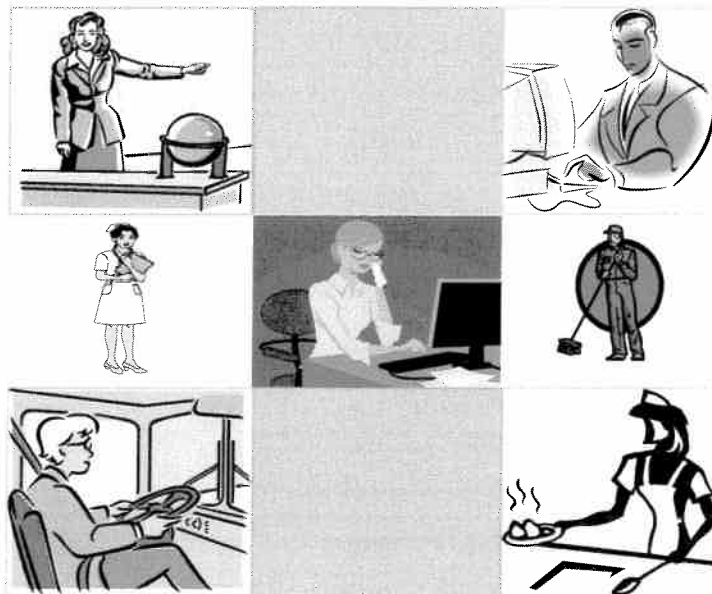


# Employee Benefit



# HANDBOOK

**October 1, 2012 - September 30, 2013**



# **Baldwin Park**

**Unified School District**

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## HEALTH BENEFIT NOTIFICATIONS FOR 2012-2013

### **DISTRICT CONTRIBUTION – DOLLAR ALLOCATION**

The District will combine the tenthly contribution amount for eligible employees. If you qualify, you must contact Business Services directly to set up your account.

### **Eligibility Requirements:**

- Married Couples (full time/part-time) both employed by the District
- Registered Domestic Partners (full time/part-time) both employed by the District

### **RETIREMENT NOTICE**

If you are considering retirement this plan year, please read Administrative Regulation 4154, 4254, 4354 for important eligibility requirements. The Regulation may be found at [www.bpusd.net](http://www.bpusd.net) under *Departments- Business Services- Health Benefit Information*.

### **OVERAGE DEPENDENTS**

One of the amendments to the Health Care Reform provisions contained in H.R. 3590 (enacted on March 23, 2010), the *Patient Protection and Affordable Care Act*, specifies that adult children up to age 26 are eligible to receive coverage, regardless of student status or marital status.

### **DEPENDENT AUDITS**

Baldwin Park Unified School District reserves the right to conduct random audits during the 2012-2013 year to verify eligible dependents listed on any of the district's sponsored group plans.

### **MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, California has a premium assistance program that can help pay for coverage. California uses funds from the Medicaid or CHIP programs to help those people who need assistance. For more information on this program you can contact **1-877-KIDS NOW** or go to [www.insurekidsnow.gov](http://www.insurekidsnow.gov).

### **PLEASE NOTE**

The Health Care Reform Act is very complex and more clarification may be released during the 2012-2013 plan year. As Baldwin Park Unified School District receives further clarification on rules and regulations that affect your coverage/benefits during the plan year, we will provide this information either through newsletters, email blasts, and/or postings on the district's website.



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# Reference Numbers at a Glance

## MEDICAL PLANS:

### Kaiser Permanente

Member Services & Claims .....(800) 464-4000  
Website .....[www.kp.org](http://www.kp.org)

### Blue Shield of California - HMO

Customer Service & Claims .....(800) 424-6521  
Urgent Care ..... Call your Primary Care Physician  
Website ..... [www.blueshieldca.com](http://www.blueshieldca.com)

### Blue Shield of California - Point of Service (POS)

Customer Service & Claims .....(800) 424-6521  
Website ..... [www.blueshieldca.com](http://www.blueshieldca.com)

## DENTAL PLANS:

### DeltaCare USA

Customer Service & Claims .....(800) 422-4234  
DeltaCare Website ..... <http://www.deltadentalins.com/index.html>

### Delta Dental - PPO

Customer Service & Claims .....(866) 499-3001  
Delta Dental Website ..... <http://www.deltadentalins.com/index.html>

## VISION PLANS:

### National Vision Administrators

Customer Service .....(800) 672-7723  
Website ..... [www.e-nva.com](http://www.e-nva.com)

## LIFE INSURANCE:

### Fort Dearborn Life Insurance Company

Customer Service ..... (800) 348-4510

## SECTION 125:

### American Fidelity Assurance Company

Customer Service & Claims .....(800) 325-0654

## OTHER IMPORTANT TELEPHONE NUMBERS:

### American Fidelity Assurance Co.

Customer Service .....(800) 323-3748  
Disability Claims .....(800) 662-1113  
Website ..... [www.americanfidelity.com](http://www.americanfidelity.com)

### Thomas E. Mestmaker Insurance & Associates – Accident / Life / Hospital

(CSEA Members Only) Customer Service Rep.– Belinda Johnson..... (877) 472-6722, Ext. 291

### California Teachers Association (CTA) Life / AD&D Protection – The Standard

Customer Service .....(800) 522-0406

### Pacific Educators – Income Protection / Life / Cancer

Customer Service & Claims.....(800) 722-3365  
Website ..... [www.peinsurance.com](http://www.peinsurance.com)

### ReliaStar (ING)

Customer Service ..... (800) 372-5288, Ext. 0

### Phase II Insurance Services

Customer Service Rep – Bret Griffin..... (800) 540-6369, Ext. 114

### AFLAC

Customer Service Rep. – Joanne Taylor.....(626) 222-2531

### Schools First Federal Credit Union

Tax Sheltered Annuity/403(b) Plans .....(800) 462-8328

### Texas Life

Customer Service .....(800) 283-9233

### Morgan and Franz Insurance Services

.....(909) 980-1194



# Section I

## BPUSD Cafeteria Plan

### INTRODUCTION:

#### BENEFITS THAT WORK FOR YOU

A good benefits program must provide options to meet the varied needs of our employees. Some employees are single, some are married, and many have spouses who also work. Many working parents, both single and married, need to provide day care for their young children. Some employees have medical or dental coverage provided through their spouse's employment, so they may not want to select and pay for such coverage under the District's plan.



Basically, this means that benefit options that are right for one person might not be right for another. In order to address this problem, Baldwin Park Unified School District and your employee representative groups have developed the **Baldwin Park Unified School District Cafeteria Plan**. The *Cafeteria Plan* allows you to tailor your benefit program to meet your own personal and family needs.

#### HOW THE BPUSD CAFETERIA PLAN WORKS

Each month, the District contributes a specific amount of money which may be used to purchase *certain* benefits. This money is called the "District Contribution." The amount of the District Contribution differs depending upon the number of hours you work per day. For the 2012-13 school year, the maximum District Contribution for all active, full-time employees is \$840.00 tenthly or \$8,400.00 annually. Employees working less than 8 hours per day receive a pro-rated contribution amount according to the following schedule.

Note: Adult Education employees should contact the Adult Education Accounting Office for their pro-rated contribution amount.

