ALPINE UNION SCHOOL DISTRICT

2001 Tavern Rd, Alpine CA 91901

NEW EMPLOYEE BENEFITS INFORMATION

CLASSIFIED

Effective 01/01/2024

Welcome to the Alpine Union School District Employee Benefits Program!
We know your benefits are important to you and your entire family and are proud to offer a comprehensive benefits package to eligible employees and their eligible dependents. To take advantage of all the programs the District offers, please review the information below to help you make the right benefits decisions for you and your family. The benefit choices you make now will be in effect through the end of the calendar year and cannot change unless you experience a qualifying life event, such as a birth, marriage, or loss of other coverage. You must enroll within 31 days of your hire date or the date you become benefits-eligible.

FRINGE BENEFIT PACKAGE FOR ELIGIBLE EMPLOYEES:

The benefits package includes (5) Benefits; **Medical, Dental, Vision, Basic Life & AD&D Insurance of $50,000, and Long-Term Disability Insurance**. Our District has a maximum employer annual contribution cap of **$13,900** that it will pay towards these (5) five benefits. Employee-only coverage for Medical Plans (Kaiser or UnitedHealthcare), Dental (Delta Dental PPO or DeltaCare DMO), Vision, Basic Life & AD&D coverage of $50,000 and Long-Term Disability is **paid by the district and are included in the district's maximum annual contribution cap of $13,900**.

All benefit-eligible employees MUST be enrolled in employee-only coverage for all (5) five benefits.

Employees hired and starting work between the 1st and the 15th of the month- Benefits will become effective on the first day of the month following the first day of paid service in a regular assignment of twenty (20) or more hours per week. EXAMPLE: An employee starting on August 5th would be eligible for benefits on September 1st.

Employees hired and starting work after the 15th of the month- Benefits will become effective on the first day of the second full month of paid service in a regular assignment of twenty (20) or more hours per week. EXAMPLE: An employee starting on August 24th would be eligible for benefits on October 1st.

Benefits Selection Sheet

All employees must indicate which medical and dental plan options they are selecting along with the employee's signature and date.

Medical Coverage

District medical plans are provided through our plan administrator VEBA. Please see the plan selection sheet for monthly insurance costs.

THE EMPLOYEE WILL NEED TO SELECT A PRIMARY CARE PROVIDER (PCP) NAME & NUMBER ON THE MEDICAL PLAN ENROLLMENT FORM FOR ALL MEDICAL PLANS SELECTED EXCEPT KAISER.

To find a Primary Care Provided (PCP), please visit https://www.whyuhc.com/csveba/health-plans

A. Kaiser 10 Rx: $10/$10
B. UnitedHealthcare Harmony HMO $10
C. VEBA Direct HMO $10
D. UnitedHealthcare Performance HMO Network 3
E. UnitedHealthcare Alliance HMO $20/$30
F. Buy-Out Option (Must submit verification of other coverage)

OTHER VEBA Benefits Included in Medical Coverage

Optum Chiropractic and Acupuncture Services
Optum Employee Assistance Program (EAP)
Advocacy and Wellness Programs, including Teledoc Medical Experts
Prescription medication coverage through Express Scripts or Kaiser Rx

Please note that your medical ID card can take up to three (3) weeks to receive in the mail.

Kaiser Member: *Pharmacy coverage is built into your Kaiser medical ID card. You will receive a separate ID card for Chiropractic services thru OptumHealth.*

UHC Member: *A separate Express Scripts ID card will be mailed to you for pharmacy coverage. Please use your UHC medical ID card for Chiropractic services thru OptumHealth.*

Dental Coverage

All employees must select at a minimum employee only dental coverage even if you are already covered with another carrier. The employee only cost is paid by the district. Our district offers two different dental plans:

A. Delta Dental PPO (**Plan A**)
B. DeltaCare USA (**Plan B**)

Please note that you WILL NOT receive a dental enrollee card in the mail. For enrollee ID number(s), please create an account at **deltadentalins.com/enrollees**.

