim Processing

Benefits are processed promptly upon proof of death, in a lump sum amount.

**More details** ▶

# BENEFIT SCHEDULE

## Premiums Below Apply to You or Your Spouse

| Premiums<br>Monthly<br>Tenthly | Plan 6<br>$39.75 each<br>47.70 each | Plan 5<br>$27.74 each<br>33.30 each | Plan 4<br>$19.49 each<br>23.40 each | Plan 3<br>$12.00 each<br>14.40 each | Plan 2<br>$8.25 each<br>9.90 each | Plan 1<br>$4.50 each<br>5.40 each | Plus<br>All Plans<br>Included |
|---|---|---|---|---|---|---|---|
| **Your Age**[1] | **Life** | **Life** | **Life** | **Life** | **Life** | **Life** | **AD&D** |
| Under 25 | $402,000.00 | $281,400.00 | $201,000.00 | $120,600.00 | $80,400.00 | $40,200.00 | $40,200.00 |
| 25-29 | 360,000.00 | 252,000.00 | 180,000.00 | 108,000.00 | 72,000.00 | 36,000.00 | 36,000.00 |
| 30-34 | 321,000.00 | 224,700.00 | 160,500.00 | 96,300.00 | 64,200.00 | 32,100.00 | 32,100.00 |
| 35-39 | 279,000.00 | 195,300.00 | 139,500.00 | 83,700.00 | 55,800.00 | 27,900.00 | 27,900.00 |
| 40-44 | 222,000.00 | 155,400.00 | 111,000.00 | 66,600.00 | 44,400.00 | 22,200.00 | 22,200.00 |
| 45-49 | 144,000.00 | 100,800.00 | 72,000.00 | 43,200.00 | 28,800.00 | 14,400.00 | 14,400.00 |
| 50-54 | 129,600.00 | 90,720.00 | 64,800.00 | 38,880.00 | 25,920.00 | 12,960.00 | 12,960.00 |
| 55-59 | 118,800.00 | 83,160.00 | 59,400.00 | 35,640.00 | 23,760.00 | 11,880.00 | 11,880.00 |
| 60-64 | 97,200.00 | 68,040.00 | 48,600.00 | 29,160.00 | 19,440.00 | 9,720.00 | 9,720.00 |
| 65-69 | 63,180.00 | 44,230.00 | 31,590.00 | 18,950.00 | 12,640.00 | 6,320.00 | 6,320.00 |
| 70 & over | 31,590.00 | 22,115.00 | 15,795.00 | 9,475.00 | 6,320.00 | 3,160.00 | 3,160.00 |

Upon retirement, you may continue your coverage under the retired schedule of benefits.

## Optional Family Life Insurance Coverage

Monthly Premium (covers all eligible family members)
**$1.00 monthly** ($1.20 paid tenthly through payroll deductions)

| | Life Insurance Amount |
|---|---|
| Spouse | **$5,000** |
| Dependent Children: | |
| Age 6 months to 23 years | **5,000** |
| Age 15 days to 6 months | **500** |

Family premium covers all eligible dependent children.
There is no AD&D benefit for dependent coverage.

## Guarantee Issue Benefit for New Employees

**How to Apply**

If you are a NEW employee, for 120 days following initial date employed, you are guaranteed acceptance under Plan 1 or Plan 2 and optional family coverage for your eligible dependents without evidence of insurability. That means you do not have to answer questions 1, 2 & 3. However, you must be actively employed on the effective date of your coverage. If you are enrolling for more than Plan 1 or Plan 2, or have been employed for more than 120 days, please complete the entire application. Your answers to the general health questions will help determine your insurability, so be sure your answers are correct and complete.

## Retirement Coverage Provision

You must notify the Plan Administrator when you retire. You may continue your coverage under the retirement plan with no evidence of insurability. Your benefits under the retirement plan are based on your attained age and will reduce as you enter a new age category. Accidental Death and Dismemberment benefits are not payable under the retirement plan or for dependents of active members. Please contact your Plan Administrator at 1-800-722-3365 for more information.

Be sure to sign and date the application form, and if you are insuring your spouse, have him or her do the same. Detach, staple, and mail to the administrator. No postage needed. Send no money; premiums will be handled through payroll deductions, if available, or you will be billed later.

You have 30 days to review your coverage after receiving your certificate. Please read it carefully. Make sure it's everything you expected. If you are dissatisfied for any reason, you have a right to send your certificate back to the insurance company, or to Pacific Educators, within 30 days of its receipt and your coverage will be cancelled with no questions asked.

Acceptance into this plan is subject to medical evidence of insurability as determined by Fidelity Security Life Insurance Company. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

### Effective Date

Coverage will become effective the first of the month following approval of your application by the underwriting company and receipt of your first premium payment.

### Personal History Interview

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

### Pre-Notice

Although your application is our main source of information, we at Fidelity Security Life Insurance Company ("FSL") may also collect or verify information pertaining to age, occupation, physical condition, health history and avocations by contacting various individuals or organizations by correspondence, telephone or personal contact. It may be necessary for us to share information we obtain with an individual or organization related to the medical or insurance industry or with an individual performing a function for us without your express written authorization.

Information regarding your insurability will be treated as confidential. FSL or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

FSL or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

**QUESTIONS? Call 1-800-722-3365**

To Apply, Any Time of Year: Complete Application & Mail
Postage is Paid

**GROUP TERM LIFE INSURANCE APPLICATION FIDELITY SECURITY LIFE INSURANCE COMPANY, KANSAS CITY, MO 64111 (the "Company")** **Policy No. TL-141**

**Proposed Insured Name** _____ ☐Male ☐Female ___/___/___
(First, Middle, Last) Date of Birth

Address _____ Height _____ Weight _____
Street City State Zip Ft. In. lb.

Place of Birth _____ Occupation _____
State/Country

**Your Beneficiary**

Name _____ Relationship _____ ☐Male ☐Female ___/___/___ Phone # _____
Date of Birth

Address _____ Social Security Number _____
Street City State Zip

**Spouse's Name** _____ ☐Male ☐Female ___/___/___
(if applying) (First, Middle, Last) Date of Birth

Place of Birth _____ Occupation _____ Height _____ Weight _____
State/Country Ft. In. lb.

**Please Select Plan:**

| | Plan 6 | Plan 5 | Plan 4 | Plan 3 | Plan 2 | Plan 1 | |
|---|---|---|---|---|---|---|---|
| Proposed Insured | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | **SPOUSE & CHILDREN** ☐ $5,000 Dependent Plan |
| Proposed Spouse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

**Dependent Coverage.** If applying for Dependent coverage, please complete the following: (Attach sheet of paper if additional space is needed)

| Dependent Full Name | Relationship | Date of Birth |
|---|---|---|
| | | / / |
| | | / / |
| | | / / |

*The Proposed Insured will be the beneficiary for the Dependents.*

**Please answer the following questions for you and your spouse, if applying:**

| | |
|---|---|
| 1. In the last 2 years, have you or your Spouse been unable to perform the full-time duties of your occupation for 10 consecutive days? If not employed, have you or your Spouse been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90-day period immediately preceding the date of this application for 10 consecutive days? | ☐Yes ☐No |
| 2. In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for: A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory systems? | ☐Yes ☐No |
| B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system? | ☐Yes ☐No |
| C. Colitis, ulcer, kidney disease or liver disease or disorder, or any disease of the digestive, urinary or reproductive systems? | ☐Yes ☐No |
| D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders? | ☐Yes ☐No |
| E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid? | ☐Yes ☐No |
| F. Arthritis, impaired sight or hearing, or any disease of the skin, bones or joints, including neck or back disorders? | ☐Yes ☐No |
| G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests? | ☐Yes ☐No |
| 3. During the past 5 years has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or have you been confined or treated in any hospital, mental health facility or similar institution? | ☐Yes ☐No |

**If any of the above questions were answered "Yes", please explain and provide the following details** (required for processing): (Attach sheet of paper if additional space is needed)

| Question Number and Condition | Name of Family Member | Dates | Physician's Name, Full Address and Phone Number |
|---|---|---|---|
| | | | |
| | | | |

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I understand and acknowledge that by applying for this group insurance, I am becoming a member of the United Associations of America Group Insurance Trust. I understand the insurance applied for will become effective on the date specified by the Company only if this application is accepted by the Company and the first premium is paid prior to the death of any proposed insured. I represent that all statements and answers recorded on this application are true and complete as of the date I signed this application and are made to obtain the insurance applied for. I understand that any false statement or material misrepresentations in the application may result in claim denial or rescission of coverage, and that if coverage is rescinded, the Company's only obligation will be to refund all premiums paid for that person. I have received and read a copy of the Pre-Notice which describes how information is obtained and used by Fidelity Security Life Insurance Company ("FSL"). I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, Inc. (MIB), IntelliScript, or other organization or institution that has any records or knowledge of me or my dependents' physical or mental health, including significant history, findings, diagnoses and treatment or non medical information, such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications of insurance, to give to FSL, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with FSL. FSL or its authorized representatives may release to its plan administrators, business associates, other insurance companies, MIB, or others whom I authorize in writing, information covered by this authorization. I authorize FSL or its reinsurers to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date shown below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64111-8131, Attention: Privacy Officer. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, FSL may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand I will receive a signed copy of this authorization.