DAILY ASSIGNMENT		TENTHLY DISTRICT ALLOWANCE
8	hrs per day	\$840.00
7 ½	hrs per day	\$787.50
7	hrs per day	\$735.00
6 ½	hrs per day	\$682.50
6	hrs per day	\$630.00
5 ½	hrs per day	\$577.50
5	hrs per day	\$525.00
4 ½	hrs per day	\$472.50
4	hrs per day	\$420.00
3 ½	hrs per day	\$367.50
3	hrs per day	\$315.00
2 ½	hrs per day	\$262.50
2	hrs per day	\$210.00

Any employee working two (2) or more hours per day may select, in any order, a medical, dental or vision plan. Employees who do not choose to enroll in a District sponsored medical plan will be required to "waive" their health benefit coverage. The next opportunity for employees to enroll will begin during the next open enrollment period with an effective date of October 1<sup>st</sup>.

**It is no longer required that an employee select a medical plan before electing a dental or vision plan!**

- If the combined cost of your medical, dental and vision coverages are **less** than the District Contribution, then there is no out-of-pocket employee expense.
- If the combined cost of your medical, dental and vision coverages are **more** than the District Contribution, the dollar difference will be deducted from the employee's paycheck on a before-tax basis.

This is considered your tenthly payroll **reduction**. Your paycheck will be automatically **reduced** by the amount in excess of the District Contribution. By reducing your paycheck on a before-tax basis, you may actually increase your "take-home pay."

If you do not wish to have your medical, dental and/or vision insurance premiums deducted from your paycheck on a before-tax basis, you may elect to pay



these premiums on an after-tax basis. Please contact fiscal services for further information.

The District Contribution **may not be used** to purchase Cancer Benefits, Income Protection Plans or Life Insurance. If you wish to purchase these benefits, the premium will be automatically **deducted** from your paycheck.

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## ELIGIBILITY

### EMPLOYEE:

All employees working two (2) or more hours per day become eligible for District sponsored benefits on the first day of the month following the completion of eleven (11) working days with paid status.

**Certificated Employees:** District holidays are not considered a working day pursuant to this business rule.

**Classified Employees:** District holidays are considered a working day pursuant to this business rule.

In order to be covered, employees must enroll in the benefit plans within 30 days of their initial eligibility date. **Failure to enroll within the 30 day time limit may result in coverage being denied until the next open enrollment date.** Check with the Business Office for exact late entrant provisions.

### DEPENDENTS:

A Dependent is defined as:

- An employee's lawful spouse/domestic partner;
- An employee's child or step-child:
  - up to age 26, regardless of student status and marital status:
    - Kaiser Permanente
    - Blue Shield (HMO)
    - Blue Shield Point of Service (POS)
  - under age 25, regardless of student status:
    - Delta Dental (PPO)

- An employee's unmarried child or step-child attending school on a full-time basis (*full time student status is considered more than 12 units per semester or may be defined by the school/university attended*):
  - under age 25 if enrolled in:
    - DeltaCare USA
    - NVA Vision Plan
- An employee's legally adopted child, court ordered guardianship of a minor child, or a child for whom adoption proceedings have begun and meets the age requirements of the Plan;
- Employee's unmarried dependent child who is incapable of self-support due to a mental or physical handicap, as long as they suffered the handicap before attainment of the above cited limiting ages. Such individuals must be dependent upon the employee for support and maintenance. Proof of incapacity must be furnished to the carrier as requested;
- Dependent children for whom a Qualified Medical Child Support Order (QMCSO) has been issued in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).

Ex-spouses, parents, parents-in-law, and other relatives are not eligible to participate in medical, dental, and vision plans.

Any dependent coverage, when elected, becomes effective on the date the employee becomes eligible for dependent coverage.

*In order for coverage to become effective, any new dependent spouse or child, must be enrolled in the benefit plans within 30 days of their becoming an eligible dependent.*

If dependent coverage is not elected at the time of the employee's enrollment in the plan, or a new dependent is not reported within 30 days after they become an eligible dependent, coverage may be delayed until the next open enrollment period. Check with the Business Office for exact late entrant procedures. At no time may a dependent be enrolled in benefit plans that the employee is not enrolled in.



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## DOMESTIC PARTNERSHIP:

Baldwin Park Unified School District has adopted the AB 2208 law for its employees. This law affects rights guaranteed to domestic partners with respect to their health plans so that a registered domestic partner has benefits equal to that of an employee's spouse.

Domestic Partnership is defined by California Law and recognized by Baldwin Park Unified School District when the following criteria are met:

- Both persons file a declaration of Domestic Partnership with the Secretary of State
- Both persons have a common residence
- Neither person is married to someone else or is a member of another domestic partnership that has not been terminated
- The two persons are not related by blood
- Both persons are at least 18 years of age
- Both persons are of the same sex
- Both persons are capable of consenting to the domestic partnership

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## QUALIFYING EVENT- Change in Family Status

If the premium for your medical, dental and/or vision plan exceeds the District Contribution amount, the amount in excess is deducted from your paycheck before payroll taxes are assessed. This may translate into tax savings for employees and an increase in take-home pay. In order to qualify for this tax break, the District and you must follow strict IRS guidelines.

Federal tax law states that if you elect to pay your portion of medical, dental and vision premiums on a before-tax basis, *you must continue to pay the same premium amount for the entire Plan Year unless you experience a **qualifying change in family status***. Qualifying changes in family status are strictly defined by the IRS as:

- ☒ Marriage, domestic partnership, divorce, or legal separation,
- ☒ Birth, adoption, or legal guardianship of a child,

- ☒ Death of a spouse or dependent child, or
- ☒ A change in the employment status that results in loss of medical coverage of the employee or spouse such as the termination or commencement of employment or change in eligibility for benefits such as going from part time to full time status or full time to part time status.

**Important Note:** A change in the District's contribution amount that reflects a decrease in the number of hours you work is not a medical qualifying event.

If one of the above occurs, you may change the amount of premium you pay on a before-tax basis. However, the change in premium amount must be consistent with the type of change in family status:

### *Example: DIVORCE*

*Type of consistent change: You may delete a spouse from your plan, but you may not add any new insurance coverage at that time. You must wait for the next Open Enrollment period.*

The District will only allow changes in your payroll deductions if one of the above cited qualifying events occurs.

**If you experience a qualified change in family status during the Plan Year, you must notify the Business Office within 30 days of the date of the qualifying change in family status.**

**You must provide documentation supporting a change in family status (i.e. Marriage, Divorce, etc.)**



# LATE ENROLLMENT RULE

A person **will not** be considered a Late Enrollee if all of the following are met:

- you did not elect Health Coverage for the person involved within 30 days of the date you were first eligible (or during an open enrollment) because at that time:
  - the person was covered under other “creditable coverage” as defined below; and
  - you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:
  - of termination of employment in a class eligible for such coverage;
  - of reduction in hours of employment;
  - your spouse dies;
  - you and your spouse divorce or are legally separated;
  - such coverage was COBRA continuation and such continuation was exhausted; or
  - the other plan terminates due to the employer’s failure to pay the premium or for any other reason; and
- you elect coverage within 30 days of the date the person loses coverage for one of the above reasons.

As used above, “creditable coverage” is a person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees’ Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee as defined, Health Coverage will become effective on the date of the election.

The term Health Coverage includes medical, dental and vision coverages.