Please let our Benefits Representative know if you currently have Delta Dental coverage from another District that will be ending so we can see if your incentive plan will transfer. There cannot be a gap in coverage to transfer the incentive.

Vision (VSP)

Vision is employee only coverage and dependent coverage is NOT available. The cost is paid by the district. Employees are automatically enrolled in this plan and NO enrollment form is needed.

Please note that you WILL NOT receive a vision enrollee card in the mail. For enrollee ID number(s), please create an account at **vsp.com**.

Basic Life and AD&D Insurance (Underwritten by The Hartford Insurance Co.)

Basic employee only life and AD&D insurance is $50,000 each and the cost is paid by the district. Employees are automatically enrolled in this plan. Please fill out the beneficiary information form. Voluntary employee and dependent coverage options are available at an additional tenthly cost.

Long-Term Disability Insurance (Underwritten by The Hartford Insurance Co.)

Employee only coverage cost is paid by the district. Employees are automatically enrolled in this plan and NO enrollment form is needed.

Voluntary Benefits Enrollment Options

Please note that all voluntary benefit plans are deducted from September through June and are paid for by the employee.

- **Voluntary Term Life Insurance (Employee, Spouse & Children) thru The Hartford**
  - **Employee Coverage:** Guaranteed issue for new hires up to $150,000 with NO Evidence of Insurability (EOI) required. Amounts that exceed the guaranteed issue amount of $150,000 will require Evidence of Insurability (EOI) that is satisfactory to The Hartford before the excess can become effective. The maximum amount you can purchase cannot be more than the lesser of 4 times your annual earnings or $250,000. During Open Enrollment, you can purchase in increments of $10,000. Amounts purchased equal to $10,000 during Open Enrollment will not require Evidence of Insurability (EOI).
  - **Spouse Coverage**: If you have elected voluntary life insurance coverage for yourself, you can purchase coverage for your spouse with a guaranteed issue up to $50,000 with NO Evidence of Insurability (EOI) required. New hires will need to provide Evidence of Insurability (EOI) for amounts that exceed $50,000. Coverage cannot exceed 50% of the amount of your employee voluntary/supplemental life insurance coverage. The maximum amount you can purchase is $100,000 in increments of $5,000.00. Amounts purchased equal to $5,000 during Open Enrollment will NOT require Evidence of Insurability (EOI).
  - **Children Coverage:** If you have elected voluntary life insurance coverage for yourself, you have the option to elect this coverage in the amounts of $2,000, $5,000, and $10,000.

- **Voluntary AD&D Insurance thru The Hartford-** The maximum coverage amount you can purchase cannot be more than $300,000. Amounts over $250,000 cannot be more than 10 times your annual earnings. During Open Enrollment, you can purchase in increments of $10,000.

- **American Fidelity Assurance Company**

  - Section 125 Plans
  - Accident Only Insurance
  - Cancer Insurance
  - Short-Term Disability Income Insurance
  - Life Insurance
  - 403 (b) and 457 (b) Plan Administrative Services

- **MetLife Legal Plan-** All employees can enroll in this plan at any time during the year as long as they remain enrolled for a minimum of one (1) year before they cancel.

- **Unum Long Term Care Insurance**
- **East County Schools Federal Credit Union Membership**
- **Deferred Compensation 403(b) and 457(b) Retirement Plans**

All forms and plan selections information can also be found on our district website http://www.alpineschools.net under Departments > Human Resources > Benefits > New Hire.

PLEASE SUBMIT ALL ENROLLMENT FORMS TO OUR BENEFITS DEPARTMENT NO LATER THAN 31 DAYS FROM YOUR BENEFITS ELIGIBILITY DATE (HIRE DATE OF QUALIFYING POSITION)

Please contact Teri Lyle at tlyle@alpineschools.net or (619) 445-3236 with any plan selection questions. Appointments are also available.