**The falsity of any statement in this Application will not bar the right to recovery under the Policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.**

Signature _____ Date _____ Signature _____ Date _____
(Proposed Insured Sign Name in full) (If applying) (Spouse's Sign Name in full)

A-01192CA M-1006

I hereby authorize my employer to deduct from my salary such amounts as may now or hereafter be payable by me and to pay this amount to The Hartford or its authorized administrator for me. The authorization will continue in effect until my employment is terminated or until I submit timely written notice of cancellation to the Payroll Department.

Date _____ Signature _____ Social Security Number _____

Original Date Employed _____ Home Phone (____) _____ Home Email Address _____

I am now a regular active employee of the _____ district Business Phone (____) _____

**Click to submit by Outlook Email - If you use an online email provider (Gmail, Yahoo, Hotmail, etc.) See page 1 for instructions**

**Click here to print, sign & mail to address on page 1**

**BUSINESS REPLY MAIL**
FIRST CLASS MAIL PERMIT NO. 335 ORANGE, CA

POSTAGE WILL BE PAID BY ADDRESSEE

**PACIFIC EDUCATORS INC**
POST OFFICE BOX 1526
ORANGE CA 92856-9975

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

# CSP
California Schools Personnel

## TERM LIFE INSURANCE BENEFITS TO $238,000.00

Underwritten by:

**Fidelity Security Life Insurance Company**
Kansas City, Missouri 64111

Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance by A. M. Best Company, an independent analyst of the insurance industry.

Administered by:

Pacific Educators Insurance Services

2808 E. Katella Ave., Suite 101 • Orange, CA 92867
**(800) 722-3365 • (714) 639-0962**
www.PEinsurance.com Lic.#0429928

Policy Form No. TL-0578-2

Policy No. FL-73
(11/11)

**CSP** California Schools Personnel


# INDIVIDUAL TERM LIFE INSURANCE PLAN

**PROTECT YOUR FUTURE**

# PROTECTION - IT'S WHAT LIFE INSURANCE IS ALL ABOUT

## DON'T GAMBLE WITH YOUR FAMILY'S FUTURE.

Life insurance is the real answer to help safeguard financial security… think about it a minute. Suppose the worst happened … what if your family lost you tomorrow or next month – or even two years from now? Someday your family's future may depend on the benefits your life insurance provides. Will there be enough? Estimate how much money you spend each month. Be sure to include your mortgage or rent payments, car loan, medical expenses, utility bills, charge accounts and grocery bills. Add in the amount you save each month for future plans such as vacations and a good college education for your children. Now, divide the amount of your present life insurance by your monthly expenditure.

How many months would your family last on your current life insurance… very few I'll bet. More life insurance is a good solution to help safeguard their financial security. Get it the economical way through California Schools Personnel Plan.

Today, you and/or your spouse have the opportunity to purchase life insurance coverage under the CSP Term Life Insurance Plan. Coverage is available for each of your eligible children.

With affordable premium rates, this coverage is too valuable to pass up! Important details are outlined in this brochure. Please take a few minutes to read about the special features this plan has to offer you and your family. Then complete the application attached and return in to the Insurance Administrator.

***TAKE ADVANTAGE OF THIS VALUABLE OPPORTUNITY RIGHT NOW!***

## YOU MAY KEEP YOUR COVERAGE FOR LIFE

Your insurance is renewable by the Company as long as you pay premiums, and all such policies bearing the same form number remain in force, even if you retire. Your family's coverage will remain in force as long as they are eligible and your coverage remains in force.

## GUARANTEED SATISFACTION

If after you receive your policy you are not pleased 100% with the terms of your new coverage, simply return it within 30 days and any money paid or deducted from your paycheck will be refunded in full -no questions asked! Your satisfaction is guaranteed 100%.

***WE WANT YOU TO BE COMPLETELY SATISFIED.***

# FEATURES

## GUARANTEED ISSUE BENEFIT FOR NEW EMPLOYEES!

**For 120 days following initial date of active employment, new employees are guaranteed one unit of coverage without evidence of insurability.** You must be actively at work on the effective date of your coverage and standard eligibility and policy provisions apply. That means you do not have to answer health question nos. 9, 10 and 11 on the application. However, if you are applying for more than one unit of coverage for you, or dependent coverage, or have been actively employed for more than 120 days, please complete the entire application.

## EFFECTIVE DATE

Coverage will go into effect after the first payroll deduction is made following approval by the Company.

## BENEFICIARY DESIGNATION

You designate your beneficiary. You may change beneficiaries at any time by giving written notice to the Insurance Company. You will be the beneficiary of your spouse's or children's insurance unless you designate otherwise.

## LIMITATION

The limitation under this policy is suicide during the first 2 years each unit of coverage is in force. (All premiums are refunded in event of suicide while sane or insane during first two years your coverage is in force.)

**More details**

# AFFORDABLE PREMIUMS

## HELPING YOU SAVE WHILE PROTECTING THE ONES YOU LOVE

### RATE SCHEDULE

**Employee or Spouse**

| Employee's Age* | One Unit Life Insurance | Tenthly Premium |
|---|---|---|
| Under Age 35 | $17,000.00 | $2.00 |
| 35-39 | $14,000.00 | $2.90 |
| 40-44 | $14,000.00 | $3.60 |
| 45-49 | $12,000.00 | $3.90 |
| 50-54 | $12,000.00 | $6.60 |
| 55-59 | $10,000.00 | $9.60 |
| 60-64 | $7,000.00 | $9.60 |
| 65-69** | $4,000.00 | $9.60 |
| 70-74** | $3,500.00 | $9.60 |
| 75 & over ** | $2,000.00 | $9.60 |

Premiums shown above are for 1 unit of coverage for employee or spouse. Spouse's premium is based on employee's age when both are insured. Spouse's premium will be based on his/her individual age when the employee cannot be insured. Maximum of 14 units each.

For more units, just multiply the premium amount by the number of units you have selected.

* All Premiums and benefits are applicable at Insured's age when insurance becomes effective and at his/her attained age on renewal anniversary due date.

** Rates shown for renewal purposes only.

### CHILDREN'S COVERAGE

**VERY AFFORDABLE! ONE PREMIUM COVERS ALL YOUR CHILDREN, NO MATTER HOW MANY.**

Only $1.20 Tenthly PER UNIT
Age 6 months to 25 years . . . . . .1 unit $2,500.00 each child

All unmarried dependent children 6 months to age 25 may be covered...up to a maximum of 4 units each.

## QUESTIONS & ANSWERS

**Q: WHO MAY APPLY?**

**A:** All actively employed full-time school personnel (minimum 20 hours a week), their spouse and their dependent children 6 months to 25 years.

**Q: WHY IS TERM INSURANCE A GOOD VALUE FOR ME?**

**A:** Term insurance is "pure protection". Your premium provides life insurance at an affordable cost since none of your premium goes toward building cash values.

**Q: WHAT IF I LEAVE MY SCHOOL DISTRICT - DO I LOSE MY COVERAGE?**

**A:** No! Since CSP's term life plan is an "Individual policy", you can take it with you.Simply contact your Administrator to arrange to be billed directly.

### PRE-NOTICE

Although your application is our main source of information, we at Fidelity Security Life Insurance Company may also collect or verify information pertaining to age, occupation, physical condition, health history and avocations by contacting various individuals or organizations by correspondence, telephone or personal contact. It may be necessary for us to share information we obtain with an individual or organization related to the medical or insurance industry or with an individual performing a function for us without your express written authorization.

