30-DAY NOTICE

To: All New Pajaro Valley Unified School District Employees
From: Benefits Department
Re: Eligibility for Health and Welfare Benefits

PVUSD offers eligible employees Medical, Dental, Vision, and Life Insurance. Coverage will begin the first of the month following your eligible hire date. Enclosed in your employee Hire Packet are the necessary enrollment forms for you to complete and return to the Benefits Office. These forms are mandated by Federal HIPAA (Health Insurance Portability and Accountability Act) Law to be completed **within 30 days of your hire date**. Failure to return the enrollment forms within this time frame will result in being automatically assigned to the WABE (Waiver of Anchor Bronze Enrollment) plan* with no option to change the benefits plans until Open Enrollment or a qualifying event. Annual Open Enrollment is the month of May with an effective date of October 1st, forms and required documents must be submitted to the Benefits Office for plan changes and/or dependents' coverage commencing October 1st.

Only those qualified individuals listed on the original enrollment form will be considered for coverage when all required documents are received in the Benefits Office at the time of enrollment. Any notification of change in dependent status is the responsibility of the employee and will require appropriate documentation to be submitted to the Benefit Office within 30 days of the qualifying event (birth of a child, adoption, marriage, divorce, loss of other coverage, etc.). Failure to submit a SISC Change Form and required documents during this time frame will result in coverage being delayed until the following Open Enrollment when all required documents are received.

The date on which an employee becomes eligible for District benefits (first day at work) is _____. All enrollment forms and required documents are to be submitted to the Benefits office within thirty days (30 days) of eligibility date, which is _____.

I understand that if I am working 90% or more and fail to return any or all of the required forms by the above date will result in my automatic enrollment into the WABE plan.* I will have to wait for Open Enrollment to make any changes to my coverage plans or to add any qualifying dependents to my plans, unless there is a qualifying event before Open Enrollment.

I understand that if I am working less than 90%, I may complete an Opt Out form and provide proof that I am enrolled in another Medical coverage plan and not be enrolled in the PVUSD coverage plans. Failure to turn in the Opt Out Form and proof of coverage by the above date will result in my automatic enrollment into the WABE plan.*

I understand that it can take 4-6 weeks from when I turn in my completed insurance paperwork to show up in the insurances system.

I have read the above statement and understand my responsibility.

_____ _____
(Print Name) Social Security Number

_____ _____
(Signature) (Date)

_____ _____
Job Title Phone Number

Checklist
- ☐ Medical Election Form
- ☐ Dental Designation Form
- ☐ Enrollment Form
- ☐ Required Documents
- ☐ Life Insurance Form
- ☐ Beneficiary Form
- ☐ American Fidelity Interest Form

*The WABE plan does not have any medical coverage, PPO Plus Premier Incentive plan for Dental, VSP for Vision, and Life insurance.

Enrollments Instructions, Documents Required and Qualifying Events

Enrollment Instructions:

Indicate Medical plan selection on the Election Form by initialing the box below plan being selected

Indicate the Dental plan selection on the Delta Dental Designation Form by initialing on the line in front of the plans being selected.

Complete the Enrollment Form. Please make sure that every blank field is completed legibly. Remember to check all benefit plans for you and any dependent(s) you are enrolling (Medical, Dental and/or Vision). You must use your legal name as it appears on your current Social Security card.

Documents Required:

SISC requires documentation to add or enroll all eligible dependents. The following eligibility documentation is required when including the following dependents on your insurance coverage plan:

Spouse - Copy of:

- Current Year Federal Income Tax Form 1040 (lines 1-6), plus
- County issued Marriage Certificate (*See below)

Registered Domestic Partner:

- State Registry of Domestic Partnership filed with the State

Children - Copy of:

- County issued Birth Certificate (for ages 0 to 25)
- Official Court Adoption Papers (for ages 0 to 25)
- Official Court Guardianship Papers (for ages 0 to 17)

These eligibility documents are **required** before the dependent will be included on the employee's coverage plans. We recommend that the employee include the dependents they would like to add even if documents are still pending; otherwise, they will have to wait until the next open enrollment.

*If you were married, during the current calendar year we need a copy of your County issued Marriage Certificate only.

Qualifying Events:

You can only add or drop dependents from your benefits during Open Enrollment or within 31 days of a Qualifying Event. You must submit all required forms and supporting documents to the Benefits Department within 31 days of the Qualifying Event.

Eligible dependents are: legal spouse, domestic partner, child (by birth or adoption) age 0 to 25; child (through legal guardianship) age 0 to 17.

- A Qualifying Event to add a dependent is the date of: birth of your child, your marriage, legal adoption of a child, Legal appointment of Guardianship of a child or in any eligible dependent has coverage elsewhere and loses the coverage. Proof of coverage loss is one of the required documents
- A Qualifying Event to drop a dependent is a divorce or dependent enrolls in another medical coverage plan. Copy of the front page of the final Divorce papers is one of the required documents.
- A Qualifying Event to enroll in the insurance coverage plans during the year is when your work hours are increased to 50% or more. Work contract(s) of 90% or more are required to enroll.
- A Qualifying Event to disenroll from the insurance coverage plans during the year is when your work hours are decrease to less than 90%.

This is a Summary. Please contact the Benefits Department if you have any further questions.