ALPINE UNION SCHOOL DISTRICT

2024 PLAN YEAR

BENEFITS SELECTION FORM

NEW CLASSIFIED STAFF

EMPLOYEE NAME:_____

RATES EFFECTIVE JANUARY 1ST, 2024

COVERAGE EFFECTIVE DATE: _____

Employees hired and starting work between the 1st and the 15th of the month- Benefits will become effective on the first day of the month following the first day of paid service in a regular assignment of twenty (20) or more hours per week. EXAMPLE: An employee starting on August 5th would be eligible for benefits on September 1st.

Employees hired and starting work after the 15th of the month- Benefits will become effective on the first day of the second full month of paid service in a regular assignment of twenty (20) or more hours per week. EXAMPLE: An employee starting on August 24th would be eligible for benefits on October 1st.

PLEASE INDICATE WHICH PLANS AND OPTIONS YOU ARE SELECTING. (Rates are 10THLY)

A MEDICAL ENROLLMENT FORM MUST BE COMPLETED

2024 MEDICAL PLANS (10THLY RATES)	TOTAL PLAN COST (Employer and Employee) Annual	Tenthly	Check only one	EMPLOYEE MONTHLY COST OVER 10 MONTHS (September through June) Delta Dental Selection	DeltaCare Selection	My Selection
KAISER 10 Rx: $10/$10 up to a 100-Day Supply	$9,810.00	$981.00	Employee	**$0.00**	**$0.00**	☐
	$19,340.00	$1,934.00	Employee + 1	**$629.88**	**$635.44**	☐
	$27,240.00	$2,724.00	Employee + Family	**$1,419.88**	**$1,425.44**	☐
HARMONY HMO $10 ***UnitedHealthcare Insurance***	$9,240.00	$924.00	Employee	**$0.00**	**$0.00**	☐
	$18,230.00	$1,823.00	Employee + 1	**$518.88**	**$524.44**	☐
	$25,580.00	$2,558.00	Employee + Family	**$1,253.88**	**$1,259.44**	☐
VEBA Direct HMO $10	$9,910.00	$991.00	Employee	**$0.00**	**$0.00**	☐
	$19,720.00	$1,972.00	Employee + 1	**$667.88**	**$673.44**	☐
	$27,700.00	$2,770.00	Employee + Family	**$1,465.88**	**$1,471.44**	☐
PERFORMANCE HMO 3 $10 ***UnitedHealthcare Insurance***	$11,040.00	$1,104.00	Employee	**$0.00**	**$0.00**	☐
	$20,030.00	$2,003.00	Employee + 1	**$698.88**	**$704.44**	☐
	$28,130.00	$2,813.00	Employee + Family	**$1,508.88**	**$1,514.44**	☐
VEBA ALLIANCE HMO $20/$30 ***UnitedHealthcare Insurance***	$10,690.00	$1,069.00	Employee	**$0.00**	**$0.00**	☐
	$20,840.00	$2,084.00	Employee + 1	**$779.88**	**$785.44**	☐
	$29,210.00	$2,921.00	Employee + Family	**$1,616.88**	**$1,622.44**	☐
$100 Monthly Payment in Lieu of Medical Benefits (Remitted from September through June) Paid on a tenthly basis, (No payments in July and August).						☐