Information regarding you or members of your family's insurability will be treated as confidential. Fidelity Security Life Insurance Company (FSL) or its reinsurer(s) may, however, make a brief report thereon to the MIB, formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB, at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Fidelity Security Life Insurance Company (FSL) or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Rev 0810

**QUESTIONS? Call 1-800-722-3365**
**COMPLETE APPLICATION & MAIL**
**Postage is Paid!**

# CSP INDIVIDUAL TERM LIFE INSURANCE

Calculate your premium here: Myself $ _____ Spouse_____ Children _____ TOTAL $ _____

## APPLICATION TO FIDELITY SECURITY LIFE INSURANCE COMPANY Kansas City, Missouri

Policy No. FL73
075-4520

Please Print or Type in Black Ink

1. Full Name _____ _____
first middle last SOCIAL SECURITY #
2. Residence Address _____
no. & street city state zip
3. Full Name of Beneficiary _____ Relationship _____
4. I hereby apply for: Employee (Maximum 14 units) # _____ units Original Date Employed _____
Spouse (Maximum 14 units) # _____ units
My Children (Maximum 4 units) # _____ units
5. Member's Place of Birth _____ Occupation _____
Birth Date _____ Age _____ Sex _____ Height _____ Weight _____
6. Are you actively employed as of this date? ..... Yes ☐ No ☐
I am now actively employed by the _____ District.
7. Check box if you wish to cover eligible dependents: if yes, list names, birth dates below ..... Yes ☐ No ☐

| RELATIONSHIP | NAME | BIRTH DATE | AGE | SEX | HT. | WT. |
|---|---|---|---|---|---|---|
| Spouse | | | | | | |
| Child | | | | | | |
| Child | | | | | | |
| Child | | | | | | |

8. Spouse's Soc. Sec. # _____ Spouse's Place of Birth _____ Spouse's Occupation _____
9. Have you or any dependent ever had or been advised that you had a brain disorder, nervous or mental disorder, heart or circulatory disorder, respiratory or lung disorder, cancer, leukemia, diabetes, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? _____ Yes ☐ No ☐
10. During the past five years, have you or any dependents had any medical, surgical or psychiatric advice or treatment, or have you had any condition requiring the use of medication, diet or physical therapy? ..... Yes ☐ No ☐
11. Do you or any dependent have any impairments, deformity, disease or limitation of physical activity other than stated above? ..... Yes ☐ No ☐

| If "Yes" to any part of Questions 9, 10 or 11 give details below | | | | |
|---|---|---|---|---|
| Name of Person | Condition & Treatment | Date — Duration | Degree of Recovery | Name of Doctor and/or Hospital |
| | | | | |
| | | | | |
| | | | | |

## AUTHORIZATION TO OBTAIN INFORMATION

I have received and read a copy of the Pre-Notice which describes how information is obtained and used by Fidelity Security Life Insurance Company (FSL). I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, Inc. (MIB), IntelliScript, or other organization or institution that has any records or knowledge of my or my dependents' physical or mental health, including significant history, findings, diagnoses and treatment or nonmedical information, such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications of insurance, to give to FSL, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with FSL. FSL or its authorized representatives may release to its plan administrators, business associates, other insurance companies, MIB, or others whom I authorize in writing, information covered by this authorization. A photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date shown below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company, P.O. Box 418131, Kansas City, MO 64111-8131, Attention: Privacy Officer. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, FSL may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I will receive a signed copy of this authorization.

Date _____ Signature of Applicant **X** _____

Spouse must sign if spouse is to be insured. Date _____ Spouse's Signature **X** _____

Home Telephone (area code and #) _____ Business Telephone _____ Home E-mail Address _____

A-00084 (3/95) Policy Form No.TL-0578-2

I hereby authorize the Payroll Department to deduct monthly from my salary the amount necessary to pay my Insurance Premium and to pay the same to the Fidelity Security Life Insurance Company or its authorized Administrator for me. This authorization will continue in effect until my employment is terminated or until I submit timely written notice of cancellation to the Payroll Department on the Prescribed form.

Date _____ Signature of Applicant **X** _____

Print Form


SHDR
Benefit Consultants
*A division of BB&T Insurance Services*

# Receipts May Still Be Required

Your SHDR Benefits Access Card will definitely improve your cash flow. However, be aware that the IRS requires the Card be used only for eligible expenses. Remember, the Card will not work at gas stations or restaurants – only at health care or dependent daycare related providers. Additionally, the IRS requires participants to save original store (or provider of service) itemized receipts for every expense transaction. In the event of an IRS audit, these documents will be needed to prove expense eligibility.

There are instances when you may receive a letter/notification from SHDR asking you to furnish an itemized receipt to verify the expense. When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved.

SHDR offers participants the option of receiving debit card receipt requests by Email. If you take advantage of this added convenience, please be aware that email requests will be sent from: *www.shdr.lh1ondemand.com* Your spam filter may need to be edited to allow emails from this source.

## What is an itemized receipt?

An itemized receipt must include: merchant or provider name, services received or item purchased, date of service, and amount of the expense. Cancelled checks, handwritten receipts, cash register receipts or previous balance invoices cannot be used to verify an expense. We suggest that you keep their itemized receipts in one place (perhaps using the "Save the Receipt" envelopes provided) so they're readily available when you receive a request.

## Auto-Substantiation

The IRS does allow auto-substantiation for transactions that can be substantiated electronically. Our card program's technology uses all of the IRS-approved methods (e.g. Inventory Information Approval Systems [IIAS], copayment matching, reoccurring expense matching, etc.) to auto substantiate transactions and reduce paperwork for cardholders. However not all debit card expenses can be auto substantiated. This is especially true for dental, chiropractic, and medical expenses that do not match exactly to your Company's health or dental plans.

## Follow-up Letter Request

For transactions that cannot be auto-substantiated, you will receive a letter(s) or e-mail notification(s) asking you to furnish an itemized receipt or other proof that the Card was used for an eligible expense. Some of the more common instances in which you will receive a letter include:

- Medical expenses that do not match the co-pay amount of your employer's health insurance.
- When the employee or dependents are not covered by your employer's insurance plan
- When the transaction is for a charge not associated with a co-pay amount, such as dental or vision expenses.

If after the third follow up letter request, documentation is not received; your debit card will be suspended pending receipt of substantiation or repayment of the transaction. If a transaction is determined to be ineligible or if further documentation is required, additional notification will be sent.

## Ineligible Items or Services

The IRS does not allow reimbursement of certain items or services please check the eligible / ineligible listing for guidance prior to purchasing. You also cannot use current plan year funds to pay for services incurred in the prior plan year.

## Overpayment process

If the transaction was deemed ineligible or you are unable to supply the required documentation, the IRS requires that the cardholder pay the money back into the benefit account. This repayment process may be accomplished by one of several methods:

- You may submit documentation for eligible expenses that you have not previously been reimbursed via your FSA.
- Have merchant or provider credit the amount back directly to your FSA.
- Send repayment via a personal check in the amount of the ineligible expense to SHDR. Repayment amount will be credited back to your FSA.

After documentation is received, eligible transactions are substantiated, or repayments have been made, the debit card will be re-activated.

**RELIANCE STANDARD**
Life Insurance Company
a BELAM company

ENROLLMENT APPLICATION

**EMPLOYER:** We do not accept faxed forms. When required, submit completed enrollment applications for insurance to:
Reliance Standard
P.O. Box 7818
Philadelphia, PA 19101-7818

Bellflower Unified School District

Policy Number: VG 180449

BG 000001
RSO Orange County
VG GI: $100,000/$10,000/$50,000/No

**All sections must be completed to ensure accurate processing. PRINT IN BLUE OR BLACK INK.**

## ▼ EMPLOYEE INFORMATION ▼

**Reason for Completing Form:** ☐ Initial Eligibility / New Hire ☐ Late Applicant ☐ Approved Annual Enrollment
☐ Change Nature of Change(s): _____

_____ / / _____ _____ ☐ F ☐ M
**First Name** **Middle Initial** **Last Name** **Date of Birth** **Age** **State of Birth** **Gender**

_____ _____
**(Home Address) Street** **Apt.** **City** **State** **Zip** **Daytime Phone Number**

_____ / / _____ _____
**Social Security Number** **Date of Hire** **Job Title or Position** **Number of Hours Worked Per Week**

Are you actively performing all the duties of your occupation or profession? ☐ YES ☐ NO
IF "NO", explain: _____

## ▼ COVERAGE SELECTION ▼

Select the insurance plans and benefit levels that meet your needs. Have your Plan Highlights sheets and Premium Table sheets handy for reference. Plans may have limitations, exclusions, reduction in benefit provisions and terms under which coverage may be continued in force or terminated. **Read your Certificate of Insurance carefully.**

| PLAN | "YES" AUTHORIZES EMPLOYER TO PAYROLL DEDUCT PREMIUMS | (A)DD or (C)HANGE | TOTAL AMOUNT OF COVERAGE APPLIED FOR | IF (C), I WANT TO CHANGE EXISTING BY | PREMIUM |
|---|---|---|---|---|---|
| **Voluntary Term Life: Employee** (Evidence of Insurability (EOI) may be required - see accompanying EOI form.) | ☐**YES** ☐**NO*** | | $_____ | + $_____<br>- $_____ | See Premium Table |
| **Voluntary Term Life: Spouse** (Evidence of Insurability (EOI) may be required - see accompanying EOI form.) | ☐**YES** ☐**NO*** | | $_____ | + $_____<br>- $_____ | See Premium Table |
| **Voluntary Term Life: Dep Children** (Coverage subject to election of employee or spouse Term Life) | ☐**YES** ☐**NO*** | | ☐$5,000 ☐$10,000<br>☐$15,000 ☐$20,000 | TO:<br>☐$5,000 ☐$10,000<br>☐$15,000 ☐$20,000 | See Premium Table |

* If you check "NO", please note that if you desire insurance on yourself and/or your spouse (if applicable) at a later date: (1) you may be required to furnish, at your own expense, evidence of each person's insurability; and (2) Reliance Standard will have the right to refuse your request.