SISC Website Information to look up Participating Medical, Dental and Vision Providers

To look up participating **Blue Shield** providers for the SISC Blue Shield plans;

www.blueshieldca.com/sisc

Scroll down to the Quick Links and Click "Find a Doctor"
You will go the Blue Shield Virtual Assistant Page.
Choose what you are looking for from the options that are provided.
*If you are looking for a Primary Care Physician, please search through multiple specialties if you do not know the name of the Physician.
Enter Zip code or full address including city and state for the best results and confirm if correct.
Choose your plan from the options provided
*Please note PVUSD does not have the SaveNet HMO plan.
*If you do not know your medical plan, please contact the Benefits Department.
Answer questions to refine your search.

To look up participating **Anthem** providers for the Select Plan;

www.anthem.com/ca/sisc

On the right side of the Home Page, select **Find Care**

On this page scroll down until you see **Select PPO**

Click on the "+" then select **"Search for Select PPO Providers"**

This next webpage is where you personalize what you are looking for and **Search.**

This will give you the providers within 20 miles. There are notes on the right side to help you broaden your search.

To look up Dentists with **Delta Dental**

www.deltadentalins.com

Scroll down to "Find a Dentist
Enter the Zip code and Select a Network
*The only options for PVUSD would be Delta Dental PPO or Delta Dental Premier
The next page will provide a list of Dentist for the network you chose
*You can also refine the search by entering the name of the Dentist, Practice or keyword.

To look up **VSP** Providers

www.vsp.com

You can search by either location, office, or doctor
You can always refine the search in "Advanced Search" at the top right section of the screen
*The plan PVUSD has for VSP is "Signature"

Insurance Carrier Information

Self-Insured Schools of California (SISC)

Medical Coverage:

Administrator:	(SISC)
Blue Shield of California	Concierge Number: (855) 599-2657 Billing Address: P. O. Box 272540 Chico, CA 95927 www.blueshieldca.com/sisc
Anthem Blue Cross	Customer Service: (800) 825-5541 Billing Address: P. O. Box 60007 Los Angeles, CA 90060-0007 www.anthem.com/ca/sisc
Kaiser Permanente	Customer Service: (800) 461-4000 Billing Address: P.O. Box 261155 Plano TX 75026 www.my.kp.org/sisc
24/7 MDLIVE	24/7 physician available by phone for medical questions - (888) 632-2738

Prescription Drug Plan

Administrator: ***Navitus Health Solutions***	Phone Number: (866) 333-2757 Billing Address: P. O. Box 272540 Chico, CA 95927 www.navitus.com

Dental Coverage:

Administrator: ***Delta Dental (SISC)***	Customer Service: (866) 499-3001 Billing address: P. O. Box 997330 Sacramento, CA 95899-7330 www.deltadentalins.com

Vision Coverage:

Administrator: ***Vision Service Plan (SISC)***	Customer Service: (800) 877-7195 Billing Address: 3333 Quality Drive Rancho Cordova, CA 95670 www.vsp.com

Life Insurance: $10,000 Group Term life insurance policy

Administrator:	Boston Mutual Life Insurance Co.

Employee Assistance Program:

Administrator: ***Anthem / SISC***	Phone Number: (800) 999-7222 www.anthemEAP.com and enter SISC
Coverage:	6 free sessions per family member per incident

Benefits Department Contact Information
1st floor
Phone number: (831) 786-2317 | Fax number: (831) 728-6996 | Email: benefits_help_group@pvusd.net

Additional information, Summary Plan Documents and forms available at http://www.pvusd.net/benefits
Revised 07/2021

SISC Self-Insured Schools of California *Schools Helping Schools*	**HMO vs. PPO – Differences You Should Know About**	
	HMO	**PPO**
Provider Choices	You must choose doctors, hospitals, and other providers in the HMO network, as directed by your primary care physician	You can choose doctors hospitals, and other providers from the PPO network or form out of network. If you choose an out-of-network. If you choose an out-of-network provider, you will have to pay the difference, which is substantially higher.
Is a primary care physician (PCP) required?	Yes, each member in the family must select a PCP. They can each have a different doctor. If one is not selected a PCP will be assigned to you. Your PCP is responsible for managing and coordinating all of your health care.	No you can receive care from any doctor you choose. But keep in mind that you will pay more if the providers are not "contracted" providers of the plan you are on.
What about specialists?	You will need a referral from your PCP to see a specialist. Your PCP is responsible for referring you to an HMO network provider.	You do not need a referral to see a specialist. However, you are responsible for making sure the specialist is a network provider.
Do I have to file any claims?	No, all of the providers in the HMO network deal directly with the carrier.	If you utilize network providers, you usually do not need to file a claim. However, if you go out of network for services you may have to pay for all or part of the services and then file a claim for reimbursement. Some of the out-of-network providers will not file the claim for you. You are responsible for any part of the provider's fee that the PPO plan does not
How do I pay for services in the network?	The only charges you should incur for the in-network services are those that require a copayment. For example, office visits, prescriptions or other procedures that have a copayment.	In most cases, you will only be responsible for the copayment.
What about services out of network?	Except for certain types of care that may not be available from a network provider, you are not covered for any out-of-network services.	If you receive services outside the PPO network, you may need to pay the provider and then be reimbursed by the plan. You are also responsible for paying any amount over what you your plan allows. For example, if the out-of-network provider charges $1,000 for a service, and the plan only allows and pays $500, you are responsible for paying the difference up to what the provider charges. Since the provider is not in the network, he/she is not obligated to write off any amount, so they will look to the member payment
What about emergencies when services were provided by out-of-network providers?	Services deemed an emergency by the plan are covered. However, it's imperative that your PCP or insurance company is notified within 48 hours of your emergency treatment.	Services deemed an emergency by the plan are covered. Although some plans make allowances to pay a higher reimbursements in cases of emergency, the member is responsible for paying the difference between what the plan pays and the billed changes.