è PLEASE SIGN AND DATE ON THE BACK

MUST CHECK ONLY ONE BOX EVEN IF YOU HAVE SELECTED THE BUY-OUT OPTION FOR MEDICAL COVERAGE

A DENTAL ENROLLMENT FORM MUST BE COMPLETED

2024 DENTAL PLANS (10THLY RATES)	TOTAL PLAN COST (Employer and Employee) Annual	Tenthly	Check only one	Medical Coverage Type	EMPLOYEE MONTHLY COST OVER 10 MONTHS (September through June) Employee Monthly Cost	My Selection
Delta Dental (Plan A)	$577.20	$57.72	Employee	ALL	$0.00	☐
	$1,115.90	$111.59	Employee +1	Kaiser-EE Only	$0.00	☐
				Buy-Out	$0.00	☐
				Harmony- EE Only	$0.00	☐
				VEBA Direct HMO- EE Only	$0.00	☐
				UHC Ntwk 3- EE Only	$0.00	☐
				Alliance HMO $20/$30- EE Only	$0.00	☐
				ALL OTHER SELECTIONS	$53.87	☐
	$1,654.40	$165.44	Employee + Family	Kaiser-EE Only	$0.00	☐
				Buy-Out	$0.00	☐
				Harmony- EE Only	$0.00	☐
				VEBA Direct HMO- EE Only	$0.00	☐
				UHC Ntwk 3- EE Only	$0.00	☐
				Alliance HMO $20/$30- EE Only	$0.00	☐
				ALL OTHER SELECTIONS	$107.72	☐
DeltaCare (Plan B)	$632.80	$63.28	Employee	ALL	$0.00	☐
	$632.80	$63.28	Employee + 1		$0.00	☐
	$632.80	$63.28	Employee + Family		$0.00	☐

All Monthly Premiums are based on 10 months.

All deductions start one month prior to the effective date of coverage.

There are "NO" premiums deducted in July & August each year.

PLEASE INITIAL ONE BOX BELOW ONLY IF YOUR SELECTION(S) ABOVE HAS AN EMPLOYEE MONTHLY COST

☐ I elect to participate in the Section 125 Premium Only Plan (POP). I authorize Alpine Union School District to reduce my salary in the amount necessary to pay for the coverage's checked above. These selections cannot be changed during the Plan Year unless a change in "Life Status" as defined by the IRS. I understand that the above selections does not necessarily include me in the insurance program, and, in most instances, an application for insurance must also be completed. I also understand that should the premium for the benefited plans selected be adjusted by the health plans, my income will be reduced or increased as necessary to pay the premium under the terms of Section 125 Plan. Dependent Care and Medical Flexible Spending Accounts (FSAs) are on a separate plan year.

☐ I elect **NOT** to participate in the Section 125 Premium Only Plan (POP). By NOT electing to participate in the Section 125 Premium Only Plan (POP), I understand that my insurance premiums will NOT be taken out pre-taxed. By declining to participate in the Section 125 Premium Only Plan (POP), I understand I may drop a dependent during the plan year, however I must have a Change in "Life Status" to enroll or add dependents during the Plan Year. I understand that the above selections does not necessarily include me in the insurance program, and, in most instances, an application for insurance must also be completed. I also understand that should the premium for the benefited plans selected be adjusted by the health plans, my income will be reduced or increased as necessary to pay the premium.

It is expressly understood and agreed that Alpine Union School District, its offers, agents and employees have made no representation regarding and are not responsible for the choice made by each employee or other consequences of the group of employees. My signature authorizes any payroll deductions that may be required towards the cost of any voluntary selections I have made to my coverage.

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet-Certificate, and Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Enrollment Form

Kaiser Permanente & UnitedHealthcare

Rev 1/2024

Welcome to the California Schools VEBA. VEBA purchases and administers your health care benefits. What this means to you is that you get more benefits at a more reasonable cost than if your district purchased benefits on its own. Based on your district, you can enroll yourself and your eligible family members in a health plan through either Kaiser Permanente or UnitedHealthcare.

VEBA is committed to helping you and your family be healthy and stay healthy. To make sure you choose the health plan and doctors that are best for you, we encourage you to research all of the plan benefits that are available to you as well as the medical groups and doctors you use. You can do this by visiting the California Office of the Patient Advocate at www.opa.ca.gov.

WHAT YOU NEED TO KNOW

This form has the following three sections.