**CONTINUED ON REVERSE SIDE►►►**

## ▼ BENEFICIARY INFORMATION ▼

♦ **Complete the following:**

| **Your Beneficiary's Name*** First / Middle Initial / Last | **Relationship to You** | **Date of Birth** Month/Day/Year | **Social Security Number** |
|---|---|---|---|
| **Primary** | | | |
| **Contingent** | | | |

* **IMPORTANT:** When naming a female beneficiary, show the name as Jane J. Doe, *not* Mrs. John H. Doe.

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. You are automatically the Beneficiary for Dependent Insurance, unless you otherwise specify. To designate more than one Primary or Contingent Beneficiary, **attach** a completed Reliance Standard Designation of Beneficiary form (obtain this form from your Benefits Administrator). Your intentions must be clearly set forth.

## ▼ ADDITIONAL INFORMATION ▼

♦ **IF YOU SELECTED TERM LIFE INSURANCE, complete the following:**

**Spouse Information (Complete ONLY if you selected TERM LIFE INSURANCE for your spouse)**

_____ ☐ F ☐ M

First Name Middle Initial Last Gender

_____ _____ ___/___/___ _____

Social Security Number Age Date of Birth State of Birth

## ▼ READ, SIGN AND DATE BELOW ▼

**I understand and agree that:** ● The information provided on this Enrollment Application is true and correct to the best of my knowledge. ● The insurance requested on this Enrollment Application will become effective in accordance with the individual effective date information in the Certificate of Insurance; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an Enrollment Application has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and for enrolled dependents confined to a hospital or at home. ● Benefits are subject to terms and conditions of the Policy. ● For a plan with age-banded rates, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next. ● If payroll deduction of premiums begins prior to Reliance Standard's processing of this Enrollment Application, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

**Please Note:** During an approved enrollment, guaranteed issue (GI) amounts of life insurance will not require evidence of insurability provided this form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to life insurance for yourself (and/or your spouse, if applicable); or b) during your present service with your employer or an affiliate, you (and/or your spouse, if applicable) have not, with respect to life insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific GI / EOI rules.

*x* _____ _____

Employee's Signature Date

**RELIANCE STANDARD**
Life Insurance Company
a BELAM company

**SUPPLEMENT TO ENROLLMENT APPLICATION** **EVIDENCE OF INSURABILITY for TERM LIFE INSURANCE**

**EMPLOYER:** We do not accept faxed forms. Submit completed enrollment applications for insurance to:
Reliance Standard
P.O. Box 7818
Philadelphia, PA 19101-7818

Bellflower Unified School District

BG 000001
RSO Orange County
VG GI: $100,000/$10,000/$50,000/No

Policy Number: VG 180449

**IF YOU SELECTED TERM LIFE INSURANCE, this Evidence of Insurability form must be completed…**

- …if you selected an Amount for yourself and/or your spouse (if applicable) that is above the Guaranteed Issue limit.
- …if you and/or your spouse (if applicable) is a late applicant.
- …if, during your present service with your employer or an affiliate, you and/or your spouse (if applicable) have, with respect to life insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated.
- …if you are enrolling during an approved annual enrollment after your initial enrollment period or initial eligibility period and there are specific Guaranteed Issue/evidence of insurability rules.

If you have any questions about completing this form, see your Benefits Administrator.

**INSTRUCTIONS:**

All sections must be completed to ensure accurate processing. **PRINT IN BLUE OR BLACK INK.**

You must sign/date this form. Your spouse (if applicable) must also sign/date this form if you complete this form with respect to insurance you selected for him/her.

## ▼ EMPLOYEE INFORMATION ▼

| First Name | Middle Initial | Last Name | Date of Birth (/ /) | Social Security Number | Date of Hire (/ /) |
|---|---|---|---|---|---|
| | | | | | |

## ▼ HEALTH QUESTIONS ▼

Current (h)eight and (w)eight: **Employee** (h)_____ (w)_____ **Spouse** (h)_____ (w)_____

Primary Care Physician: (Full name, address, telephone)
**Employee** _____
**Spouse** _____

Have you or your spouse (if applicable) had, been told you had/have or been treated for any of the following within the past five (5) years:

| | | | |
|---|---|---|---|
| 1. | Consultation with any physician or received any medical care, treatment or advice? | ☐ YES | ☐ NO |
| 2. | To the best of your knowledge, any physical impairment or disease? | ☐ YES | ☐ NO |
| 3. | AIDS, AIDS-related complex (ARC) or disorder of the immune system? | ☐ YES | ☐ NO |
| 4. | A disease of the nervous, genito-urinary or digestive systems, heart or lungs, high blood pressure, diabetes, cancer or a tumor of any kind? | ☐ YES | ☐ NO |

**If you answered "YES" to any of the above questions, give details in #5 below.**

| 5. Question # | Person to Whom it Applies | Illness or Nature of Injury | Date | Physician's Full Name (and address if different from Primary) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

(If you need more space, use a separate sheet of paper, **sign and date it, check here** _____ and **attach it** to this page.)



**CONTINUED ON REVERSE SIDE►►►**

## ▼ READ, SIGN AND DATE BELOW ▼

**I understand and agree that:** • The information provided on this Evidence of Insurability form is true and correct to the best of my knowledge. • The insurance requested on the Enrollment Application will become effective in accordance with the individual effective date information in the Certificate of Insurance; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an Enrollment Application has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and for enrolled dependents confined to a hospital or at home. • Benefits are subject to terms and conditions of the Policy. • For a plan with age-banded rates, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next. • If payroll deduction of premiums begins prior to Reliance Standard's processing of the Enrollment Application, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I acknowledge receipt of the "Notice Regarding Information Practices".

**AUTHORIZATION:** I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the Medical Information Bureau (MIB) to release any information or record(s) on me or my health to be used in determining the acceptability of my application for insurance. I authorize any such information or record(s) to be released to Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize Reliance Standard or its reinsurers to make a brief report to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I may elect to be interviewed if an investigative consumer report is to be prepared in connection with this application and that I am entitled to a copy thereof. I further understand that I (or my authorized representative) will be sent a copy of this Authorization upon request.

**Please Note:** During an approved enrollment, guaranteed issue (GI) amounts of life insurance will not require evidence of insurability provided the Enrollment Application is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to life insurance for yourself (and/or your spouse, if applicable); or b) during your present service with your employer or an affiliate, you (and/or your spouse, if applicable) have not, with respect to life insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific GI / EOI rules.

x_____ _____

Employee's Signature Date

x_____ _____

Spouse's Signature Date

(Your spouse must sign/date if you completed this form with respect to insurance you selected for him/her.)

**Attach this form to your Enrollment Application.**
**Submit both forms at the same time.**

**Keep the "Notice Regarding Information Practices" for your records.**

## NOTICE REGARDING INFORMATION PRACTICES

In considering this Application, Reliance Standard Life Insurance Company ("we", "us" or "our") collects certain information about all proposed insureds ("you" or "your"). The precise information varies according to the amount and type of coverage you apply for. Generally, we seek information about your: (1) age; (2) occupation; (3) physical condition; (4) medical history; (5) hobbies; and (6) other relevant activities.

You are the most important source of information, but we may also verify or collect information on you or your family from: (1) physicians; (2) other health care providers; (3) employers; (4) other insurers to which you have applied; (5) consumer investigative organizations; and (6) the Medical Information Bureau ("MIB").

The MIB is a not-for-profit organization of life insurance companies which operates an information exchange for its members. This information may alert us to a need for further investigation, but under MIB rules such information cannot be used: (1) either wholly or in part to increase the premium for insurance; or (2) to deny issuance of insurance.

We may collect information by: (1) phone; (2) correspondence; or (3) personal contact.

Information will be treated as confidential. Reliance Standard Life Insurance Company or its reinsurers may, however, with your authorization make a brief report to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. The information supplied to other member companies may alert them to a need for further investigation.

In some circumstances, however, information may be released to third parties without your authorization (with the exception of the MIB). These include persons or organizations who are: (1) performing business functions for us; (2) conducting actuarial or scientific studies or audits; or (3) our reinsurers. We or our reinsurers may also release information to other life insurance companies to whom you apply for life or health insurance coverage, or to whom a claim for benefits is submitted. Please be assured that although such disclosures may occur, they are not always or even often made. When a disclosure is necessary, only as much information as is reasonably necessary to achieve the intended purpose will be disclosed.

You have the right to acquire and, if necessary, correct any personal information we or the MIB collect. Upon written request to us, we will within 30 days of receipt: (1) inform you of the nature and substance of the recorded information; (2) permit personal viewing and copying of the information in our possession; (3) disclose the identities of those persons such information has been disclosed to within the last two years; and (4) provide you with procedures for correction, amendment or deletion of the recorded information. Medical information will be disclosed to a physician that you choose. You may write to us for a fuller explanation of our information practices.