SISC Self-Insured Schools of California School Helping Schools

District Name _____

Bargaining Unit _____

2020-2021	Blue Shield	Blue Shield	Blue Shield	No PAMF Anthem	Blue Shield	No PAMF Blue Shield	No PAMF Kaiser
	100-A $20	80-M $40	HSA-A	100-A $20	HMO Access $10	HMO Trio $10	Trad HMO $10
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0	$3,000/$6,000	$1500/$3000	$0/$0	$0/$0	$0/$0	$0
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$4,000/$8,000	$3000/$6000	$1,000/$3,000	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000
			*Includes Rx				
PROFESSIONAL SERVICES							
Office Visit (OV) co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$20	$40	Deductible, then 10%	$20	$10	$10	$10
Urgent Care co-pay	$20	$40	10%	$20	$10	$10	$10
Specialists/Consultants co-pay	$20	$40	10%	$20	$10	$10	$10
Prenatal, postnatal office visit co-pay	$20	$40	10%	$20	$0	$0	$0
Scans: CT, CAT, MRI, PET etc.	0%	20%	10%	0%	$0	$0	$0
Diagnostic X-ray & Laboratory Procedures	0%	20%	10%	0%	$0	$0	$0
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	Not covered	Not covered	Not covered	Not covered	50%	50%	Co-pay applies
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	$0	$0	$0
HOSPITAL & SKILLED NURSING FACILITY SERVICES							
Emergency Room visit (waived if admitted)	0% $100 co-pay	20% $100 co-pay	10% $100 co-pay	0% $100 co-pay	$100	$100	$100
Inpatient Hospital (preauthorization required) - limits may apply	0%	20%	10%	0%	$0	$0	$0
Outpatient Hospital	0%	20%	10%	0%	$0	$0	$10
Surgery, Outpatient (performed in Surgery Center)	0%	20%	10%	0%	$0	$0	$10
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	20%	10%	0%	$0	$0	$10
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT							
INPATIENT: Facility Based Care (preauth required)	0%	20%	10%	0%	$0	$0	$0
OUTPATIENT: Facility Based Care (preauth required)	0%	20%	10%	0%	$10	$10	$10
OTHER SERVICES							
Acupuncture - Limits apply	0%	20%	10%	0%	$10/30 visits combined w/chiro	$10/30 visits combined w/chiro	$10/30 visits combined w/chiro
Ambulance (Ground or Air)	0% $100 co-pay	20% $100 co-pay	10% $100 co-pay	0% $100 co-pay	$100	$100	$50
Chiropractic - Limits apply	0%	20%	10%	0%	$10/30 visits combined w/acu	$10/30 visits combined w/acu	$10/30 visits combined w/acu
Durable Medical Equipment (DME)	0%	20%	10%	0%	0%	0%	no charge
Physical and Occupational Therapy - Limits apply	0%	20%	10%	0%	$10	$10	$10
Hearing Aids	Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	Amount in excess of $700 allowance/24 months	50% Coinsurance 1 device/24 months	50% Coinsurance 1 device/24 months	amount in excess of $500 allowance every 36 months
PHARMACY BENEFITS							
Plan	**5-20**	**5-20**	**HSA Rx**	**5-20**	**5-10 (Non-Marketed)**	**5-10 (Non-Marketed)**	**Trad HMO $10**
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	none	Included w/ Medical ded	none	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$1,500/$2,500	Included w/ Med OOP Max	$1,500/$2,500	$1,500/$2,500	$1,500/$2,500	Included w/ Med OOP Max
Generic co-pay/30 days supply	$0 at Costco $5 at Other Network	$0 at Costco $5 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	$0 at Costco $5 at Other Network	$0 at Costco $5 at Other Network	$0 at Costco $5 at Other Network	$10 up to 100 day supply
Brand co-pay/30 days supply	$20	$20.00	Deductible, then $35	$20.00	$10.00	$10.00	$10 up to 100 day supply
Specialty co-pay/up to 30 days supply	$20 Must Use Navitus Mail	$20 Must Use Navitus Mail	Deductible, then $35 (Must Use Navitus Mail)	$20 Must Use Navitus Mail	$10 Must Use Navitus Mail	$10 Must Use Navitus Mail	$10 up to 30 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$50	$0-$50	Deductible, then $18-$90	$0-$50	$0-$20	$0-$20	$10-$10/up to 100 day supply
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Kaiser Mail Order Pharmacy

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.

Medical Plan Election Form

INSTRUCTIONS: Review the plan options available to you. The plan you are selecting to enroll in is designated by initial-ing the box at the bottom of the plan information.