Section 1. Employee Enrollment Information *(ALL employees must complete Parts A, B and C of this section)*

- ☐ Fill in all the information requested *(Kaiser Permanente members plan members do NOT have to include a Primary Care Provider (PCP) name or number. UnitedHealthcare (UHC) HMO members can either include a PCP name OR leave the information blank and have UHC assign a PCP based on your zip code.)*
- ☐ Check with your employer to determine if domestic partnership coverage is available
- ☐ You can enroll your eligible dependents up to age 26
- ☐ Proof of permanent disability is required for dependents over age 26

Section 2. Employee Signature Required for Binding Arbitration Agreement

- ☐ All employees must sign the Binding Arbitration agreement as a requirement of the plan you select
- ☐ If you don't sign your health plan's Binding Arbitration agreement your enrollment may be denied

Section 3. UnitedHealthcare (UHC) Information

- ☐ Employees enrolling in a UHC Plan must review and sign the "Release of Medical Information" section

IMPORTANT NOTE: If you enroll in the **UnitedHealthcare Performance HMO Plan:**

- ☐ You and any dependents must ALL enroll in the same network
- ☐ You and each of your dependents will remain in your selected network and HMO plan for the ENTIRE plan year
- ☐ You and your dependents can choose separate Medical Groups as long as they are in the same network
- ☐ You must select a Primary Care Provider—if you do not select a PCP, one will be assigned to you

SECTION 1. ENROLLMENT INFORMATION

A. Your Information *(please print on all sections of form)*

School District Name:	Social Security No.*(SSN)*:	Date of Hire:
Name *(First, MI, Last)*		☐Male ☐Female ☐Non-Binary
Residence Mailing Address:		Birth Date *(mm-dd-yy)*:
City:	State: Zip Code:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Domestic Partner
Telephone: ☐Mobile ☐Home ☐Work	Telephone: ☐Mobile ☐Home ☐Work	
Email Address:		
PCP Name : *(UHC Members)*	PCP ID*: *(UHC Members)*	Are You an Existing Patient? ☐Yes ☐No

Are you currently on COBRA? ☐Yes ☐No
If "Yes," COBRA Qualifying Event & Effective Date______________________________
(Required)ie: Marriage, Newborn, Loss of Coverage, Newly benefit eligible, Return from LOA

** if an incorrect or incomplete PCP ID is provided, we cannot guarantee PCP assignment*

D. Employer to Complete This Section

Group #/Plan Code:

Requested Effective Date:

Source of Enrollment/Change Event:
☐Open Enrollment
☐Employee Status Change
☐Dependent Status Change
☐New Hire
☐Rehire
☐Termination
☐QMCSO
(*Qualified Medical Child Support Order)*

Enrollment Event Date:

Employee Class:

☐Active ☐Retired ☐Leave ☐COBRA

B. Select Your Coverage

Enrollees	Health Plan					
☐Self ☐Self + 1 ☐Self + family	☐ **Kaiser Permanente HMO** *(If your district offers a choice, select a plan below)* ☐ High Plan ☐ Low Plan	☐**UnitedHealthcare (UHC) PHMO** *(If your district offers the Performance HMO, you must choose one network for your family.)* ☐Network 1 ☐Network 3	☐**UHC Alliance HMO** ☐Alliance 10 ☐Alliance 15 ☐Alliance 20 ☐Alliance 20/30	☐**UHC Harmony HMO** ☐Harmony 10 ☐Harmony 15 ☐Harmony 20 ☐Harmony 20/30	☐ **UHC Journey HMO** ☐VEBA Direct Journey ☐Harmony ☐Alliance ☐ **UMR Select Plus**	☐ **VEBA Direct HMO** ☐VEBA Direct 10 ☐VEBA Direct 15 ☐VEBA Direct 20 ☐VEBA Direct 20/30