## Additional Exceptions to the Late Enrollment Rule

A person **will not** be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 30 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.
- You subsequently acquire a dependent, who meets the definition of a dependent, through marriage/domestic partnership, and you subsequently elect coverage for yourself and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the election.
- You subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the child’s birth, the date of the child’s adoption, or the date the child is placed with you for adoption.
- You and your spouse subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the child’s birth, the date of the child’s adoption, or the date the child is placed with you for adoption, whichever is applicable.

*NOTE: Late Enrollment provisions will not be waived based solely on an increase in your hours worked and/or a raise in the District’s contribution amount. The Late Enrollee provision is only waived if you or your dependent(s) are becoming eligible for District benefits for the first time.*





# Section II

## Employee Benefit Plans

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### MEDICAL BENEFITS

The Baldwin Park Unified School District offers several medical plans to its employees. You choose the one that best meets your health needs and those of your family.

- **HMO Plan Options**

*Blue Shield*

*Kaiser Permanente*

- **Point of Service Plan Option**

*Blue Shield*



*Refer to the spreadsheet included with this handbook for a more detailed description of the benefit options available.*

All of the plans available to employees of Baldwin Park Unified School District provide comprehensive coverage, including treatment by a physician either in or out of a hospital and outpatient prescription drugs. The differences among the plans are: 1) network of physicians and hospitals, 2) amount that you pay for treatment, and 3) premium rates.

- ♦ **A Health Maintenance Organization (HMO)** is an organized system of health care that generally provides a wide range of inpatient and outpatient health care services to their members. Members choose a Primary Care Provider (PCP) from a list of doctors contracted with the HMO. Most medical services are provided to members by their Primary Care Physician. If your Primary Care Physician determines a Specialist is needed, he/she will make a referral to other physicians within the HMO network. It is important to understand that all HMO medical services (inpatient, outpatient and emergency) must be coordinated through your Primary Care Physician. Failure to do so will result in denial of benefits.

HMO's emphasize preventive care such as general physicals, immunizations and wellness programs. Physicians are contracted to provide healthcare services, therefore, out-of-pocket expenses for medical services are kept to a minimum. Services

performed in a doctor's office usually require a co-payment. Most eligible hospital expenses are covered in full. HMO's do not require claim forms, deductibles or coinsurance.

There are two types of HMO's:

- 1) **"Staff" Model or "Group" HMO's** employ physicians that serve on the staff of that HMO and treat patients at facilities owned or contracted by the HMO. Kaiser is an example of this type of HMO. Individuals selecting this type of HMO need not select a Primary Care Physician, however, all medical services must be rendered at an HMO facility owned or contracted by the HMO.
- 2) **Individual Practice Association's (IPA's)** contract with independent physicians or groups of physicians to provide services to HMO members in their own offices. Individuals enrolling in an IPA, must select a participating physician or medical group from a directory provided by the IPA and the member will visit that physician in his/her private medical office. The Blue Shield HMO is an example of this type of HMO.
- 3) Blue Shield's HMO directory or website lists the Primary Care Physicians (PCP's) by City, along with the name of the Medical Group or IPA to which they belong. You should also look at the Participating Physician Group Index which lists all PCP's as well as the affiliated hospitals in each Medical Group or IPA. The directory also has a Specialist Index listing all specialists and identifying the Medical Group or IPA with which they are affiliated. A comparison of each index allows you to determine which hospitals and specialists your PCP would be most likely to use.



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- ♦ **A Point of Service Plan (POS)** incorporates several types of insurance coverage under one plan. In such a plan, members may receive necessary medical treatment from any provider they choose, however, the level of reimbursement, or the amount the insurance company will pay, is determined by the type of provider selected. Generally, there are three types of providers:

- 1) HMO providers, discussed earlier;
- 2) Preferred Providers (PPO Providers) which are comprised of physicians, hospitals, laboratories and pharmacies who have contracted with employers or insurers to provide health care services to members at discounted rates; and
- 3) Out-of-Network or Non-Contracted Providers. These are doctors, hospitals, laboratories and pharmacies that are not contracted with the employer or insurer in any way. Charges for services received from these providers are not discounted and are higher than those received from either an HMO or PPO provider.

Individuals who enroll in a Point of Service plan must select a Primary Care Provider from the HMO network. If they utilize the Primary Care Provider for all necessary services and treatments, the member will receive HMO benefits. However, if the member does not wish to use or coordinate all of their care through the Primary Care Provider, the member may choose another provider not affiliated with the HMO. Treatments received by non-HMO providers, or treatments received by HMO providers which have not been authorized, will result in higher out-of-pocket costs to the member.

A Point-of-Service Plan is really three different insurance plans with three different reimbursement rates and three different benefit levels. Although the plan allows members the freedom to choose the type of care they receive, the type of provider selected at the point of service determines the insurance coverage available. It is important to understand that the type of provider selected not only affects the amount the insurance company will pay, but also the amount of coverage available. Some benefits covered under the HMO

may not be covered, or may be limited in scope, under the PPO or Out-of-Network portions of the Point of Service plan.

For prescriptions, the POS plan uses a formulary (a list of preferred covered drugs). The plan gives you the option of obtaining a non-formulary drug for a higher copayment.

#### **PRESCRIPTION DRUG BENEFIT:**

**Blue Shield** has the same Prescription Drug benefit in both the HMO and POS plans. They have two copayment levels for prescription drugs:

Brand Name Drugs (Formulary):

- \$25 Copayment for a 30-day supply

Generic Drugs:

- \$10 Copayment for a 30-day supply

Mail Order:

- \$20 / \$50 for 90-day supply

**Kaiser** has 2 copayment levels for prescription drugs:

Brand Name Drugs (Formulary):

- \$25 Copayment for a 30-day supply

Generic Drugs:

- \$10 Copayment for a 30-day supply

Mail Order:

- 2 x Copayment for up to 100-day supply



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## CHIROPRACTIC BENEFITS:

The **Blue Shield HMO** plan and the **HMO-tier of the Blue Shield POS** plan include a chiropractic benefit.

Blue Shield Chiropractic Care coverage allows you to self-refer to a network of participating chiropractors. No physician referral required. Benefits are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans).

The plan covers medically-necessary chiropractic services including:

- Initial and subsequent examinations
- Office visits and adjustments (30 visits per calendar year)
- Adjunctive therapies
- X-rays and laboratory tests
- \$50 calendar-year chiropractic appliance benefit as authorized by ASH Plans

All covered services, except the initial examination, are subject to prior authorization from ASH Plans. The copayments and maximums are shown on the plan outlines.

*Chiropractic services are not covered under the PPO or non-network tiers of the Blue Shield POS plan.*

The **Kaiser HMO** plan also includes a chiropractic benefit. Services are covered when a participating chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders. You can obtain services from any American Specialty Health Plans of California, Inc. (ASH Plans) Participating Chiropractor without a referral from a Plan physician.

The plan covers medically-necessary chiropractic services including:

- Office visits and adjustments (30 visits per calendar year)
- X-rays and laboratory tests

- \$50 calendar-year chiropractic appliance benefit prescribed and provided by an ASH Plans Participating Chiropractor

The list of Participating Chiropractors is available on the ASH Plans Website at [www.ashcompanies.com](http://www.ashcompanies.com) or from the ASH Plans Member Services Department at (800) 678-9133.