DUE DATE: This Plan Election Form and any applicable enrollment forms or dependent Documentation, if adding a dependent, is due to the Benefits Department within 30 days of your date of hire

2019-2020	Blue Shield PPO	Blue Shield PPO	Blue Shield PPO	Anthem Select PPO	Blue Shield HMO	Blue Shield HMO-Trio	Kaiser
Network Details	Includes PAMF	Includes PAMF	Includes PAMF	No PAMF	Includes PAMF	No PAMF	No PAMF
Plan Name	100-A $20	80-M $40	H.S.A-A	100-A $20	$10-0	$10-0	Trad. HMO $10

Medical Plan Election -Initial you plan.							

> I understand tht the only time I may change plans or make dependent overage changes is during Open Enrollment Period (Month of May) for an October 1 effective date unless there is a Mid-Year Qualifying event and that event is reported to the district's Benefits Office with 30– days of the event by turning in a completed SISC Membership Change Form

>If adding a dependent due to a qualifying event or during open enrollment I must provide the required dependent eligibility documentation.

>See reverse for monthly rebates for plans selected.

Print name | **Signature** | **Date**

Address | **Phone**

Last 4 of SSN

* You must select a Primary Care Physician (PC) or Medical Group when enrolling in a Blue Shield HMO plan.

PVUSD Health Insurance Incentive Plans
Effective 10/01/2021

SISCconnect

By modifying your current health plan you can increase your total compensation.

SINGLE	PLUS 1	FAMILY
The amounts listed below are gross earnings subject to taxes. **Your monthly income can increase or decrease based on plan selected.**		
Blue Shield PPO **No Rebate Offered**	**Blue Shield PPO** **No Rebate Offered**	**Blue Shield PPO** **No Rebate Offered**
Blue Shield HMO Access **$531 Annual** $44.25 12 months/$48.27 11 months	**Blue Shield HMO Access** **$1,143 Annual** $95.25 12 months/$103.91 11 months	**Blue Shield HMO Access** **$1,692 Annual** $142.50 12 months/$155.45 11 months
Anthem Blue Cross **$666 Annual** $55.50 12 months/$60.55 11 months	**Anthem Blue Cross** **$1,332 Annual** $111.00 12 months/$121.09 11 months	**Anthem Blue Cross** **$1,899 Annual** $158.25 12 months/$172.64 11 months
Blue Shield HMO Trio **$1,206 Annual** $100.50 12 months/$108.00 11 months	**Blue Shield HMO Trio** **$2,484 Annual** $207.00 12 months/$225.82 11 months	**Blue Shield HMO Trio** **$3,627 Annual** $302.25 12 months/$329.73 11 months
Kaiser **$1,512 Annual** $126.00 12 months/$137.45 11 months	**Kaiser** **$2,916 Annual** $243.00 12 months/$265.09 11 months	**Kaiser** **$4,032 Annual** $336.00 12 months/$366.55 11 months
Blue Shield HSA **$2,223 Annual** $185.25 12 months/$202.09 11 months	**Blue Shield HSA** **$4,023 Annual** $335.25 12 months/$365.73 11 months	**Blue Shield HSA** **$5,373 Annual** $447.75 12 months/$488.45 11 months
Blue Shield M-Plan **$2,691 Annual** $224.25 12 months/$244.64 11 months	**Blue Shield M-Plan** **N/A**	**Blue Shield M-Plan** **N/A**

For Questions please contact: Mark Bernhardt or Kristina Carrillo in the benefits office at 831.786.2317

Revised: 07/27/2021

* Incentives are modified based on SISC annual renewals

SISC
Self-Insured Schools of California
Schools Helping Schools

Pajaro Valley Unified School District – Delta Dental Plan Summary – Comparison Sheet

PPO plus Premier Incentive Plan- 5363-1000

In the incentive plan Delta Dental pay 70% of the contract allowance for covered diagnostic, preventative, basic services and for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Eligibility: Primary enrollee, spouse (domestic partner) and eligible dependent children to age 26

Calendar Year Maximum: $1,200 per person per calendar year in-network PPO
: $1,000 per person per calendar year out-of0netowrk

Benefits and Covered Services	In-PPO Network	Out-of-PPO Network
Calendar Year deductible	NONE	NONE
Diagnostic & Preventive services (D&P): Exams, Cleanings, X-Rays	70-100%	70-100%
Basic Services: Fillings, simple tooth extractions, sealants	70-100%	70-100%
Endodontics: (root canals) Covered Under Basic Services	70-100%	70-100%
Periodontics:(gum treatment) Covered Under Basic Services	70-100%	70-100%
Oral Surgery: Covered Under Basic Services	70-100%	70-100%
Major Services: Crowns, inlays, onlays and cast restorations	70-100%	70-100%
Prosthodontics: Bridges and dentures	50%	50%
Orthodontic Benefits/Maximums: Adults and dependent children	N/A	N/A

PPO plus Premier Incentive Plan-BUY UP- 5363-1200

In the PPO plus Premier Incentive BUY UP plan Delta Dental pays 100% of the contract allowance for covered diagnostic and preventive services Basic and major services will pay at the attained 70-100% for both PPO, Premier and non-network providers. Delta dental will pay 50% for prosthodontics services for both PPO, Premier and non-network providers. If you choose to change to the Incentive Plan from the PPO non-incentive plan during Open Enrollment, benefits will start at 70%. You will save approximately 20% on services performed by a PPO Network provider.