C. Dependent Information *(attach additional sheets if necessary)*

☐Add ☐Delete ☐Change	SSN:	Spouse/Domestic Partner Name	☐M ☐F ☐NB	Birth Date *(mm-dd-yy)*	Address *(if different from yours)*	PCP Name: ________ PCP ID.:________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	*SSN:*	Dependent Name *(First, MI, Last)*	☐M ☐F ☐NB	Birth Date *(mm-dd-yy)*	Address *(if different from yours)*	PCP Name: ________ PCP ID.:________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	*SSN:*	Dependent Name *(First, MI, Last)*	☐M ☐F ☐NB	Birth Date *(mm-dd-yy)*	Address *(if different from yours)*	PCP Name: ________ PCP ID.:________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	*SSN:*	Dependent Name *(First, MI, Last)*	☐M ☐F ☐NB	Birth Date *(mm-dd-yy)*	Address *(if different from yours)*	PCP Name: ________ PCP ID.:________ Existing Patient? ☐Yes ☐No

SECTION 2. EMPLOYEE SIGNATURE REQUIRED FOR BINDING ARBITRATION AGREEMENT

Based on the health plan you enroll in, you must sign the plan's Binding Arbitration agreement for your enrollment to be effective.

- Sign **A** below for **Kaiser plan**
- Sign **B** below for **UnitedHealthcare plan**

A. Kaiser Foundation Health Plan Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a Kaiser Permanente Plan)*

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

Employee Signature required for Kaiser Permanente Plan	**Employee Name** (please print)	**Date** (month/day/year)

* Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration 1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

B. UnitedHealthcare Plan Members Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a UnitedHealthcare Plan)*

UnitedHealthcare Binding Arbitration Agreement

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

YOUR SIGNATURE

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

Employee Signature	**Employee Name** (please print)	**Date** (month/day/year)

SECTION 3. UNITEDHEALTHCARE PLAN *(UHC plan members must sign "Authorization to Release Medical Information" below)*

HIV Disclaimer
"California law prohibits an HIV test from being required or used by health care service plans and insurance companies as a condition of obtaining coverage."

Legal Entities Disclaimer
Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by UnitedHealthcare Insurance Company, United HeathCare Services, Inc., PacifiCare Health Plan Administrators, Inc., Prescription Solutions or Optum Health Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Authorization to Release Medical Information
I authorize UnitedHealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment and risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed. I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments. UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

☐ *By checking this box, I am indicating that I have carefully read the above "Authorization to Release Medical Information" and agree to its terms.*

Employee Signature	**Employee Name** (please print)	**Date** (month/day/year)

ALPINE UNION SCHOOL DISTRICT

Insurance Buy-Out Option (2024)

Certification of Insurance Coverage

I, _____, understand that if I have medical benefits through another source, I can take the option of the $1,000 cash payment ($100 per month, September - June). I understand it is my responsibility to investigate the current plan offered outside the District to make sure that I am covered under all circumstances.

I certify that I will be covered under the _____ (health plan) sponsored by _____ (company), through my spouse's employer, and that I will notify the Alpine Union School District if my coverage should be cancelled at any time during 2024 (see Notice of Special Enrollment Rights below).

It is expressly understood and agreed that the District, its officers, agents and employees, have made no representation regarding, and are not responsible for, any choice made by me or other consequences of the group of employees, and I understand that I may not make changes until the next open enrollment in October, 2024.

_____ _____

Signature Date

** NOTICE OF SPECIAL ENROLLMENT RIGHTS **

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

All employees participating in the Insurance Buy-Out Option must return this completed form to the Benefits Department each year at Open Enrollment and attach evidence of other coverage.