The list of Participating Chiropractors is subject to change at any time without notice.

## WELLNESS PROGRAMS:

Both Blue Shield and Kaiser offer their members a variety of wellness /health education programs.

Information regarding these programs is available on their websites.



	KAISER HMO		BLUE SHIELD HMO		BLUE SHIELD POINT-OF-SERVICE (POS)	
	DEDUCTIBLE (per individual/per family) :	NONE	NONE	Primary Care Provider NONE	Network Provider NONE	Out-of-Network \$300 Ind. / \$600 Family
1. Outpatient Services Physician Office Visits Access + Specialist (Self-Referral) Preventive Care Physician Home Visits Surgical Procedures Lab & X-Ray	\$15 Copayment \$15 Copayment \$15 Copayment EXCLUDED \$15 Copayment 100%	\$15 Copayment \$30 Copayment 100% \$15 Copayment 100% 100%	\$15 Copayment \$30 Copayment 100% \$15 Copayment 100% 100%	\$15 Copayment N/A 100% \$15 Copayment \$50/Surgery 100%	\$25 Copayment N/A 100% 80% 80% 80%	60% after ded. N/A EXCLUDED 60% after ded. 60% after ded. 60% after ded.
2. Inpatient Services Room & Board Surgical Services Lab & X-Ray Physician Inpatient Visit	100% 100% 100% 100%	100% 100% 100% 100%	100% 100% 100% 100%	100% 100% 100% 100%	80% 80% 80% 80%	60% after ded. 60% after ded. 60% after ded. 60% after ded.
3. Maternity Care: Pre & Post Natal Visits Delivery	100% 100%	100% 100%	100% 100%	100% 100%	80% 80%	60% after ded. 60% after ded.
4. Family Planning: Counseling Vasectomy Tubal Ligation Infertility	\$15 Copayment \$15 Copayment \$15 Copayment	\$15 Copayment \$75 Copayment \$100 Copayment	\$15 Copayment \$75 Copayment \$100 Copayment	100% \$75 Copayment \$100 Copayment	EXCLUDED 50% 50% EXCLUDED	EXCLUDED 50% after ded. 50% after ded. EXCLUDED
5. Emergency Services: At Plan Hospital ER Physician In Service Area Out Service Area Ambulance	\$35 Copayment (waived if admitted) 100% \$35 Copayment (waived if admitted) \$35 Copayment (waived if admitted) 100%	\$35 Copayment (waived if admitted) 100% \$35 Copayment (waived if admitted) \$35 Copayment (waived if admitted) 100%	\$35 Copayment (waived if admitted) 100% \$35 Copayment (waived if admitted) \$35 Copayment (waived if admitted) 100%	\$50/visit (waived if admitted) 100% \$50/visit (waived if admitted) \$50/visit (waived if admitted) \$50 Copayment	\$50/visit (waived if admitted) 80% coinsurance \$50/visit (waived if admitted) \$50/visit (waived if admitted) 80% coinsurance	\$50/visit (waived if admitted) 20% coinsurance \$50/visit (waived if admitted) \$50/visit (waived if admitted) 80% after ded.
6. Mental Health Services* Inpatient Outpatient	100% \$15 Copayment	100% \$15 Copayment	100% \$15 Copayment	100% \$15 Copayment	N/A N/A	60% after ded. 60% after ded.
7. Substance Abuse* Inpatient (IP) Partial Hospital/Day Treatment Outpatient (OP)	100% N/A \$15 Copayment	100% N/A \$15 Copayment	100% \$50 Copayment \$15 Copayment	100% \$50 Copayment \$15 Copayment	N/A N/A N/A	60% after ded. 60% after ded. 60% after ded.
8. Prescription Drugs: Brand Name (Formulary) Generic Mail Order	\$25 Copayment-30 day supply \$10 Copayment-30 day supply 2 x copay for up to 100 day supply	\$25 Copayment-30 day supply \$10 Copayment-30 day supply \$20/\$50 for 90 day supply	\$25 Copayment-30 day supply \$10 Copayment-30 day supply \$20/\$50 for 90 day supply	\$25 Copayment - 30 day supply \$10 Copayment - 30 day supply \$20/\$50 for 90 day supply	\$25 Copayment - 30 day supply \$10 Copayment - 30 day supply \$20/\$50 for 90 day supply	60% after ded. 100 days/yr. 60% after ded. 100 days/yr. 50% of allowed charges EXCLUDED
9. Miscellaneous Services: Skilled Nursing Facility Home Health Care Durable Medical Equipment Chiropractic (ASHP)	100%; 100 days per year 100% 100% \$15 Copay; 30 visits/year	100%; 100 days per year \$15 Copay; 100 visits per year 100% \$10 Copay; 30 visits/year	100%; 100 days per year \$15 Copay; 100 visits per year 100% \$10 Copay; 30 visits/year	100%; 100 days per year \$15 Copay; 100 visits per year 50% of allowed charges \$10 Copay; 30 visits/year	80% - 100 days/yr. 80% - 100 days/yr. 50% of allowed charges EXCLUDED	60% after ded. 100 days/yr. 60% after ded. 100 days/yr. 50% of allowed charges EXCLUDED
10. Vision: Eye Exam Lenses (Standard lenses) Frames (Credit Allowance)	\$15 Copayment EXCLUDED EXCLUDED	\$15 Copayment EXCLUDED EXCLUDED	\$15 Copayment EXCLUDED EXCLUDED	\$15 Copayment EXCLUDED EXCLUDED	EXCLUDED EXCLUDED EXCLUDED	EXCLUDED EXCLUDED EXCLUDED
11. Annual Out-of-Pocket Max: Individual Family	\$1,500 \$3,000	\$1,000 \$2,000	\$1,000 \$2,000	\$1,000 \$2,000	\$2,000 \$4,000	\$5,000 \$10,000
Lifetime Maximum Benefit	N/A	N/A	N/A	N/A	N/A	N/A

\*Under the new Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Mental Health and Substance Abuse will be covered as any other medical condition  
This Benefit Summary is intended as illustrative only. Refer to the Carrier's Evidence of Coverage for details.

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## DENTAL BENEFITS

Baldwin Park Unified School District offers two dental plans which differ in cost, choice of providers and level of benefits. To help you make the best choice for you and your family, we have provided a description of the plans.

**There are two types of dental plans offered:**

- **DeltaCare USA (Prepaid Dental Plan)**
- **Delta Dental PPO (Indemnity)**

A **Prepaid Dental Plan** is similar to an HMO in that members must select a dentist from a list of participating providers. Once selected, this provider is contracted to take care of your dental needs. If your dentist determines a Specialist is needed, he/she will make a referral to other contracted physicians. Like an HMO, once you have selected a dentist, you must receive all dental care services from or through that dentist. Diagnostic & preventive services are covered at no charge to the patient; however, other procedures may require a copayment or coinsurance.

Employees, spouses and dependent children who enroll in the Prepaid Dental Plan are covered for Orthodontia treatment for malocclusion and abnormal tooth positioning. Treatments must be provided by a member of the DeltaCare panel of orthodontics and are subject to a large copayment and start-up fees.