You may also contact the MIB via its website (www.mib.com) or by telephone to arrange for disclosure of any information it may have on you. The MIB's toll-free telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired). If you question the accuracy of information in the MIB's file, you may contact the MIB in writing and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

# KEEP THIS NOTICE FOR YOUR RECORDS.

RELIANCE STANDARD
Life Insurance Company
a DELPHI company

Home Office: Chicago, Illinois
Administrative Office: Philadelphia, Pennsylvania

RELIANCE STANDARD
Life Insurance Company

# Bellflower USD

## *Voluntary Life Benefit Summary*

Providing your family with financial security in the event of your death is a benefit that most employees find unpleasant to think about, but is nonetheless important. This plan provides you with life insurance options in addition to any life insurance provided to you by your employer.

**Eligibility**
Each active employee working a minimum of 30 hours per week, except any person employed on a temporary or seasonal basis

**Who Pays for the coverage**
Employee pays 100% of the cost. Premiums are paid through payroll deductions.

**Other Features of the plan**
Waiver of Premium
Portability
Conversion
Coverage during approved FMLA and Illness leave
Living Benefit

**Conversion or Portability option**
Terminated employees may either convert to an individual Whole Life policy or continue their Term Life policy.

**Exclusions and Limitations**
Death by suicide is not covered during the first two years of coverage. The policy becomes incontestable after two years except for non-payment of premium.

**Example of Cost**

| | Election | Cost per Month |
|---|---|---|
| Employee age 30 | $ 100,000 | $ 10.00 |
| Spouse age 30 | $ 50,000 | $ 5.00 |
| Children (2) | $ 20,000 | $ 4.00 |
| | | $ 19.00 |

**VOLUNTARY LIFE HIGHLIGHTS**

**Schedule of Benefits**
**Employee and Spouse:**
Increments of $10,000 to a maximum of $500,000
**Children:**
14 days but less than 6 months: $1,000
6 mos. to Age 20*: Options of $5,000, $10,000, $15,000 or $20,000
*Child coverage is to age 23 if FT Student

**Guarantee Issues:**
**Employee under age 60:** $100,000
**Employees age 60 to 70:** $10,000
**Spouse under age 60:** $50,000
**Children:** Any amount is guaranteed provided the Employee and/or spouse is approved for coverage

**Evidence of Insurability Requirements**:
- Amounts over Guarantee Issue
- Any amount for a late entrant

**Employee and Spouse** Tenthly **Rates per $10,000**

| Age | Voluntary Life Rate |
|---|---|
| Under 30 | $.60 |
| 30 – 34 | $1.00 |
| 35 – 39 | $1.10 |
| 40 – 44 | $1.30 |
| 45 – 49 | $1.80 |
| 50 – 54 | $3.10 |
| 55 – 59 | $5.20 |
| 60 – 64 | $8.10 |
| 65 – 69 | $15.50 |
| 70 + | $25.00 |

Dependent Rates Per Dependent Unit

| Coverage | Rate per Dependent Unit |
|---|---|
| $5,000 | $1.00 |
| $10,000 | $2.00 |
| $15,000 | $3.00 |
| $20,000 | $4.00 |

# Reliance Standard Voluntary Plans
# Voluntary Group Term Life Insurance
# Premium Table
# Plan Holder: Bellflower Unified School District - VG # 180449

**Scheduled Benefit:** Each eligible employee may elect for himself and/or his eligible spouse an amount of insurance shown in the Table below.
For employees age 75 and older:
Benefit amounts are reduced according to the age-based reduction chart shown in the Voluntary Term Life brochure. When selecting an amount of insurance, you must select a pre-age 75 benefit amount.
Employee/Spouse Premiums:

To find you and your spouse's premium -

- Determine your age band: Your age = your age at your last birthday.
- Select a benefit amount (employees age 75 and older: see above comment - **do not select a calculated reduced amount**).
- Spouse premium: Repeat the steps above for your spouse at his/her age at his/her last birthday. Your spouse must be under age 70 to be enrolled.
- Employee and spouse rates change as insured moves from one age bracket to the next.

## Monthly Premiums

| Benefit Amount | Age 00-29 | Age 30-34 | Age 35-39 | Age 40-44 | Age 45-49 | Age 50-54 | Age 55-59 | Age 60-64 | Age 65-69 | Age 70+ |
|---|---|---|---|---|---|---|---|---|---|---|
| $10,000 | $0.60 | $1.00 | $1.10 | $1.30 | $1.80 | $3.10 | $5.20 | $8.10 | $15.50 | $25.00 |
| $20,000 | $1.20 | $2.00 | $2.20 | $2.60 | $3.60 | $6.20 | $10.40 | $16.20 | $31.00 | $50.00 |
| $30,000 | $1.80 | $3.00 | $3.30 | $3.90 | $5.40 | $9.30 | $15.60 | $24.30 | $46.50 | $75.00 |
| $40,000 | $2.40 | $4.00 | $4.40 | $5.20 | $7.20 | $12.40 | $20.80 | $32.40 | $62.00 | $100.00 |
| $50,000 | $3.00 | $5.00 | $5.50 | $6.50 | $9.00 | $15.50 | $26.00 | $40.50 | $77.50 | $125.00 |
| $60,000 | $3.60 | $6.00 | $6.60 | $7.80 | $10.80 | $18.60 | $31.20 | $48.60 | $93.00 | $150.00 |
| $70,000 | $4.20 | $7.00 | $7.70 | $9.10 | $12.60 | $21.70 | $36.40 | $56.70 | $108.50 | $175.00 |
| $80,000 | $4.80 | $8.00 | $8.80 | $10.40 | $14.40 | $24.80 | $41.60 | $64.80 | $124.00 | $200.00 |
| $90,000 | $5.40 | $9.00 | $9.90 | $11.70 | $16.20 | $27.90 | $46.80 | $72.90 | $139.50 | $225.00 |
| $100,000 | $6.00 | $10.00 | $11.00 | $13.00 | $18.00 | $31.00 | $52.00 | $81.00 | $155.00 | $250.00 |
| $110,000 | $6.60 | $11.00 | $12.10 | $14.30 | $19.80 | $34.10 | $57.20 | $89.10 | $170.50 | $275.00 |
| $120,000 | $7.20 | $12.00 | $13.20 | $15.60 | $21.60 | $37.20 | $62.40 | $97.20 | $186.00 | $300.00 |
| $130,000 | $7.80 | $13.00 | $14.30 | $16.90 | $23.40 | $40.30 | $67.60 | $105.30 | $201.50 | $325.00 |
| $140,000 | $8.40 | $14.00 | $15.40 | $18.20 | $25.20 | $43.40 | $72.80 | $113.40 | $217.00 | $350.00 |
| $150,000 | $9.00 | $15.00 | $16.50 | $19.50 | $27.00 | $46.50 | $78.00 | $121.50 | $232.50 | $375.00 |
| $160,000 | $9.60 | $16.00 | $17.60 | $20.80 | $28.80 | $49.60 | $83.20 | $129.60 | $248.00 | $400.00 |
| $170,000 | $10.20 | $17.00 | $18.70 | $22.10 | $30.60 | $52.70 | $88.40 | $137.70 | $263.50 | $425.00 |
| $180,000 | $10.80 | $18.00 | $19.80 | $23.40 | $32.40 | $55.80 | $93.60 | $145.80 | $279.00 | $450.00 |
| $190,000 | $11.40 | $19.00 | $20.90 | $24.70 | $34.20 | $58.90 | $98.80 | $153.90 | $294.50 | $475.00 |
| $200,000 | $12.00 | $20.00 | $22.00 | $26.00 | $36.00 | $62.00 | $104.00 | $162.00 | $310.00 | $500.00 |
| $210,000 | $12.60 | $21.00 | $23.10 | $27.30 | $37.80 | $65.10 | $109.20 | $170.10 | $325.50 | $525.00 |
| $220,000 | $13.20 | $22.00 | $24.20 | $28.60 | $39.60 | $68.20 | $114.40 | $178.20 | $341.00 | $550.00 |
| $230,000 | $13.80 | $23.00 | $25.30 | $29.90 | $41.40 | $71.30 | $119.60 | $186.30 | $356.50 | $575.00 |
| $240,000 | $14.40 | $24.00 | $26.40 | $31.20 | $43.20 | $74.40 | $124.80 | $194.40 | $372.00 | $600.00 |
| $250,000 | $15.00 | $25.00 | $27.50 | $32.50 | $45.00 | $77.50 | $130.00 | $202.50 | $387.50 | $625.00 |