Calendar Year Maximum: $1,500 per person per calendar year in-network PPO
: $1,200 per person per calendar year out-of0netowrk

Benefits and Covered Services	In-PPO Network	Out-of-PPO Network
Calendar Year deductible	NONE	NONE
Diagnostic & Preventive services (D&P): Exams, Cleanings, X-Rays	100%	100%
Basic Services: Fillings, simple tooth extractions, sealants	70-100%	70-100%
Endodontics: (root canals) Covered Under Basic Services	70-100%	70-100%
Periodontics:(gum treatment) Covered Under Basic Services	70-100%	70-100%
Oral Surgery: Covered Under Basic Services	70-100%	70-100%
Major Services: Crowns, inlays, onlays and cast restorations	70-100%	70-100%
Prosthodontics: Bridges and dentures	50%	50%
Orthodontic Benefits/Maximums: Adults and dependent children	50%/$1,500 lifetime per person	

PPO ONLY Non-Incentive Plan- 5363-1100

In the Non-Incentive plan Delta Dental pays 100% of the contract allowance for covered diagnostic, preventive Basic services and Major services when receiving services from a PPO Network provider. Delta Dental will pay 50% for prosthodontics and Orthodontics benefits when receiving services from a PPO Network provider. If you choose to change to the Incentive plan from the Non-Incentive plan during Open Enrollment, benefits will start at 70%.

Calendar Year Maximum: $1,500 per person per calendar year in-network PPO
: $1,000 per person per calendar year out-of0netowrk

Benefits and Covered Services	In-PPO Network	Out-of-PPO Network
Calendar Year deductible	NONE	NONE
Diagnostic & Preventive services (D&P): Exams, Cleanings, X-Rays	100%	50%
Basic Services: Fillings, simple tooth extractions, sealants	100%	50%
Endodontics: (root canals) Covered Under Basic Services	100%	50%
Periodontics:(gum treatment) Covered Under Basic Services	100%	50%
Oral Surgery: Covered Under Basic Services	100%	50%
Major Services: Crowns, inlays, onlays and cast restorations	100%	50%
Prosthodontics: Bridges and dentures	50%	50%
Orthodontic Benefits/Maximums: Adults and dependent children	50%/$1,500 lifetime per person	
Claims Address P.O. Box 997330 Sacramento, CA 95899-7330	Customer Service 866-499-3001	deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitation or exclusions for your plan, please consult your benefits representative.

*Limitations or waiting periods may apply for some benefits; some services may be executed from your plan. Reimbursement is based on Delta Dental contract allowance and not necessarily each dentist's actual fees.

**Reimbursement is based on PPO contracted frees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

PVUSD
DELTA DENTAL DESIGNATION FORM

District name Pajaro Valley Unified School District		District ID# 69799
Personal Information		
[ ] Male [ ] Female	Name: Last, First, MI	
Street Address	City, State, Zip code	Phone Number
Social Security Number	Birthdate	

Select Coverage:

INITIAL <u>ONE</u> SELECTION ONLY

_____PPO PLUS PREMIER - INCENTIVE PLAN - premium is district paid

_____PPO PLUS PREMIER - INCENTIVE **<u>BUY-UP</u>** PLAN - **<u>$18.50 PER MONTH premium paid by employee</u>**

_____PPO ONLY- NON-INCENTIVE PLAN - premium is district paid

By choosing the PPO ONLY Non-Incentive Plan I understand that I am responsible for a greater portion of my dental costs when I use a non-PPO provider. I realize that I cannot change to the Delta Dental Incentive (PPO PLUS PREMIER) Plan until a subsequent Open Enrollment period with an October 1 effective date. I understand that if I choose to change to the Incentive Plan from the PPO non-incentive plan during an Open Enrollment, benefits will start at 70%.

Signature	Date

SISC III ENROLLMENT FORM (DO NOT use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)

(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)

ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE ☐ COBRA

QUALIFYING DATE: ____________ EFFECTIVE DATE: ____________ HIRE DATE: ______________ DISTRICT APPROVED INITIALS: ______

DISTRICT NAME (DO NOT ABBREVIATE)	EMPLOYEE GROUP (BARGAINING UNIT)	EMPLOYEE TYPE
Pajaro Valley Unified School District	☐Certificated ☐Classified ☐Management	☐ Full-Time ☐ Part-Time ☐ Variable/Temporary/Seasonal

MEDICAL GROUP NO.	DELTA DENTAL GROUP NO.	VISION GROUP NO.	LIFE GROUP NO.
	5363-	2606615A	N/A

SECTION II: EMPLOYEE / APPLICANT INFORMATION – REQUIRED

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	DATE OF BIRTH	☐ MALE ☐ FEMALE

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NO.	E-MAIL ADDRESS	IPA (HMO ONLY–REQUIRED)	PCP (HMO ONLY–REQUIRED)	CURRENT PROVIDER? ☐ YES ☐ NO

MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.