In an **Indemnity Dental Plan**, sometimes referred to as a Reimbursement Plan or Fee for Service Plan, you may choose any Dentist you wish. There is no deductible and the benefit maximum is \$2,500 per covered family member per year.

Various reimbursements apply to different types of services according to the following list:

- 100% Preventive & Diagnostic** procedures include routine oral examinations, prophylaxis (cleanings), bitewing X-rays fluoride treatments, biopsy/tissue examinations, space maintainers, specialist consultations.
- 80% Basic Restorations** include restorations of natural teeth such as fillings, oral surgery, root canals, periodontic (gum) treatment, sealants for children.
- 70% Major procedures** include prosthodontic services such as crowns, inlays, bridges and dentures.

Employees, spouses and dependent children who enroll in the Indemnity Dental Plan are covered for Orthodontia treatment. You may use an orthodontist of your choice under the PPO Indemnity Dental Plan. Orthodontia is covered at 50% to a \$1,000 lifetime maximum.

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<b>DENTAL PLAN OPTIONS</b>	<b>Delta Preferred Option (PPO) In-Network</b>	<b>Delta Preferred Option (PPO) Out-of-Network</b>	<b>DeltaCare Dental HMO Plan 11A</b>
<b>Annual Deductible:</b> Per Individual Family Maximum  <b>Maximum Annual Benefit</b>  <b>Diagnostic &amp; Preventive Procedures:</b> Basic Exam Cleanings (Prophylaxis) Third Cleaning for Pregnancy Fluoride Treatment - to age 18 X-Ray (Bite Wings)  <b>Dental Restorations:</b> Fillings Endodontics Periodontics Crowns  <b>Major Dental Procedures:</b> Bridges Prostodontics Dental Implants  <b>Orthodontia (Adult &amp; Children):</b> Comprehensive	Not Applicable Not Applicable  \$2,500  100% 100% 100% 100% 100%  80% 80% 80% 80%  70% 70% 70%  50% to \$1,000 Lifetime Maximum	Not Applicable Not Applicable  \$2,500  100% 100% 100% 100% 100%  80% 80% 80% 80%  50% 50% 50%  50% to \$1,000 Lifetime Maximum	Not Applicable Not Applicable  Not Applicable  No Copayment No Copayment No Copayment No Copayment No Copayment  No Copayment \$55 - \$250 Copayment \$15 - \$280 Copayment \$50 - \$295 Copayment  \$95 - \$240 Copayment \$120 - \$210 Copayment  \$1,700 - \$1,900 *Additional fees may apply for Orthodontia services

This is a summary only. Please refer to the EOC/Benefit Summary for a more detailed/comprehensive description.



## VISION BENEFITS

The Kaiser and Blue Shield medical plans provide a basic eye exam as a standard medical benefit but not frames and lenses. Members under the Blue Shield plan may self refer to an MES provider. No primary care physician needed.

**NVA/Premier Plus PPO Vision Plan A** is available to employees who wish to supplement their Vision benefits included under the medical plans.



### NVA/PREMIER PLUS PPO VISION PLAN A

	In-Network	Out-of-Network
Plan Year Copay	\$10 copay	N/A
Exam (every 12 mos.)	100% Covered	Reimbursed Amounts Up to \$55
Lenses (every 12 mos.)	Standard Glass or Plastic 100% Covered	Single Vision \$35 Bi-Focal \$65 Tri-Focal \$85 Lenticular \$130 Multifocal \$200
Frames (every 12 mos.)	Up to \$200 Retail Allowance	Up to \$50
Contact Lenses:	(In lieu of Lenses/Frames)	
Elective Contact Lenses (every 12 mos.)	Up to \$100 Retail Allowance**	Up to \$85**
Medically Necessary (every 12 mos.)	100% Covered**+	\$200

**\*\*Includes exam, fitting & lenses**

**+ With pre-approval from NVA**

**Note:** The above comparison is for illustrative purposes only. Actual contract provisions will apply. Please refer to the brochure for exact wording of benefits.



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# FORT DEARBORN GROUP LIFE INSURANCE

The District offers to all full-time and part-time employees Life/AD&D Insurance administered through the Fort Dearborn Life Insurance Company. The District pays for each benefit eligible employee to participate in this group insurance with no out of pocket expense and with no deduction to the district's contribution amount. Exempt employees and substitute employees are excluded.

Employees are automatically enrolled into this benefit after the eleven (11) day business rule has been satisfied. Employees are responsible for completing the Fort Dearborn Beneficiary Form and submitting the signed original to the Business Office. Failure to complete a beneficiary form and have it on file with the school district may result in the employee forfeiting their benefit.

## District Paid Group Life/AD&D Insurance Coverage

Certificated Employees: \$25,000

Classified Employees: \$25,000

Certificated Management Employees: \$50,000

Classified Management Employees: \$50,000



Fort Dearborn Beneficiary Forms and Employee Benefit Booklets can be obtained by stopping by Business Office or by downloading them from the district's website at [www.bpusd.net](http://www.bpusd.net).

For inquiries, contact the Business Office at (626) 856-4451.





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## ANCILLARY VOLUNTARY PRODUCTS

In addition to the core benefits provided by the District, you may purchase additional benefits. These benefits are, but not limited to:

- Life
- Disability
- Accident
- Cancer

As courtesy to Baldwin Park Unified School District employees, we are providing you with the following names and contact numbers of Union endorsed companies:

**American Fidelity**

(800) 323-3748

[www.americanfidelity.com](http://www.americanfidelity.com)

**CSEA Accident/Life/Hospital**

(877) 472-6722 Ext. 59 (ACSA Members Only)

(877) 472-6722 Ext. 60 (CSEA Members Only)

**CTA Income Protection (Teacher Unit only)**

(800) 522-0406

**Pacific Educators**

(800) 722-3365

[www.peinsurance.com](http://www.peinsurance.com)

**ReliaStar (ING)**

(800) 372-5288 Ext. 0

**Phase II**

(800) 540-6369 Ext. 114

[bgriffin@pars.org](mailto:bgriffin@pars.org)

**Texas Life**

(800) 283-9233

[www.texaslife.com](http://www.texaslife.com)

**Aflac**

(626) 222-2531

[Joannetaylor@us.aflac.com](mailto:Joannetaylor@us.aflac.com)

*The purchase of these policies may be elected only during the open enrollment period or upon your eligibility.*



A representative from these companies will explain the policies and their criteria to you. Once your purchase has been made, the premiums for your policy will be deducted from your paycheck.



# Section III

## Section 125 Plan

To provide you with the most cost effective method of purchasing your benefits, the District has adopted a Section 125 plan.

A **Section 125 Plan** allows you, the employee, to select from a list of available benefits that will meet your needs. The benefits that you choose are then paid for through a salary reduction agreement with your employer. Salary reduction means that you may be able to use "*pre-tax*" dollars to pay for certain benefits that you may have previously paid for with "*after-tax*" dollars.

By offering this plan, the District is helping you reduce your taxes and increase your spendable income. The cost saving advantage of the plan is simple. Any benefit costs or insurance premiums you pay under the plan may be eligible to be paid on a pre-tax basis. The

example below illustrates the advantage of the Section 125 Plan in comparison to a plan without the benefits.

The benefits you may purchase under a Section 125 Plan fall into two categories: ***Before tax payroll reduction*** and ***Expense Reimbursement Accounts***.