Rev. 10/3/2023

DELTA DENTAL

ENROLLMENT/CHANGE FORM – CA
DUAL CHOICE
Enrollment and Billing Department

deltadentalins.com

Select a Plan: ❑ **Delta Dental PPO (Plan A)** OR ❑ **DeltaCare® USA[1] (Plan B)**

Delta Dental PPO (Plan A):
P.O. Box 429086
San Francisco, CA 94142-9086

DeltaCare® USA[1] (Plan B):
P. O. Box 1803
Alpharetta, GA 30023

VERY IMPORTANT – Please Print Legibly

Enrollee/Change Information

- ❑ New Enrollment
- ❑ Add/Delete Dependent
- ❑ Marital Status Change
- ❑ Address Change
- ❑ Terminate Enrollee Coverage
- ❑ Change Dental Plans*
- ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

*Enrollees can change plans only during open enrollment or due to a qualifying status change unless allowed by the group contract.

Change Dental Plan*

- ❑ **Delta Dental PPO – Cancel**
- ❑ **DeltaCare USA – Cancel**

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	❑ Non-binary ❑ Male ❑ Female	❑ Single ❑ Married

First Name	Last Name	Middle Initial

Mailing Address (Street)	City	State	Zip Code

Email Address (internal use only)	Phone Number ( ) -	Phone Type
		Cell ❑ Work ❑ Home ❑

Network Facility Name (DeltaCare USA only)	Network Facility Number (DeltaCare USA only)

Name of Other Dental Carrier	Policy Holder Name (first/last)	Date of Birth
		/ /

Effective Date of Other Policy	Policy Holder Street Address	City	State	Zip Code
/ /				

FOR GROUP USE ONLY

Group No.	Division	State

Effective Date	Hire Date
/ /	/ /

Name of Employer

Location	Pay Code	Benefit Package

Enrollee Classification

- ❑ Full-Time ❑ Hourly ❑ Certified
- ❑ Part-Time ❑ Salaried ❑ Classified
- ❑ Retired ❑ Member/Other _____

COBRA (if applicable)

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce/Legal Separation**
- ❑ Widowed/Surviving Dependent**
- ❑ Dependent Child No Longer Eligible**

Indicate qualifying date: ____/____/____

If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided.

Dependent Information

Relationship	Dependent First Name (last name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Non-binary/ Male/Female	Student / Disabled***	Name of School (overage student)***	Network Facility Number‡ (DeltaCare USA only)
Spouse/Partner		❑ ❑		/ /	❑ ❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑		

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. ***Additional documentation will be required for disabled and student status. ‡Maximum of three facilities per family.

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I decline coverage at this time.

Signature of Enrollee _____ Date ____/____/____

[1] DeltaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enrollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to receive this document in Spanish or Chinese. For free help, please call Delta Dental:

Delta Dental Premier®
and Delta Dental PPO™: 1-800-765-6003
DeltaCare® USA: 1-800-422-4234

IMPORTANTE: ¿Pueda leer este documento? Si no, podenmos ayudarle. También puede recibir este documento en español o chino. Para obtener ayuda gratis, llame a Delta Dental al:

Delta Dental Premier®
and Delta Dental PPO™: 1-800-765-6003
DeltaCare® USA: 1-800-422-4234

重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。您也能取得這份文件的西班牙文或中文譯本。如需免費協助，請電 Delta Dental。

Delta Dental Premier®
and Delta Dental PPO™: 1-800-765-6003
DeltaCare® USA: 1-800-422-4234

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box),* I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number: NA	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer: Archdiocese of St. Louis		Policy Number: 677885

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)