ARE YOU RETIRED? ☐ YES ☐ NO
IF YES, DO YOU HAVE MEDICARE? ☐YES ☐NO (Copy of Medicare card required)
TOTALLY DISABLED? ☐ YES ☐ NO

DO ANY OF YOUR DEPENDENTS HAVE MEDICARE? ☐ YES ☐ NO
(Copy of Medicare card required)

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SPOUSE ☐ DOMESTIC PARTNER GENDER ☐ M ☐ F	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
- DEDUCTION AUTHORIZATION: If applicable, I authorize my school district to deduct from my wages the required contribution.
- NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- HIV Testing Prohibited: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- EFFECTIVE DATE: The effective date of coverage is subject to SISC III approval.
- Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

SECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

____

Applicant Signature Required Date

California Region Kaiser Permanente Group Enrollment Form

Please print or type in black ink only. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER:		
District Name: Pajaro Valley Unified School District		Hire Date (mm/dd/yyyy)
Medical Group Number:	Enrollment Unit:	Effective Enrollment Date (mm/dd/yyyy)

Complete this section **ONLY** if dental, vision and/or life insurance is offered through SISC:

Delta Dental Group#: 5363- Vision Group#: 2606615A SISC Life Ins Group#: Employee Only N/A

A. ENROLLMENT: New group: Yes ☐ ☐ No

❑ New Hire (complete sections A, B, C, D) ☐ Full Time ☐ Part Time ☐ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ❑ HMO Plan ❑ Deductible Plan ❑ Other

❑ Loss of Other Coverage (complete sections A, B, C, D) ❑ Other (please specify) _____

❑ Event Date (mm/dd/yyyy) _____

B. EMPLOYEE: Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. (if known)	Social Security No.	Gender M F
Name (Last, First, MI)	Birth Date (mm/dd/yyyy)	
Home Address	City State ZIP	
Work Phone	Home Phone Email	
Ethnicity	Preferred Language	

C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)

☐ Add ☐ Spouse ☐ Domestic partner Spouse/domestic partner name: Gender: Male ☐ Female ☐	☐ Med ☐ Den ☐ Vision	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ Den ☐ Vision	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ Den ☐ Vision	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ Den ☐ Vision	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

D. 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.

Signature required for all Kaiser Permanente Plans **Date**

(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

**Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration1) 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.*

KAISER PERMANENTE®

BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

0026954 — Group Number-Division Number
Pajaro Valley Unified School District — Employer/Policyholder
Dept. ID

Employee Name *(Last, First, Middle)*
Social Security Number

Home Address *(Street, City, State, Zip)*
Telephone #

Gender *(M/F)* | Occupation or Job Title | Date of Birth | Age
PAYROLL TYPE: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Annual Earnings: $

Average Hours Worked | Date of Hire | or Date of Full Time Employment if different | Effective Date | State | Class | Rate Basis

Spouse *(Last, First, Middle)* | Gender *(M/F)* | Date of Birth | Age | No. of Dependents

LIFE - DISABILITY

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

BASIC	YES	NO	Insurance Amount
LIFE	☒	❑	$ 10,000

VOLUNTARY	YES	NO	Insurance Amount
LIFE	❑	❑	$
DEPENDENT LIFE:			
SPOUSE LIFE AND AD&D	❑	❑	$
CHILD(REN)	❑	❑	$

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS: ***(Attach Additional Beneficiaries on a signed and dated separate sheet)***

Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit
Contingent Beneficiary(ies)						

SEE ATTACHED

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

Please complete as much beneficiary information as you can provide.

SIGNATURE

REFUSAL OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer *(or the Association with whom I am affiliated)* and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

❑ All Coverages ❑ Life & AD&D ❑ Dependent Coverage ❑ Short Term Disability ❑ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

EMPLOYEE SIGNATURE REQUIRED

I apply for the insurance for which I am now eligible *(or for which I may become eligible)* under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. *I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Group Life Beneficiary Designation Form

Employer	Group Number	Employee Phone Number
Pajaro Valley Unified School District	0026954	
Employee Name	**Employee SSN**	**Employee DOB**

It is important to clearly indicate your primary beneficiary(ies) and contingent beneficiary(ies). Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). This beneficiary designation supersedes and cancels all prior beneficiary designations by the insured person for the policy indicated. The undersigned hereby declares that he/she has not been declared incompetent and no court order or laws prevent naming the below designee(s). Subject to the provisions of the policy and applicable laws it is requested the beneficiary of any policy proceeds payable at the death of the insured person be as follows:

Primary Beneficiary(ies)

Name	Relationship	DOB	SSN	Address	Percentage

Contingent Beneficiary(ies)

Name	Relationship	DOB	SSN	Address	Percentage

Community Property State Consent for Residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin. If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any rights that I may have to the proceeds of such insurance under applicable community property laws.

_____ _____

Spouse's signature and consent (if applicable) Date

_____ _____ _____

Signature of Insured **Printed Name** **Date**

_____ _____ _____

Signature of Witness Printed Name Date

(The witness must have no interest in the policy or be a named beneficiary)

GROUP TERM LIFE INSURANCE BENEFIT SUMMARY

Death Benefit

The amount of life insurance for which an employee is insured will be paid lo the beneficiary in the event of the employee's death from any cause at any time or place. An employee may name any beneficiary desired, other than the employer, and may change this designation at any time.

Accelerated Death Benefit

An insured employee with a life expectancy of twelve months or less, and who qualifies for the Accelerated Death Benefit may elect to receive a portion of the death benefit while still living. This benefit is payable only once during the insured's lifetime and will result in the proportionate reduction of the Life Insurance. The remaining Life Insurance will be payable to the beneficiary upon the insured's death.
Not available in all states.