Under the **Before Tax Payroll Reduction** category, you may elect to pay *premiums* for various insurance products on a pre-tax basis. Some examples of eligible expenses include the contributions you must make for:

- ◆ **Medical Insurance**
- ◆ **Dental Insurance**
- ◆ **Vision Insurance**



### EXAMPLE

	<u>Without Section 125 Plan</u>	<u>With Section 125 Plan</u>
<b>AVERAGE TENTHLY SALARY</b>	<b>\$2,000</b>	<b>\$2,000</b>
<b>BENEFITS (Pre-Tax Payroll Deduction)</b>	--	(250)
<b>TAXABLE EARNINGS:</b>	--	<b>\$1,750</b>
<b>PAYROLL DEDUCTIONS:</b>		
Federal & State Income Taxes (20%)	(\$400)	(\$350)
FICA (7.65%)	(\$153)	(\$134)
Employee Benefits	(\$250)	--
<b>TAKE HOME EARNINGS:</b>	<b>\$1,197</b>	<b>\$1,266</b>
<b>SAVINGS: TENTHLY.....</b>		<b>\$69.00</b>
<b>ANNUAL.....</b>		<b>\$690.00</b>



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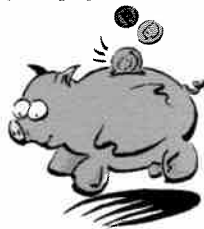
**Expense Reimbursement Accounts** allow you to establish an account to reimburse certain types of expenses on a tax exempt basis. There are two types of reimbursement accounts: **Health Care Reimbursement Accounts** and **Dependent Care Expense Reimbursement Accounts**. Money that you may now spend on Dependent Child Care, medical deductibles or paying for items not covered under the medical plan can be transferred to a tax-free account. That way the cash will be there when you need it, like a savings account that can only be used for medical, dental, vision or dependent care expenses. Since you deposit the money into your Reimbursement Accounts before it is taxed, your take home pay may actually increase. Because the IRS has specific regulations regarding these two items, they will each be discussed in more detail on the following pages.

You should be aware that because these plans enable you to lower your W-2 earnings and, therefore, your taxes, you will also have slightly less deducted for Social Security. Thus, your Social Security benefits will be reduced somewhat. The reduction in benefits is small, however, in comparison to the savings that you might achieve by participating in one or both of the Reimbursement Accounts. It is recommended you seek the advice of a tax preparer to determine if this benefit is right for you.

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## EXPENSE REIMBURSEMENT ACCOUNTS

Expense Reimbursement Accounts are an important way for you to save tax dollars when you pay for health and dependent care. If you answer "yes" to any of the following questions, participating in one or both of the Reimbursement Accounts might save you money.



- ☒ Do you have to pay for child care on a regular basis so that you and your spouse can work or attend school full time?
- ☒ Are you thinking about getting contact lenses or glasses?

- ☒ Do you expect to pay deductibles and copayments under your medical insurance plan?
- ☒ Do you make regular visits to the dentist?
- ☒ Does someone in your family expect to start orthodontia treatment soon?

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## HOW DO THE EXPENSE REIMBURSEMENT ACCOUNTS WORK?

With the Expense Reimbursement Accounts, you set aside money, before taxes are withheld. That money is deposited into an account set up in your name to be paid back to you *tax free* when you file a claim under your Reimbursement Account.

You may choose to participate in either the Health Care Reimbursement Account or the Dependent Care Expense Reimbursement Account or both. You *may not* use funds deposited in the Health Care Reimbursement Account for Dependent Care expenses or vice versa.

These accounts work very much like checking accounts. If you choose to participate, you decide how much you want to deposit in each account. Your deposits are placed into the account, in equal installments, each pay period.

Here's how much you can deposit during the short plan year (October 1 thru August 31):

• **Health Care Reimbursement:**

Minimum Annual Election:	\$0
Maximum Annual Election:	\$3,300

• **Dependent Care Reimbursement:**

Minimum Annual Election:	\$0
Maximum Annual Election:	\$4,583



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## HOW DO I GET REIMBURSED FOR MY QUALIFIED EXPENSES?

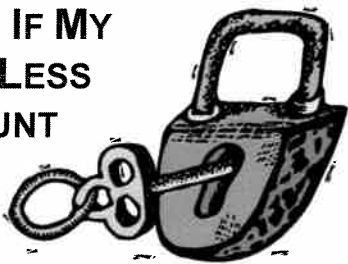
Each month, in which you incur an expense, you may submit a claim form for reimbursement. This claim form must be accompanied by your original receipts or, in the case of a dependent care expense, a dependent care provider acknowledgment form.

The claim for reimbursement forms can be obtained from the American Fidelity website at [www.americanfidelity.com](http://www.americanfidelity.com) or from the Business Office.

The claim form will be processed, and you will be sent a check to reimburse you for expense(s). The dependent care expense check will be for the expense you claimed up to the amount you have in your account. The Health Care reimbursement check will be for the expenses claimed up to the maximum benefit you elected for the year less any expenses previously reimbursed. You may also sign up for direct deposit and receive payment directly to your checking account.

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## WHAT HAPPENS IF MY EXPENSES ARE LESS THAN THE AMOUNT SET ASIDE?



**Any expense dollars not used for qualified expenses are forfeited. This is known as the "use it or lose it" provision of Section 125.**

It is very important that you be conservative and accurate when estimating your expenses for the plan year. You should use the enclosed Reimbursement Account Worksheets to estimate the medical and dependent care expenses for the coming year.

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## MAY I CHANGE MY CONTRIBUTION AMOUNTS DURING THE YEAR?

**Medical Reimbursement Account** – Generally, no changes to the Medical Expense Reimbursement Account are allowed, with the exception of termination.

*Dependent Daycare Account* – You can make an election if (1) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan, (2) the election change is on account of and corresponds with a change in status that affects eligibility of dependent care expense under Section 125 or (3) the election change is on account of and corresponds with a change in cost or change in coverage provided under the employer's plan.

### Some Examples:

- Change in legal marital status
- Change in number of tax dependents
- Change in employment status affecting benefit eligibility of you, spouse or dependent
- Tax dependent satisfies or ceases to satisfy eligibility requirements
- Residence change of you, spouse or dependent affecting your eligibility for coverage

There may be other qualifying events, please call your American Fidelity Representative at (800) 365-9180 or the American Fidelity Flex Department at (800) 325-0654.



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## HEALTH CARE REIMBURSEMENT ACCOUNT

The Health Care Reimbursement Account can benefit you if you have any predictable out-of-pocket medical, dental or vision expenses. Only expenses incurred for you or your dependents during the plan year may be reimbursed.

You can deposit up to \$3,300 in before-tax dollars in your Health Care Reimbursement Account this year. These before-tax dollars may be used to reimburse you for eligible medical expenses including the following:



- Deductibles, copayments and unreimbursed medical expenses under your Medical Plan or another health plan your spouse has through his or her employer.
- Medical, dental and orthodontia expenses not covered under any health plan
- Eye examinations, lenses (including contact lenses) and frames
- Laser Eye Surgery
- Hearing examinations and hearing aids
- Any other expenses allowed as medical deductions by the IRS on your federal tax return that are not reimbursed by any other plan.