## Monthly Premiums

| Benefit Amount | Age 00-29 | Age 30-34 | Age 35-39 | Age 40-44 | Age 45-49 | Age 50-54 | Age 55-59 | Age 60-64 | Age 65-69 | Age 70+ |
|---|---|---|---|---|---|---|---|---|---|---|
| $260,000 | $15.60 | $26.00 | $28.60 | $33.80 | $46.80 | $80.60 | $135.20 | $210.60 | $403.00 | $650.00 |
| $270,000 | $16.20 | $27.00 | $29.70 | $35.10 | $48.60 | $83.70 | $140.40 | $218.70 | $418.50 | $675.00 |
| $280,000 | $16.80 | $28.00 | $30.80 | $36.40 | $50.40 | $86.80 | $145.60 | $226.80 | $434.00 | $700.00 |
| $290,000 | $17.40 | $29.00 | $31.90 | $37.70 | $52.20 | $89.90 | $150.80 | $234.90 | $449.50 | $725.00 |
| $300,000 | $18.00 | $30.00 | $33.00 | $39.00 | $54.00 | $93.00 | $156.00 | $243.00 | $465.00 | $750.00 |
| $310,000 | $18.60 | $31.00 | $34.10 | $40.30 | $55.80 | $96.10 | $161.20 | $251.10 | $480.50 | $775.00 |
| $320,000 | $19.20 | $32.00 | $35.20 | $41.60 | $57.60 | $99.20 | $166.40 | $259.20 | $496.00 | $800.00 |
| $330,000 | $19.80 | $33.00 | $36.30 | $42.90 | $59.40 | $102.30 | $171.60 | $267.30 | $511.50 | $825.00 |
| $340,000 | $20.40 | $34.00 | $37.40 | $44.20 | $61.20 | $105.40 | $176.80 | $275.40 | $527.00 | $850.00 |
| $350,000 | $21.00 | $35.00 | $38.50 | $45.50 | $63.00 | $108.50 | $182.00 | $283.50 | $542.50 | $875.00 |
| $360,000 | $21.60 | $36.00 | $39.60 | $46.80 | $64.80 | $111.60 | $187.20 | $291.60 | $558.00 | $900.00 |
| $370,000 | $22.20 | $37.00 | $40.70 | $48.10 | $66.60 | $114.70 | $192.40 | $299.70 | $573.50 | $925.00 |
| $380,000 | $22.80 | $38.00 | $41.80 | $49.40 | $68.40 | $117.80 | $197.60 | $307.80 | $589.00 | $950.00 |
| $390,000 | $23.40 | $39.00 | $42.90 | $50.70 | $70.20 | $120.90 | $202.80 | $315.90 | $604.50 | $975.00 |
| $400,000 | $24.00 | $40.00 | $44.00 | $52.00 | $72.00 | $124.00 | $208.00 | $324.00 | $620.00 | $1,000.00 |
| $410,000 | $24.60 | $41.00 | $45.10 | $53.30 | $73.80 | $127.10 | $213.20 | $332.10 | $635.50 | $1,025.00 |
| $420,000 | $25.20 | $42.00 | $46.20 | $54.60 | $75.60 | $130.20 | $218.40 | $340.20 | $651.00 | $1,050.00 |
| $430,000 | $25.80 | $43.00 | $47.30 | $55.90 | $77.40 | $133.30 | $223.60 | $348.30 | $666.50 | $1,075.00 |
| $440,000 | $26.40 | $44.00 | $48.40 | $57.20 | $79.20 | $136.40 | $228.80 | $356.40 | $682.00 | $1,100.00 |
| $450,000 | $27.00 | $45.00 | $49.50 | $58.50 | $81.00 | $139.50 | $234.00 | $364.50 | $697.50 | $1,125.00 |
| $460,000 | $27.60 | $46.00 | $50.60 | $59.80 | $82.80 | $142.60 | $239.20 | $372.60 | $713.00 | $1,150.00 |
| $470,000 | $28.20 | $47.00 | $51.70 | $61.10 | $84.60 | $145.70 | $244.40 | $380.70 | $728.50 | $1,175.00 |
| $480,000 | $28.80 | $48.00 | $52.80 | $62.40 | $86.40 | $148.80 | $249.60 | $388.80 | $744.00 | $1,200.00 |
| $490,000 | $29.40 | $49.00 | $53.90 | $63.70 | $88.20 | $151.90 | $254.80 | $396.90 | $759.50 | $1,225.00 |
| $500,000 | $30.00 | $50.00 | $55.00 | $65.00 | $90.00 | $155.00 | $260.00 | $405.00 | $775.00 | $1,250.00 |

**DEPENDENT CHILD(REN) Monthly PREMIUMS:**

| Benefit Amount | Premium |
|---|---|
| $5,000 | $1.00 |
| $10,000 | $2.00 |
| $15,000 | $3.00 |
| $20,000 | $4.00 |

*(One rate for all eligible children in family, regardless of number)*

**PREMIUM CALCULATION (Add your elections here):**

| | |
|---|---|
| Employee Premium | |
| Spouse Premium | |
| Dependent Children Premium | |
| Total Premium | |

*(Rates are calculated as of coverage effective date and are based on insured's age in relation to Plan anniversary date. Billed rates may be higher if, at application, the person is at the highest age in an age band).*

**Please read this important information:**

- You may not have coverage as both an employee and as a dependent.
- Only one insured spouse may cover the eligible dependent children.
- Neither you nor your spouse may hold more than a total of $500,000 of group term life insurance with Reliance Standard under the master Group Policy. Insurance over that amount will be void and the premium refunded.

***Rates are subject to change.***

SHDR
Benefit Consultants
A division of BB&T Insurance Services

careplus

# Eligible and Ineligible Expenses

**Health Care Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA) contain pre-tax funds that can be used for a variety of out-of-pocket health care expenses. The following is a list of eligible and ineligible expenses.**

## Eligible Expenses

### BABY/CHILD TO AGE 13
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby/Well Child Care

### DENTAL
- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

### EYES
- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

### HEARING
- Hearing Aids and Batteries
- Hearing Exams

### LAB EXAMS/TESTS
- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

### MEDICAL EQUIPMENT/SUPPLIES
- Air Purification Equipment*
- Arches and Orthotic Inserts
- Compression Stockings*
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

### MEDICAL PROCEDURES/SERVICES
- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

### MEDICATIONS
- Insulin
- Prescription Drugs

### OBSTETRICS
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

### PRACTITIONERS
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

### THERAPY
- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis*
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

The IRS does not allow the following expenses to be reimbursed as they are not prescribed by a physician for a specific ailment.

## Ineligible Expenses

- Cosmetic Surgery/Procedures
- Electrolysis
- Marriage or Career Counseling
- Insurance Premiums and Interest (FSA plan)
- Long-Term Care Premiums (FSA plan)
- Personal Trainers
- Sunscreen (spf less than 30)
- Swimming Lessons

**On January 1, 2011, funds can no longer be used to purchase OTC medicines and drugs unless the medicine or drug is prescribed.** A "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

If you have a prescription for an OTC medicine or drug, you can use your SHDR Benefit Access Visa® Card for this purchase as long as the prescription is filled by the pharmacist with an Rx number assigned. **CHECK WITH YOUR PHARMACIST TO MAKE SURE THEY CAN FILL AN OTC PRESCRIPTION.** If your OTC prescription is not filled by a pharmacist, you must pay out-of-pocket and submit a manual claim requesting reimbursement.

## Eligible Over-the-Counter Items

**Note:** Product categories are listed in bold; common examples of products are listed in regular face.

The following is a list of example Over-the-Counter (OTC) items that clearly are not medicine or drugs and are eligible for purchase with Health Care FSA dollars. You can use your benefits card for these items.

- **Antiseptics, Wound Cleansers**
  Alcohol, peroxide, epsom salt
- **Baby Electrolytes**
  Pedialyte, Enfalyte
- **Denture Adhesives, Repair, and Cleansers**
  PoliGrip, Benzodent, Efferdent
- **Diabetes Testing and Aids**
  Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products
- **Diagnostic Products**
  Thermometers, blood pressure monitors, cholesterol testing
- **Elastics/Athletic Treatments**
  ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts
- **Eye Care**
  Contact lens care
- **Family Planning**
  Pregnancy and ovulation kits
- **First Aid Dressings and Supplies**
  Band Aid, 3M Nexcare, non-sport tapes
- **Hearing Aid/Medical Batteries**
- **Incontinence Products**
  Attends, Depend, GoodNites for juvenile incontinence
- **Reading Glasses and Maintenance Accessories**

For additional information, please contact your Plan Administrator.


This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact your Plan Administrator. Please note that this listing is subject to change at any time and without notice due to new legislation. The SHDR Benefit Access Visa Card is issued by Branch Banking and Trust Company, Member FDIC. Your Benefit Access VISA® Debit Card gives you immediate access to funds stored in your health care or dependent day care accounts. Just select "Credit;" no PIN is required.

