Bellflower Unified School District

BENEFITS OVERVIEW GUIDE

2016 - 2017

MEDICAL DENTAL VISION LIFE/AD&D FLEXIBLE SPENDING ACCOUNTS

CLASSIFIED & MANAGEMENT

!

IMPORTANT – ACTION REQUIRED

Classified and Management 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. Only the employee's contribution rate will be changed as per information shown on page 5.

Open Enrollment for Classified & Management: August 30th – September 9th

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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
Once Source – Char Lambert, Account Manager
Ph: 310-609-1917
Email: healthinsurance@busd.k12.ca.us

Benefit	Group Number	Telephone	Web Address
Medical - Classified & Management			
Kaiser HMO Plan	101805	(800) 464-4000	www.kaiserpermanente.org
Chiropractic/Acupunture Plan		(877) 519-8839	www.busdchiro.com
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
Life - Confidential and Management			
Sun Life Assurance	63568	(800) 247-6875	www.sunlife.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 October 1st.

Effective Date - Employees

For the Classified & Management employees: Effective the date the enrollment form is received (must be within 30 days 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.

ONLINE ENROLLMENT

SunGard Online Enrollment

Bellflower Unified School District has set up an online enrollment system through SunGard. Classified and Management 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. Only the employee's contribution rate will be changed as per information shown on page 5.

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!

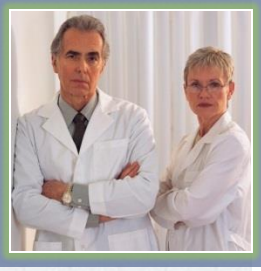
The system will only allow three attempts to match your password to your employee ID number . Otherwise it will lock you out and require you to email sungardsupport@busd. k12.ca.us to have your account re-set.
We are excited to offer this service to you!

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 14.

CLASSIFIED & MANAGEMENT:
KAISER HMO PLAN RATES
CHIROMETRICS



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. Classified & Management employees (if eligible) are offered a Health Maintenance Organization (HMO) through Kaiser. Please see the rates below and a Plan Summary on the following page for details of the plan. The District continues to contribute 1% of the unit member's annual salary toward the Health Insurance Premium.

Kaiser HMO	Employee Contribution (10thly)
Employee Only	$82.22
Employee + 1	$137.04
Employee + Family	$171.30

Effective October 1, 2016 Chiropractic and Acupuncture Benefits, provided by ChiroMetrics, Classified & Managment Bellflower Unified School District enrollees will have Chiropractic and Acupuncture coverage , provided through Chirometrics.

WHO IS CHIROMETIRCS?

ChiroMetrics is a team of experienced chiropractic and acupuncture benefit administrators. ChiroMetrics specializes in school districts, covering nearly 70,000 school district employees throughout California.

Our Medical team consists of experienced chiropractors and acupuncturists. Our friendly, accessible staff are available to answer any questions and offer quick and accurate resolution of any concerns.

We believe in whole health: mind, body, and spirit. That's why we're proud to facilitate this care for thousands for people every day!

YOUR BENEFIT

Classified & Management Bellflower USD members with this coverage:

- $7 copay per visit
- 40 acupuncture/chiropractic visits per year
- Members have access to a statewide network of providers
- For more information please visit www.busdchiro.com

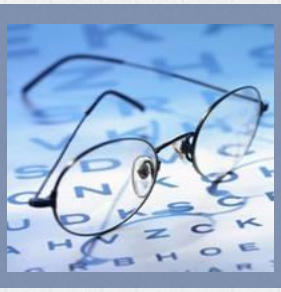
Phone: 1-877-519-8839
Web: www.busdchiro.com

CLASSIFIED & MANAGEMENT:
KAISER HMO PLAN
PLAN SUMMARY

	Plan Options
	Kaiser HMO
BENEFITS	***HMO***
Plan Out-Of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Plan Deductible	
	None
Professional Services (Plan Provider office visits)	
Most Primary Care Visits for evaluations and treatment	$15 per visit
Most Specialty Care Visits for consultations, evaluations, and treatment	$15 per visit
Routine physical maintenance exams, including well-woman exams	No Charge
Well-child preventive exams (through age 23 months)	No Charge
Family planning counseling and consultations	No Charge
Scheduled prenatal care exams	No Charge
Routine eye exams with a Plan Optometrist	No Charge
Hearing exams	No Charge
Urgent care consultations, evaluations, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit
Outpatient Services	
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	No Charge
Most immunizations (including the vaccine)	No Charge
Most X-rays and laboratory tests	No Charge
Covered individual health education counseling	No Charge
Covered health education programs	No Charge
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No Charge
Emergency Health Coverage	
Emergency Department visits	$150 per visit
Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance Services	
Ambulance Services	$150 per trip
Prescription Drug Coverage	
Covered outpatient items in accord with our drug formulary guidelines	
Most generic items at a Plan Pharmacy	$15 for up to a 30-day supply
Most generic refills through our mail-order service	$30 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply
Durable Medical Equipment	
DME items that are essential health benefits in accord with our DME formulary guidelines	No Charge
Mental Health Services	
Inpatient psychiatric hospitalization	No Charge
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit
Chemical Dependency Services	
Inpatient detoxification	No Charge
Individual outpatient chemical dependency evaluation and treatment	$15 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	
Home health care (up to 100 visits per calendar year)	No Charge
Other	
Skilled nursing facility care (up to 100 days per benefit period)	No Charge
Prosthetic and orthotic devices that are essential health benefits	No Charge
All Services related to covered infertility treatment	50% Coinsurance
Hospice care	No Charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

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 • Every 12 months	$10 for exam and glasses
Prescription Glasses		
Frame	• $120 allowance for a wide selection of frames • 20% off amount over your allowance • Every 12 months	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Combined with exam
Lens Options	• Tints/Photochromic lenses-Transitions • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 35-40% off other lens options	$0 $50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $120 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation) • Every 12 months	$0
Additional Coverage	• Diabetic Eyecare Program	
Extra Savings and Discounts	**Glasses and Sunglasses** • 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. **Retinal Screening** • Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • 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).

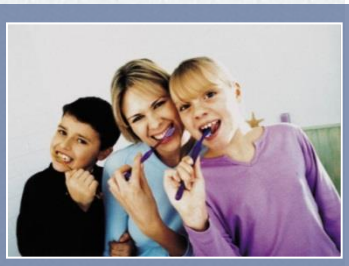
Orthodontic treatment in progress may be covered for new DeltaCare enrollees. See the Limitations and Exclusions of Benefits.

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

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:

Management/Confidential has the option of Voluntary Life Insurance through Sun Life Assurance at the following rates:

Benefits	Basic Employee Life	Basic AD&D
Rate Basis	Per $1,000 volume	Per $1,000 volume
Rate	$0.207	$0.020

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

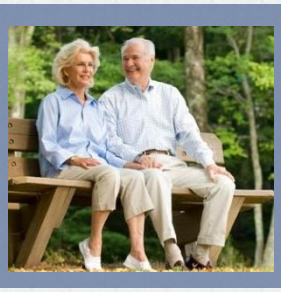
Age	Voluntary Life Rate
Under 30	$.60
30 – 34	$1.00
35 – 39	$1.10
40 – 44	$1.30
45 – 49	$1.80
50 – 54	$3.10
55 – 59	$5.20
60 – 64	$8.10
65 – 69	$15.50
70 +	$25.00

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 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).


BELLFLOWER UNIFIED SCHOOL DISTRICT
BELLFLOWER • CERRITOS • LAKEWOOD

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.