Some examples of items that **would not** be considered eligible for reimbursement include the following:

- Non-medical expenses such as electronic air filters and hot tubs unless prescribed by a physician

- Cosmetic surgery
- Teeth Whitening

**Expenses for which you have been reimbursed from your Health Care Reimbursement Account cannot be claimed as an itemized deduction on your federal income tax return**, but keep in mind your medical and dental expenses may be deducted from your federal income tax return only if they total 7.5% or more of your income. Since few people's medical expenses reach that high a percentage, most find the Health Care Reimbursement Account works to their best tax advantage. Even if you expect your medical expenses to be large enough to be deducted, you may find this Account saves you more on taxes.

The following is a list of eligible expenses. Some of these are covered under one or more of your insurance plans and thus, would not be eligible for reimbursement. To determine if this account is right for you, identify which non-reimbursable expenses you are likely to incur during the upcoming year. If the amount is less than 7.5% of your income, this may be an option for you.

**Eligible expenses are those allowed by the IRS under Section 213(d). For a complete list contact your local IRS office and request a copy of IRS Publication 502. You can also visit their website at [www.irs.gov](http://www.irs.gov).**



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# Important Changes To Your Unreimbursed Medical Expense Account

By now, most everyone is aware of the recent passage of the health care reform law (Affordable Care Act). Included in the law are some new requirements that will affect your Unreimbursed Medical Expense Account. Below is an overview of these requirements and when the changes will be implemented.

## OVER-THE-COUNTER DRUGS AND MEDICINES

*Effective January 1, 2011, in order to be reimbursed for over-the-counter drugs and medicines purchased on or after this date, the participant must provide a medical practitioner's prescription for the item(s).*

American Fidelity will require a new prescription be submitted as they will not be able to use any information that may have been previously provided (doctor's statements will no longer be accepted). The prescription must be legible and will be valid for one year from the date of issue. It must include the same information as required for a drug or medicine that is available by prescription only.

This normally includes:

1. The name and address of the patient;
2. The name and quantity of the drug prescribed and directions for use;
3. The date of issue;
4. The name, address, and phone number of the prescriber, his or her license classification, and his or her federal registry number;
5. A description of the condition for which the drug is being prescribed;
6. The signature of the medical practitioner issuing the order.

Items that do not fall into the category of drug or medicine, such as bandages, reading glasses, sunscreen (SPF 30 or above), hot/cold packs, hearing aid batteries, etc. will require a cash register receipt.

The new law does not affect eligible medical expenses that are not considered over-the-counter, such as prescription drugs, co-pays, deductibles, prescription eyeglasses or contact lenses, orthodontia, etc.



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## DEPENDENT CARE REIMBURSEMENT ACCOUNT

Childcare and costs for the care of dependent adults unable to care for themselves are very predictable. You probably know what those costs will be for each year. That predictability helps you determine how much to put into your Dependent Care Expense Reimbursement Account. The Dependent Care Account works in much the same way as the Health Care Account, but it is a completely separate account with its own provisions and procedures.



You decide how much you want to deposit in your Dependent Care Expense Reimbursement Account -- up to \$4,583 this year.

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### ELIGIBILITY

- The care must be necessary in order for you and your spouse (if married) to work or attend school full time.
- The amount to be reimbursed must not be greater than your annual earnings or your spouse's, whichever is lower.
- If your spouse is a full-time student or is mentally or physically incapacitated.

**If the dependent is a *child* the following rules apply:**

- He or she must be younger than 13 and dependent upon you for at least 50% of his or her financial support.
- Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent for income tax purposes, such as one of your older children or family member.
- The daycare must be a fully licensed facility and provide a tax identification number.

**If the dependent is an *adult* the following rules apply:**

- He or she must be physically or mentally incapable of caring for himself or herself.
- He or she must be dependent upon you for at least 50% of his or her financial support.
- Care may be provided either inside or outside your home; however, expenses outside your home (such as adult day care) are eligible only if the dependent regularly spends at least eight hours each day in your household.

For dependent care expenses, the IRS requires that you identify the provider of dependent care. When identifying the provider, you must include the provider's name, address and taxpayer identification number (TIN). Submit this information when you send in your voucher for reimbursement.

### DEPENDENT CARE ELIGIBLE EXPENSES:

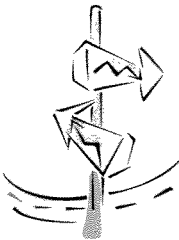
**The following is a partial list of eligible expenses. For a complete list contact your local IRS office and request a copy of IRS Publication 503. You can also visit their website at [www.irs.gov](http://www.irs.gov).**



Eligible for Reimbursement	NOT Eligible for Reimbursement
> At-home day-care provider(s)	> Overnight camps
> Properly licensed day-care centers	> Baby-sitting so you can attend a social event
> Nursery Schools	> Food and education expenses for a child in the 1st grade or higher
> Preschools	> Payment for dependent health care expenses

## DEPENDENT CARE VS. FEDERAL INCOME TAX CREDIT

You may want to compare the tax advantages of using the Dependent Care Expense Account against those of taking a tax credit on your IRS tax return. In some instances, you may be better off taking a federal tax credit. Tax savings can vary based on your income, filing status, expenses, and number of dependents. You cannot submit the same expenses to both, so compare.



## CLAIM REIMBURSEMENT FOR DEPENDENT CARE

Unlike the health care reimbursement accounts, the reimbursement for dependent care expenses cannot be more than the employee has contributed to date. The employee cannot have a negative balance in their dependent care accounts.

At the beginning of the plan year, an employee will have to have the amount taken out of their paycheck, pay their dependent care provider and then get reimbursed through the plan. This may result in a “double hit” during the first month, when the money is subtracted from your paycheck at the same time you have to pay your dependent care provider.

### *You should consider that:*

- Your eligible dependent care expenses are the same expenses as those that qualify for a credit on your Federal income tax return.
- You may not take a tax credit on your income tax return for expenses paid through your Expense Reimbursement Account. In fact, each dollar you place in the Dependent Care Expense Reimbursement Account reduces the amount you can claim for a tax credit by one dollar.

*To help you decide if the tax credit offers you a greater tax advantage than the Reimbursement Account, consult your tax advisor.*





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## IMPORTANT GUIDELINES FOR ENROLLMENT IN AN EXPENSE REIMBURSEMENT ACCOUNT

1. Be sure that the amount set aside is conservative—amounts not used for qualified expenses cannot be carried over or returned to you.
2. You cannot switch dollars between the dependent care and health care accounts. The dollars must be used in each account as specified on your election form.
3. You cannot be reimbursed for these expenses from any other source.
4. All expenses must be incurred in the plan year in which your contributions are made.
5. Dependent care expenses or medical expenses reimbursed under the plan cannot be claimed for income tax purposes.
6. You have a 70 day grace period at the end of the plan year to request reimbursement for expenses you incurred during the plan year.



**Please contact our Section 125 Provider, *American Fidelity*, at (800) 325-0654**

### Exceptions for “Short” Plan Year 2012 - 2013

The current plan year will start October 1, 2012 and end August 31, 2013 which will only allow for nine (9) deductions this plan year. The amounts available for each plan are as follows:

- Medical Reimbursement Account – Minimum \$0 – Maximum \$3,300
- Dependent Daycare Account – Minimum \$0 – Maximum \$4,583

This exception is necessary to keep our district plan in compliance with IRS guidelines for the 2012-2013 plan year. We will return to 10 deductions next plan year. If you have any questions regarding these changes and how it can affect your account please contact your American Fidelity Representative at (800) 365-9180 or the American Fidelity Flex Account Department at (800) 325-0654.