**Bellflower Unified School District**
**Flexible Spending Account**
**Election Form for the period September 1, 2016 through August 31, 2017**

| | |
|---|---|
| **Name:** | **SSN:** |
| **Address:** | **Employee ID:** |
| | **DOB:** |
| **Home Phone #:** | **Work Phone #:** |
| **Email Address:** | **Date of Hire:** |

## Tax Savings Illustration

Flexible Spending Accounts are a TAX FREE way to get reimbursed for your Medical and Day Care expenses. The following is an illustration of the SAVINGS with the Plan (***your actual savings may differ***):

| **Annual Contribution** | **$5,000.00** | **$ 2,550.00** | **$ 1,000.00** | **$ 500.00** | **$ 250.00** |
|---|---|---|---|---|---|
| Per Pay Period (12 pay periods) | $ 416.66 | $ 212.50 | $ 83.33 | $ 41.66 | $ 20.83 |
| Estimated **TAX SAVINGS (30%)** | $ 125.00 | $ 63.75 | $ 25.00 | $ 12.50 | $ 6.25 |
| **TOTAL ANNUAL TAX SAVINGS** | **$ 1,500.00** | **$ 765.00** | **$ 300.00** | **$ 150.00** | **$ 75.00** |

**Annual Election**: Health Flexible Spending Account (FSA) and Dependent Daycare Flexible Spending Account (FSA) allow you to set aside PRE-TAX dollars for reimbursement. Indicate below the annual amount you would like to contribute to each benefit:

| Per Pay Period | Annual Amount | | |
|---|---|---|---|
| $_____ | $_____ | Health FSA | Reimbursement for out-of-pocket medical expenses for you, your spouse and your dependents. Some qualifying expenses include: dental, vision, contacts, prescriptions, orthodontia, deductibles and co-pays. The maximum annual election amount is **$2,550** |
| Per Pay Period<br>$_____ | Annual Amount<br>$_____ | Dependent Daycare FSA | Reimbursement for work-related Dependent Daycare expenses for dependents under the age of 13 or incapable of self-care. Care may be provided by an individual or licensed day care facility for full time, after school, or summer care. The maximum annual election amount is **$5,000** (head of household or married filing jointly) or **$2,500** (married filing separately). These amounts will not change. |

**I understand that:**

- The Annual Election remains in effect for the entire Plan Year unless I experience a "change in status" with regards to the Health FSA and a "change in family status" in regards to my Dependent Daycare FSA. These changes include such events as: change in marital status; change in number of dependents; or termination or commencement of employment-specifics are outlined in the Summary Plan Description. All election changes must be necessitated by and consistent with the change and notification must be made in a timely manner to the administrator of the Plan.
- Any amounts that are not used during the Plan Year to reimburse qualifying expenses will be forfeited by me.
- Reimbursements will be available only for qualifying expenses as described by the Internal Revenue Service. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.
- I agree to indemnify and reimburse the Employer on demand for any liability the Employer may incur for failure to withhold federal, state or social security tax from any reimbursement I receive for a non-qualifying expense.
- The guidelines for the administration and compliance of the Plan are outlined in the Summary Plan Description and Plan Document.
- Effective 1/1/2011 FSA funds can no longer be used to purchase OTC medicines and drugs unless the medicine or drug is prescribed. A "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

- This agreement is subject to the terms of the employer's Flexible Benefits Plan. This plan shall be governed by and construed in accordance with the applicable laws. Completing this form revokes any prior Election Form relating to such plan.

| | | |
|---|---|---|
| O I elect to participate<br>O I elect not to participate | Employee Signature: | Date: |

*Effective Date (if other than September 1, 2016):*_____

**Benefits, rules and regulations to consider for the Plan Year beginning September 1, 2016**

**Your Section 125 Plan has the following benefits available:**
A) Health Care Spending Account and
B) Dependent Daycare Spending Account.

You may choose one or both of these features. You will be subject to the rules and regulations of the Plan as summarized in employee handouts, and found in the official Plan document, which is available for your review. Should you not wish this pre-tax feature for any reason, you may check the "I elect not to participate" located at the bottom of the front and sign the form.

**With all of these features, there are some rules that must be followed to keep the Plan in compliance with IRS regulations:**

*Your choices will be in effect for the entire Plan Year September 1, 2016 through August 31, 2017). You may add, drop or change this coverage annually at enrollment or when any of the following Status Changes occur:*

| | |
|---|---|
| Marriage | Death of a Dependent |
| Divorce | Birth or Adoption of a Dependent |
| Change in Your Employment Status | Change in Your Spouse's Employment Status |

*Any changes you wish to make must be consistent with your change in status.*

**With the Health Care Account the following rules must be followed:**

- Health related expenses are reimbursable if they can be considered "deductible" medical expenses on your tax return as defined under Section 213(d).
- The maximum you may contribute is **$2,550** annually.
- Your claims will be paid for the amount of your "out-of-pocket" expense up to your annual election, less previous claims paid.
- If you terminate employment you may submit claims for expenses incurred prior to your termination only.
- You may continue to participate in this plan after termination, but on an after-tax basis, through COBRA.

**With the Dependent Daycare Spending Account, the following rules must be followed:**

- Dependent Daycare must be necessary for you and your spouse to be employed or attend school full time.
- Dependent Daycare expenses must be for your dependent child under age 13 or other dependents such as physically or mentally handicapped relative or household member who is unable to care for himself and over half of whose support you pay.
- You can contribute up to **$5,000** per year if you are a single parent or married and filing a joint return. The maximum is the total family contribution allowable. Your maximum may be lower under the following circumstances:
    - you or your spouse earns less than $5,000
    - your spouse is a full-time student or incapable of self care or you are married but file a separate federal tax return.
    - Contact the Personnel Office if any of these exceptions apply.
- Care cannot be provided by your spouse or anyone you claim as a tax dependent.
- You cannot claim the same day care expenses reimbursed under this plan as a tax credit.
- Claims will be paid for the amount of your expense up to the amount of your account balance.
- You will be required to identify the person performing the child care services to the IRS by providing his/her Federal I.D. number or Social Security number.

For both Health Care and Dependent Daycare Spending Accounts you will have 90 days after the end of the Plan Year to file claims for this Plan Year's expenses. Any money left in your account after you have claimed all of your expenses will not be reimbursed to you. IRS regards the date of a claim as being when the service is rendered, not when you actually pay the bill.

Because amounts contributed through the various Section 125 Plan features are not subject to Social Security taxes, a Plan participant may receive slightly less Social Security at retirement. If maximum retirement income is a concern, an employee may direct part of the tax savings as an additional contribution to the 401(k) Plan.

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Benefit Consultants
*A division of BB&T Insurance Services*

# Flexible Spending Accounts

Save time, money and paper work!

## What are you waiting for?

**Sign up now and start savings!**
Consider adding a Health Care Flexible Spending Account (FSA) to your benefits program. Access to your FSA will be as easy as a swipe of a card, and the more you use your FSA, the more you save. So, if you haven't considered an FSA in the past, it pays to take another look.

## An FSA adds spendable income.

Let's face it, you work hard for your money, and you want to keep as much of it as you can. A Health Care FSA helps you do just that!

You elect to have your annual health care contribution deducted from your paycheck each pay period in equal installments throughout the year – before federal income, state income (in most cases) and Social Security taxes are taken out. So every dollar you put in your FSA is tax-free, spendable income.

## An FSA covers many expenses!

Your tax-free FSA dollars are ready to pay for health-related, out-of-pocket costs not covered by your insurance for you, your spouse and dependents – things like copayments, deductibles, prescriptions, dental bills and vision expenses. And don't forget eligible over-the-counter items. Even if your annual health care expenses are just a couple hundred dollars, an FSA can keep more money in your wallet.

### Did you know?

The average family of four in the U. S. can expect to pay close to $2,420 each year on out-of-pocket expenses like doctor visits, prescription copays, dental work and new glasses – or an unexpected hospital stay…

**If that $2,420 goes into a Health Care FSA, a family can save more than $600 in taxes.**

## With the CarePlus Benefit Access Card, your FSA is:

**Cash flow friendly**
No cash to pay at the time of purchase

**Easy**
Simply a swipe of the card

**Convenient**
No forms to fill out

**Fast**
Funds are automatically deducted from your FSA

**Simple to track**
Your current balance available is online 24/7

careplus

## Your Flexible Spending Account includes a CarePlus Benefit Access Card.

**This is a fast and easy way to access your FSA funds.**

An FSA is a good idea, and here's a feature that makes it even better – the CarePlus Benefit Access Card. This card contains the value of your annual health care FSA election amount, so you can use it to pay for eligible medical expenses such as:

- Covered prescription copayments and deductibles
- Health plan deductibles and coinsurance
- Doctor and emergency room copayments
- Orthodontics
- LASIK surgery and eyeglasses
- Coinsurance
- Out-of-pocket dentist or other provider fees
- Patient due balances
- Mail service and online prescriptions copays and deductibles
- Limited over-the-counter items (if covered by your plan) at pharmacies and participating supermarkets and discount stores

## Say hello to the CarePlus Benefit Access Card, and good-bye to "paying twice."

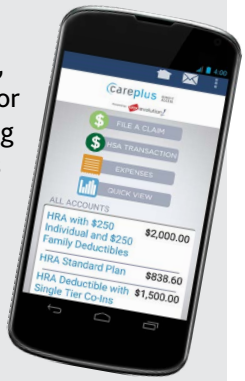
Using the CarePlus Benefit Access Card helps you keep cash in your wallet. You'll never "pay twice"– first from your paycheck into your FSA and then again at time of purchase. You'll have no claim forms to complete, and you won't have to wait to get a check in the mail. You can check balances or account details anytime – online or with a quick phone call.