Conversion Privilege

The employee has 31 days to convert any or all of his life insurance, which has terminated for any reason other than the employee did not pay the required premium. The employee may convert his/her Life Insurance to an individual whole life policy without evidence of insurability, subject to the policy provisions. The premium rate for the converted policy is based on the insured's age at the time of conversion. Waiver of premium is not available on a convened policy. Spouse and dependent coverage, if in force, may also be converted in accordance with policy provisions governing conversion.

Layoffs, Leave of Absence

The Group Policy permits continuance of insurance on employees who are temporarily laid offor granted a leave of absence.

Portability

If the employee terminates employment, the insured employee may continue the employee and dependent Group Life Insurance. The employee pays the premium on the ported coverages directly to Boston Mutual. To be eligible for Portability the employee must be under age 60 on the day employment ends; and the employee's coverage not continued under the Waiver of Premium; and the employee's Group Life Insurance coverage not converted. The Insured Dependent's Life Insurance may not be continued if the Employee's Group Life Insurance is not continued; or if the Insured Dependent is age 60 or greater. Waiver of Premium and Accidental Death and Dismemberment arc not available on the ported policy. The ported coverage terminates at age 70. At which time the insured is eligible to convert under the Conversion Provision of the policy.

Total Disability Waiver Premium (if elected)

If an employee is totally disabled prior to age 60 and otherwise qualified, premiums will be waived for the employee, spouse and dependent children. Should death occur during total disability, the amount of Life Insurance will be paid to the designated beneficiary.

Actively At Work

Eligible Employees who are disabled on the date their insurance would otherwise become effective shall become insured on the date they return to Active Work.

Eligibility

All employees working at least 30 hours a week, or the minimum hours specified in the group application, arc eligible for insurance on the effective date of the plan provided they are actively at work on that date. New employees are eligible on the date specified in the group application.

Spouse of an Insured employee, under the age of70 and unmarried children age 14 days to 19 years, 25 if full-time student or handicapped children over the age of 19 arc also eligible for insurance.
Dependent, may not be insured if they are confined in a medical facility.

A spouse or child who is an Employee cannot be insured as a Dependent. If both spouses are Employees then their children will be insured as Dependents of only one spouse.

Guaranteed Issue

Guarantee Issue coverage will become effective on the later of, the effective date of the group policy or the date the application is received by Boston Mutual provided the application is received within 31 days of first becoming eligible. Evidence of insurability satisfactory to Boston Mutual is required for amounts in excess of the Guaranteed Issue amounts and for applications received after 31 days of first becoming eligible. Coverage in excess of the Guaranteed Issue amount will become effective on the date the evidence of insurability is approved by Boston Mutual.

120 ROYALL STREET • CANTON MA 02021 • TEL 800-669-2668 • FAX 78t-770-0497•
WWW.BOSTONMUTUALCOM

GROUP TERM LIFE INSURANCE BENEFIT SUMMARY

Reduction Provisions

The Employee's, Spouse's and Dependent's Life and AD&D Insurance may be subject to reductions in amounts of insurance as stated in the Schedule of Benefits. Reductions become effective on the employee's birthday unless noted otherwise on the group application.

Please refer to the Schedule of Benefits for possible reductions in amounts of insurance for Spouses and Dependents.

Employee Termination

Employee Insurance will terminate on the first of the following dates: termination of the Group Policy. If the employee pays all or part of the premium for his or her coverage, the date the employee fails to make a required premium contribution on or before the end of the grace period; termination of employment; the date the employee is no longer in an eligible class under the group policy.

Spouse/Dependent Termination

The insurance for dependents will terminate on the earliest of the following dates: date the insured employee's insurance ends; tire dale the insured employee's employment ends; the date the person ceases to be a dependent as defined in tire group policy; the dote the coverage or the group policy is terminated.

Evidence of insurability

Evidence of insurability satisfactory to the Company will be required if: (1) The amount of insurance requested exceeds the Guarantee Issue Amount. (2) Any Enrollment or increase is requested more than 31 days after the individual was first eligible.

Bereavement Counseling

Our counseling partner, Health Management Systems of America - a nationally recognized leader in the field of Mental and Behavioral Health Care services, provides this service to all beneficiaries who experience the loss of a loved one. HMSA offers access to a toll-free counseling service supported by professional counselors experienced with the human emotions associated with the death of a loved one.

This proposal

This proposal constitutes Boston Mutual's entire offer of insurance. It is based upon the employee census and other information provided to Boston Mutual. If the enrollment census or any other information provided to Boston Mutual differs from the information upon which the proposal was based, the Company reserves the right to modify or withdraw this offer. Changes to the terms of this proposal may only be made by Boston Mutual and must be communicated in writing.

This summary is intended to provide a brief description of important features of Boston Mutual's group plan. This summary docs not constitute the policy and may not contain all the policy limitations and exclusions. Any discrepancies between this proposal and the policy will be resolved by the wording contained in the policy. State variations to plan design, benefit maximums, and other policy provisions may apply. A sample copy of the policy may be obtained from the Group Sales Representative.

The insurance described in this proposal shall not take effect until Boston Mutual, at its Home Office and prior to the requested effective date, has received the application, enrollment forms, one month's premium and has approved the application for insurance.