Dependent Eligibility Verification Requirements

Eligible Dependent Type	Eligible Dependent Definition	Required Documentation for Proof of Eligibility
Legal Spouse	Legally married spouse as defined by State law	• Marriage Certificate if married less than one year; otherwise, a copy of the most recent Federal Tax Return with signature of Employee and Spouse (blackout financial information)**
State-Registered Domestic Partner	Same-sex or opposite-sex domestic partners age 18 or older	• California Certificate of Domestic Partnership issued by the California Secretary of State
Unregistered Domestic Partner	Same-sex domestic partners age 18 or older who meet District requirements in their Declaration of Domestic Partnership	• Declaration of Domestic Partnership (including joint residence and financial interdependence documentation) and Domestic Partner HealthCare Enrollment Statement
Child- Biological	Direct biological child (under age 26)	• Government-issued Birth Certificate reflecting that the child is the Employee's child, or • A copy of the most recent Federal Tax Return with signature of Employee listing child as dependent (blackout financial information) **
Child- Step	Direct biological child (under age 26) from a spouse/domestic partner's prior marriage	• Government-issued Birth Certificate reflecting that the child is the Spouse/Domestic Partner's child, AND you and your spouse's Marriage Certificate if married less than one year, or • Government-issued Birth Certificate reflecting that the child is the Spouse/Domestic Partner's child, AND a copy of the most recent Federal Tax Return with signature of Employee and Spouse listing child as dependent (blackout financial information) **
Child- Adopted	Legally adopted child under the age 26	• Government-issued Adoption Order, AND government issued Birth Certificate, or • Foreign adoption approved by the INS or legal adoption documents from foreign country AND home government-issued Birth Certificate
Child- Guardianship	Persons under the age of 18 for whom you have legal guardianship	• Court Order of Legal Guardianship, AND a copy of most recent Federal Tax Return with signature of Employee listing child as dependent (blackout financial information).** Excludes temporary guardianship orders.
Child- Disabled	Disabled child over the age of 26 for whom you have the legal responsibility to care	• Notice of disability determination from medical carrier prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship), or • Notice of disability determination from the Social Security Administration prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship)

Dependents who do not meet the definitions as listed above are not eligible dependents

** Copies of the Federal Tax Return must be signed and be for the tax year prior to adding the dependents.

American Fidelity Assurance Company
A member of the American Fidelity Group

Plan Year Beginning: January 1, 2024 Ending: December 31, 2024

Enrollment in the Section 125 Premium Only Plan allows active employees to reduce their taxable income by withholding certain qualifying benefit premiums BEFORE taxes.

Pre-tax Payroll Deductions

If you elect to participate in the Section 125 pre-tax salary reduction, your elections are irrevocable. You cannot add or drop a dependent during the Plan Year unless you experience a Change in Status also known as "Qualifying Life Event" under the Section 125 Internal Revenue Code regulations.

Post-tax Payroll Deduction

If you decline to participate in the Section 125 pre-tax salary reduction, you may drop a dependent during the Plan Year. However, you must have a Change in Status to enroll or add dependents during the Plan Year.

Employee/Dependent Participation Provisions

Coverage for an Employee/Retiree and his or her Dependent(s) will terminate in accordance with provisions of the applicable Collective Bargaining Agreement, Memorandum of Understanding, Employer Administrative Policy, or subject to the contractual provisions of the insurance plan.

Participant elections are irrevocable and cannot be changed during the Plan Year. Certain exceptions to the rule, known as a Change in Status or Qualifying Life Events examples are:

- **Legal Marriage or Domestic Partnership**
- **Divorce, Annulment, Legal Separation**
- **Birth, Adoption or placement for Adoption of a Child**
- **Death**
- **Change in Employment Status**
  (Part-Time to Full-Time or Full-Time to Part-Time, Loss of Coverage)
- **Loss of Eligibility** (for example, dependent child no longer eligible due to age)
- **Judgments, Decrees or Order Requiring Coverage**
  Applies to a judgment, decree or order resulting from a divorce, legal separation, annulment, changes in legal custody or Qualified Medical Child Support Order (QMCSO)
- **Significant Change in Cost** (subject to special note below)
- **Family Medical Leave Act (FMLA)**
  An employee taking FMLA may revoke their election for medical, dental and vision and choose another option for the remaining period of leave.

Special Note:
VEBA Special Mid-Contract Open Enrollment

In order for a mid-year special open enrollment which allows members to change their elections under the VEBA Participation Agreement, an exception must be granted and approvals need to be obtained by VEBA.