Simply present the card at participating locations that accept MasterCard® or Visa®. The amount of your eligible expense will be automatically deducted from your account. If you use the CarePlus Benefit Access Card at participating pharmacies, discount stores and supermarkets, in most cases you won't be asked to submit receipts for those purchases. (DON'T FORGET! Always save receipts for FSA purchases made with the CarePlus Benefit Access Card as you may be asked to submit receipts to verify your expenses comply with IRS guidelines.)

Already have an FSA? Maybe now is the time to increase your contributions. If you're not currently participating in a health care FSA, now's the time to enroll. An FSA is a valuable benefit – and a CarePlus Benefit Access Card can make it even better.

## Mobile App Now Available

Get on-the-go access to account balances right in your hand. Simply login to the mobile app to check the balance in any of your accounts, submit claims and receipts for reimbursement, and send receipts for substantiation using the mobile device's camera. You can also receive text messages to keep up to date on your claims and payments.




## And how do you get a CarePlus Benefit Access Card?

**Look for details during open enrollment.**

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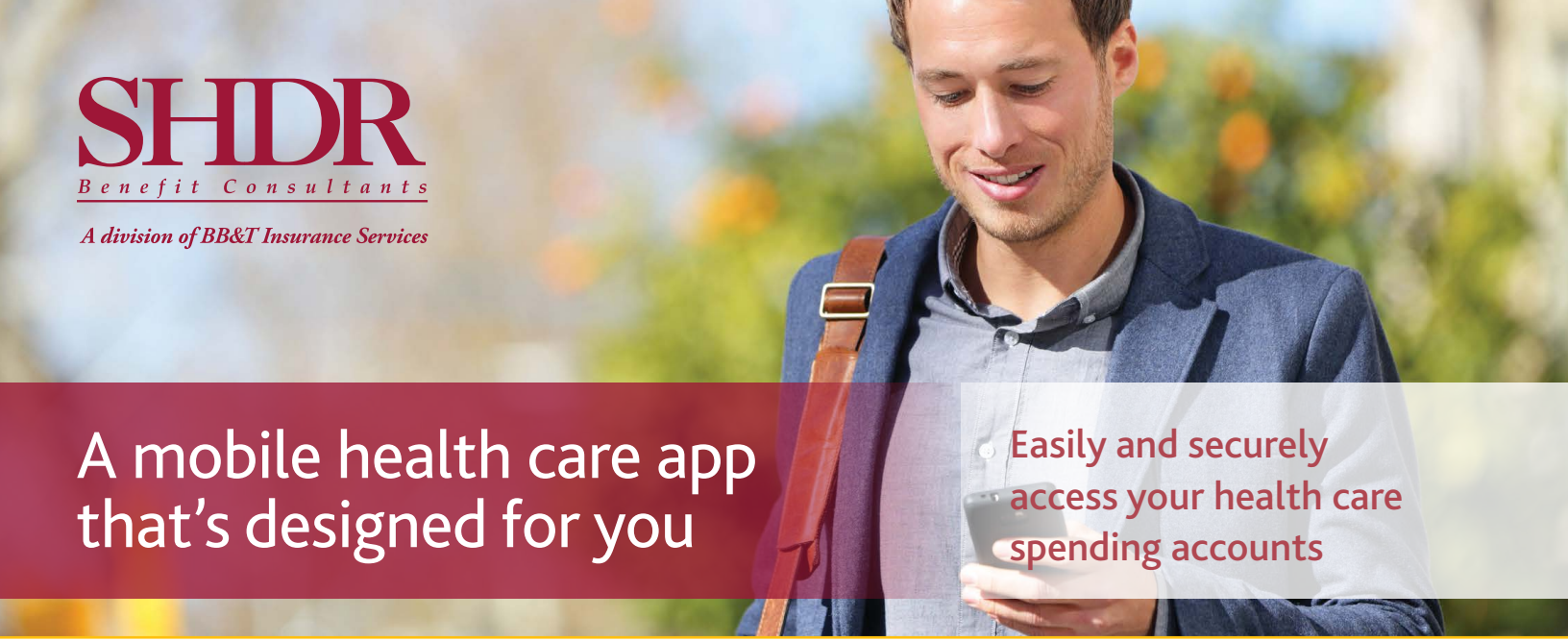
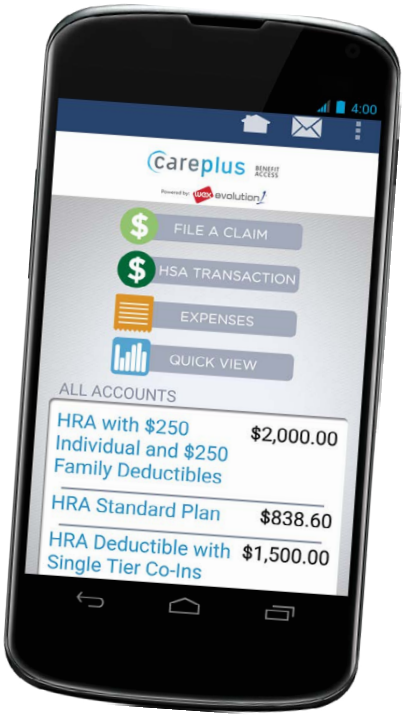


# A mobile health care app that's designed for you

**Easily and securely access your health care spending accounts**

Want to check your health care account balances and submit receipts anywhere, anytime? *There's an app for that!* Want to submit a dependent day care claim anywhere, anytime? *There's an app for that!*

It enables you to easily and securely access your health care spending accounts. You can view account balances and detail, submit health care account claims, and capture and upload pictures of your receipts anytime, anywhere on any iPhone, Android or tablet device. You can also sign up to receive account alerts by text message.




## The CarePlus Benefit Access app from SHDR provides time-saving features for you to:

- Check current account balances; FSA, TSA, HRA and HSA
- View account activity and receive alerts by text message
- View FSA, TSA, HRA and HSA transaction details
- File new claims with receipt images
- Review expense information
- Enter a new expense
- Submit health care claims and upload receipts using the mobile device's camera
- Manage expense receipts
- Promptly file claims for their reimbursement accounts

The CarePlus Benefit Access app provides you with seamless account access to the SHDR portal – and doesn't require you to set up any additional credentials. By using your smartphone you can assess your FSA, TSA, HRA and HSA account balances, and you'll know how much money you have available to spend on qualified medical expenses at the time of purchase.

Conveniently manage your health care information when you want, from wherever you want.

Simply download the CarePlus Benefit Access App for your Android or iPhone (also compatible with iPad® and iPod touch®) and log in using the same password you use to access the SHDR consumer portal.

CarePlus is a robust suite of employee benefits programs, solutions, and strategies that improves the health and wealth of its enrolled members and employers. These benefits are only available through BB&T Insurance Services and its affiliated organizations, including SHDR.

Deposit products are offered through Branch Banking and Trust Company. Member FDIC. Only deposit products are FDIC insured. Information presented is for Tax Year 2015. Investment solutions are provided by Branch Banking and Trust Company. Securities, insurance and advisory products or services are: NOT A DEPOSIT. NOT FDIC-INSURED. NOT GUARANTEED BY A BANK. NOT INSURED BY STATE OR FEDERAL GOVERNMENT AGENCY. MAY GO DOWN IN VALUE. SHDR and its representatives do not offer tax advice. Please consult with your tax professional regarding your individual circumstances.



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BELLFLOWER UNIFIED SCHOOL DISTRICT

MEDICAL INSURANCE "OPT-OUT" PLAN 1

2016-2017 PLAN YEAR ELECTION FORM

I, _____, hereby acknowledge that I am currently covered
*(Print Name)*
as either a subscriber or dependent on a medical insurance plan enabling me to participate in the "Opt-Out" Program.

By participating in the "Opt-Out" Plan 1, I fully understand that once this election is made I will be unable to participate in the medical insurance benefits during the plan year unless there is a qualifying event. A qualifying event means loss of the other coverage, change in legal marital status or termination of employment.

I also understand that I must re-enroll in the "Opt-Out" Plan at open-enrollment each.

I also wish to Opt out of Dental & Vision plans ☐ Yes ☐ No (you must mark yes or no)

_____ _____
Signature Date

_____ _____
Printed Name Marital Status

_____ _____
Home Phone Number Social Security #

_____

_____
Mailing address, including city, state and zip code

_____
Home Email address

***NOTE: Incomplete forms will NOT be accepted. <u>This is the ONLY form the District will accept – do NOT submit older forms</u>.***