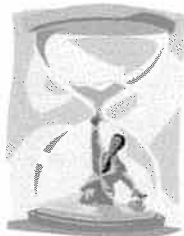


# Section IV

## Benefit Plan Provisions

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### COBRA— CONTINUATION OF COVERAGE



A Federal Law referred to as “COBRA” requires that employees and their families be offered the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates when coverage under the plan would otherwise end. This notice is intended to inform you in a summary fashion of your rights and obligations under the continuation coverage provisions of the law. *Both you and your spouse should read this notice carefully.*

The right to continue coverage applies only to Medical, Dental and Vision benefits. Continued coverage will be exactly the same coverage as you or your dependents would have been entitled to if your status had not changed. Any future change in premiums and benefits including open enrollment options will apply to you and/or your dependents. A continuation option does not apply to life insurance. Life insurance, however, may be converted to an individual policy. Contact your insurance carrier for details and Life conversion rates and applications.

If you do not elect to continue any of the available coverages under COBRA, your group Medical, Dental and Vision benefits will end on the last day as determined by the eleven (11) day business rule or retiree date of separation from the district. Call the Business Office for more information.

Employees may elect to continue coverage for themselves and/or their covered dependents at their own expense for up to eighteen (18) months if coverage ends due to either:

- a) a reduction in the number of hours worked by the employee that does not meet benefit eligibility; or
- b) termination of employment of the employee for any reason other than gross misconduct.

If you are the spouse of an employee covered by the Plan, you have the right to continue coverage up to thirty-six (36) months for yourself if you lose group health coverage under the Plan for any of the following reasons:

- 1) The death of your spouse; or
- 2) Divorce or legal separation from your spouse; or
- 3) Your spouse becomes entitled to Medicare benefits; or
- 4) Your spouse's employer files for Chapter 11 re-organization.

In the case of a dependent child of an employee covered by the Plan, he or she has the right to continue coverage up to thirty-six (36) months if group health coverage under the Plan is lost for any of the following reasons:

- 1) The death of a parent; or
- 2) Parents' divorce or legal separation; or
- 3) A parent becomes entitled to Medicare benefits; or
- 4) The dependent ceases to be a “dependent child” under the Plan;
- 5) The parent's employer files for Chapter 11 re-organization.

If an individual is disabled and becomes entitled to Social Security Disability benefits, medical benefits may be continued up to twenty-nine (29) months at which time the individual becomes eligible for Medicare. The Social Security Administration must determine the qualified beneficiary is disabled any time during the first 60 days of “continuation coverage”. The qualified beneficiary must notify Baldwin Park Unified School District within 60 days after determination of disability is made by Social



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Security and within the 18-month period of continuation coverage. Premiums from the nineteenth (19th) through the twenty-ninth (29th) months will be 150% of the applicable premium.

If, during the first eighteen (18) months of continuation coverage another event takes place that also entitles you to coverage, coverage may be extended. In no case may the total amount of continued coverage be more than thirty-six (36) months. At the end of the eighteen (18) month, twenty-ninth (29) month or thirty-six (36) month continuation coverage period, you must also be allowed to enroll in an individual conversion health plan, if one is available.

*The employee or a family member has the responsibility to inform Baldwin Park Unified School District of a divorce, legal separation, or a child losing dependent status within 60 days of the qualifying event. Baldwin Park Unified School District has the responsibility to notify the employee or spouse of eligibility due to the employee's death, termination of employment or reduction in hours, or Medicare eligibility.*

An employee may elect continuation coverage for him/herself and any previously covered dependents. Should you decline coverage for yourself, your previously covered spouse and any covered dependents must also review the election forms and decide whether to elect or decline continuation coverage.

Continuation of coverage must be requested **within 60 days** following the date you would lose coverage because of one of the events described above. Unless you and your dependents elect to continue coverage by returning an executed enrollment form within 60 days, you will be excluded under the Plan and will be responsible for the costs of any medical, dental or vision treatment received after the date coverage ends.

Coverage will continue for the time periods specified above or until:

- You become a covered employee under any group health plan; unless the other group coverage is limited with respect to, or excludes certain conditions; or

- You or your dependent(s) become eligible for Medicare; or
- You fail to pay the monthly charge for this coverage in a timely fashion; or
- Baldwin Park Unified School District no longer provides health coverage to any of its employees.

You must pay premiums retroactively for the period between the termination date and the date when you commence the payment of premiums within 45 days of electing coverage. Subsequent monthly premiums are due on or before the first day of each month. **If your premium payment is not received within thirty (30) days of the due date, your coverage will be terminated as of the due date.**

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## AB1401 CAL-COBRA EXTENSION

Once your Federal COBRA has expired, you may have the right to enroll in Cal-COBRA, which could extend your medical coverage up to an additional 18 months. Total coverage period for Federal COBRA and Cal-COBRA will not exceed 36 months from the date of the original Qualifying Event. Please call your medical carrier 30 days prior to the termination of your Federal COBRA for Cal-COBRA information.

## FAMILY MEDICAL LEAVE ACT (FMLA)

Employees who qualify for Family Medical Leave under the Family Medical Leave Act of 1993, will remain eligible for District sponsored benefits under the same terms and conditions in force prior to their leave. Leave may be taken all at once or intermittently and needs to be discussed with the District at least 30 days (or as soon as reasonably possible) before the leave is to be taken. *In order to ensure you receive all of the benefits you are entitled to, it is important that you contact the Human Resources Office for the exact terms, conditions and requirements pertaining to any leave of absence.*



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## HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

### IMPORTANT NOTICE OF YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE

Recent changes in Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 180 days. The 180 days exclusion period is reduced by your prior health coverage. To show evidence of your prior health coverage, you are entitled to receive a certificate of creditable coverage from your health plan. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. Contact the State insurance department for further information.

You have the right to receive a certificate of credible health coverage since July 1, 1996. When you terminate, lose or change your health insurance coverage, please check with your new plan administrator to see if the new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage.

To obtain a certificate from either Kaiser or Blue Shield for you or your dependent, contact the Business Office. The certificate must be provided to you promptly. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

## QUESTIONS AND ANSWERS ON HIPAA

### 1. What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a complex federal regulatory effort that has many parts and purposes. One part of HIPAA called Administrative Simplification concerns standards for health care administration and the transmission of health information. Most important, HIPAA focuses on the privacy and security of your health information.

### 3. How does the HIPAA Privacy Rule affect me?

Although there are already state and other federal laws covering health care organizations, the HIPAA Privacy Rule creates a comprehensive minimum federal standard for the use and disclosure of protected health information by these organizations. The HIPAA Privacy Rule also grants some new rights and protections to you as a health care consumer. For example, HIPAA gives you the right to receive a Notice of Privacy Practices from covered health organizations like Kaiser Permanente. You can find out more about your rights and our obligations concerning your protected health information by reviewing your Notice.

These new privacy regulations took effect April 14, 2003.