Boston Mutual reserves the right to withdraw or revise the terms of this proposal following our review of these materials.

Boston Mutual Life Voluntary Insurance Rates

Employees have the option to purchase additional voluntary life insurance. These rates are fixed rates and will be deducted from the employee's paycheck every month for 10 months (September – June). If the employee wishes to purchase life insurance for spouse and/or children, the employees will need to purchase life insurance for themselves. The employee's life insurance policy should be equal to spouse and/or children life insurance policy or greater than. The life insurance is guaranteed for the first 30 days, the employee will need to qualify for life insurance after the 30 days.

Employee – Coverage in 10k amounts

Age	Rate	10k	20k	30k	40k	50k	60k	70k	80k	90k	100k	110k	120k	130k	140k	150k
0-24	0.05	0.60	1.20	1.80	2.40	3.00	3.60	4.20	4.80	5.40	6.00	6.60	7.20	7.80	8.40	9.00
25-29	0.06	0.72	1.44	2.16	2.88	3.60	4.32	5.04	5.76	6.48	7.20	7.92	8.64	9.36	10.08	10.80
30-34	0.08	0.96	1.92	2.88	3.84	4.80	5.76	6.72	7.68	8.64	9.60	10.56	11.52	12.48	13.44	14.40
35.39	0.09	1.08	2.16	3.24	4.32	5.40	6.48	7.56	8.64	9.72	10.80	11.88	12.96	14.04	15.12	16.20
40-44	0.12	1.44	2.88	4.32	5.76	7.20	8.64	10.08	11.52	12.96	14.40	15.84	17.28	18.72	20.16	21.60
45-49	0.20	2.40	4.80	7.20	9.60	12.00	14.40	16.80	19.20	21.60	24.00	26.40	28.80	31.20	33.60	36.00
S0-5S	0.34	4.08	8.16	12.24	16.32	20.40	24.48	28.56	32.64	36.72	40.80	44.88	48.96	53.04	57.12	61.20
56-59	0.57	6.84	13.68	20.52	27.36	34.20	41.04	47.88	54.72	61.56	68.40	75.24	82 .08	88.92	95.76	102.60
60-64	0.84	10.08	20.16	30.24	40.32	50.40	60.48	70.56	80.64	90.72	100.80	110.88	120.96	131.04	141.12	151.20
65-69	1.41	16.92	33.84	50.76	67.68	84.60	101.52	118.44	135.36	152.28	169.20	186.12	203.04	219.96	236.88	253.80
70-74	2.47	29.64														

Spouse – Coverage in 5k amounts

Age	Rate	5	10	15	20	25
0-24	0.05.	0.30	0.60	0.90	1.20	1.50
25-29	0.06	0.36	0.72	1.08	1.44	1.80
30-34	0.08	0.48	0.96	1.44	1.92	2.40
35.39	0.09	0.54	1.08	1.62	2.16	2.70
40-44	0.12	0.72	1.44	2.16	2.88	3.60
45-49	0.20	1.20	2.40	3.60	4.80	6.00
50-55	0.34	2.04	4.08	6.12	8.16	10.20
56-59	0.57	3.42	6.84	10.26	13.68	17.10
60-64	0.84	5.04	10.08	15.12	20.16	25.20
65-69	1.41	8.46	16.92	25.38	33.84	42.30

Children

Every eligible child has $10,000 life insurance policy from ages 0-19 or 25 if still enrolled in school. The cost for children's life insurance policy is $1.80.

If you have any questions, please contact the Benefits Department

Pajaro Valley Unified School District

Section 125 Flexible Benefits Plan

Interest Form for New Employees

Please mark the appropriate line and/or boxes and return to American Fidelity

- ☐ I would like more Information about pre-taxing my benefits under the Section 125 Plan.
- ☐ I would like information about the following voluntary products.
  - ☐ Cancer Insurance *,+
  - ☐ Accident Insurance*,+
  - ☐ Life Insurance*,**
  - ☐ Permanent, Portable Life Insurance*,**,++
  - ☐ Annuities**
  - ☐ Health Savings Account (must be enrolled onto a H.S.A eligible medical plan)
- ☐ I would like more information on the following reimbursement accounts available through Section 125
  - ☐ Health Flexible Spending Account (Unreimbursed Medical Account) Maximum $2,500/plan year
  - ☐ Dependent Day Care Flexible Spending Account Maximum $5,000/plan year1
- ☐ I am not interested in participating in the Section 125 Plan at this time

*These products may contain limitation, exclusions, and waiting periods.
**Not generally qualified benefits under Section 125 Plans
+**This product is inappropriate for people who are eligible for Medicaid coverage.**
++Underwritten by TX Life Insurance Company
1Maximum $2,500 if you are married and file a separate tax return.

I would like to be contacted by American Fidelity Assurance Company to learn more about American Fidelity's products and services. With my signature below, I understand that a representative will call me to schedule my appointment and/or discuss my benefit options.

Print Name	Signature*	Date
Work Phone	Home Phone	
Job Location	Classified/Certificated/Management	Date of Hire

Central California Branch Office
3649 W. Beechwood Ave., Suite 103
Fresno, CA 93711
866-504-0010 · 559-230-2107
americanfidelity.com

SB-29522-0114

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®