CSU The California State University

CSU Benefits Open Enrollment

SEPTEMBER 16 to OCTOBER 11, 2013

My Benefits

Your benefits can make a difference in your health, wellness and lifestyle. Open enrollment is your once-a-year opportunity to learn about new offerings and to make additions, changes or deletions to your benefits, which will be effective January 1, 2014.

The CSU partners with the California Public Employees' Retirement System (CalPERS) to provide your health and retirement benefits. CalPERS manages pension and health benefits for more than 1.6 million public employees, retirees and their families and more than 3,000 employers.

What's new this year:

MORE CHOICES:
Four new HMO options are available in 2014 from Anthem Blue Cross, Health Net, Sharp and UnitedHealthcare.

SOME COST REDUCTIONS:
Premiums have gone down on certain existing plans and risen on others.

New and existing plans are briefly described in this brochure. Check the information packet mailed by CalPERS for full details on health plans.

For comprehensive, up-to-date information, visit:
https://csyou.calstate.edu/Employee-Resources/Benefits/open-enrollment/

My **Health**

Health Plans

The CalPERS website can help you understand and select the best health plan for your needs:
www.calpers.ca.gov/index.jsp?bc=/member/health/open-enroll/home.xml

Before you begin, it's important to understand the different plans and terminology:

HMO—Health Maintenance Organization
Requires you to receive care through a network of providers. You must select a primary care physician, who is responsible for coordinating your health care, including referrals to specialists.

PPO—Preferred Provider Organization
Lets you choose from a network of preferred providers. A primary care physician is not required and no referrals are necessary for other in-network providers. You pay more to use an out-of-network provider. Members of PPO plans are also subject to an annual deductible.

EPO—Exclusive Provider Organization
Offers in-network coverage only. You must select in-network providers when seeking medical care, but a primary care physician and referrals are not required.

New Plans for 2014

HMOs	**Anthem Blue Cross Traditional HMO and Anthem Blue Cross Select HMO California** www.anthem.com/ca/calpershmo/ (855) 839-4524	• Dedicated to delivering quality care and great value • Both plans offer 360° Health, a program that helps members become involved in their health and wellness
	Health Net Salud y Mas and Health Net SmartCare www.healthnet.com/portal/member/content/iwc/mysites/calpers/home.action (888) 926-4921	• Budget-friendly HMO plans with a tailored list of quality providers for selected California counties • Ideal for employees who want one primary care physician to coordinate all their medical care
	Sharp Performance Plus California www.sharphealthplan.com/index.php/calpers/ (855) 995-5004	• Local HMO plan serving residents of San Diego • Commitment to healthcare delivered in a convenient and cost-effective manner
	UnitedHealthcare Alliance HMO http://calpers.welcometouhc.com/ (877) 359-3714	• Quality patient-centered healthcare at lower costs • Distinct network of providers offers collaborative care and health management

Existing Plans for 2014

PPOs

PERS Choice and PERS Care PPOs
www.anthem.com/ca/calpers
877-737-7776

- Choose your health care providers and pharmacy without referral
- Offers significant savings through a preferred provider network (doctors and hospitals that agree to charge a pre-negotiated rate for everyone on the plan)
- PERS Choice pays 80 percent of the allowable amount (in-network), member pays 20 percent; co-pays are applicable
- PERS Care pays 90 percent of the allowable amount (in-network), member pays 10 percent; co-pays are applicable

PERS Select PPO
www.anthem.com/ca
877-737-7776

- Offers a unique, affordable plan design
- Access to a list of preferred providers through the PERS Select network

PORAC PPO
Limited to dues paying members of the Peace Officers Research Association of California
http://porac.org/insurance-and-benefits/prudent-buyer-plan/
877-542-0284

- Choose your health care providers and pharmacy without referral
- Offers significant savings through a preferred provider network

HMOs

Blue Shield Access+ HMO
www.blueshieldca.com/sites/calpersmember/home.sp
800-334-5847

- Access to more than 11,000 personal physicians and 300 hospitals
- No annual deductible; copayment at each physician visit

Blue Shield NetValue HMO
www.blueshieldca.com/sites/calpersmember/home.sp
800-334-5847

- Comprehensive benefits through the Blue Shield NetValue network
- No annual deductible; copayment at each physician visit

Blue Shield EPO *Available only in Colusa, Mendocino and Sierra counties*
www.blueshieldca.com/sites/calpersmember/plans-benefits/home.sp
800-334-5847

- Same benefits as Access+ HMO plan
- Choose from physicians and hospitals in the PPO network

Kaiser Permanente California
http://my.kaiserpermanente.org/ca/calpers/
800-464-4000

- Integrated health care system
- No annual deductible, affordable copayment at each physician visit

WAIVE COVERAGAE

Flexcash *Must complete and submit Flexcash Enrollment form to Benefits Office*

CSU Stanislaus, Benefits Office
MSR 340
(209) 664-6730
http://www.csustan.edu/HR/Employee_Benefits/HealthCare/HealthCare-Medical.html

- May waive health and/or dental when employee has other non-CSU coverage
- Cash in lieu of health enrollment per month: $128.00
- Cash in lieu of health enrollment per month: $12.00

Did You **Know?**

Significant health benefits can be obtained by 30 minutes of physical activity 5 or more days per week.

My Choice

Lots of options means lots of choice.

During Open Enrollment, you can enroll, change or cancel CalPERS health, dental, HCRA, DCRA, and the MetLaw plan. You can enroll in the other voluntary plans throughout the year.

Additional CSU Benefit Plans

DENTAL	
Delta Dental PPO www.deltadentalins.com/csu/ 888-335-8227	• Choose a dentist from Delta Dental PPO, Premier Networks or a non-Delta dentist • Plan pays up to applicable percentage for covered services up to annual maximum
DeltaCare USA www.deltadentalins.com/csu/ 800-422-4234	• Choose a dentist from the DeltaCare USA network • No claim forms to complete; no maximum or deductibles apply
FLEXIBLE SPENDING ACCOUNTS	
ASI Flex www.asiflex.com/ 800-659-3035	Health Care Reimbursement Account (HCRA) and Dependent Care Reimbursement Account (DCRA) Pay for qualified medical or dependent care expenses pre-tax. Enrollment is required each year. HCRA maximum is $2,500 per year and a debit card is available. DCRA maximum is $5,000 per year. Funds must be used during 2014 or the 2½ month grace period in 2015.
LEGAL SERVICES	
MetLaw Legal Plan https://mybenefits.metlife.com 800-438-6388	Managed by MetLife Easy, low-cost access to a variety of personal legal services.
INSURANCE OFFERINGS	
AFLAC (Group Critical Illness) www.aflac.com/csu 800-433-3036	Critical illness insurance provides payments for certain wellness exams, and a cash benefit if you're diagnosed or treated for a covered critical illness.
Standard Insurance www.standard.com/mybenefits/csu 800-378-5745 for general questions	Employer Paid and Voluntary Life (includes Life Services Toolkit), AD&D and Long Term Disability Insurance
California Casualty www.calcas.com/csu 866-680-5143	Auto and Home Insurance

Your benefits office is an important resource for information about health plans, and the rich array of other benefits available to you as an employee. Contact your benefits office to determine eligibility for plans mentioned on this brochure.

Benefits Office Contact: Rose Jones, Benefits Coordinator

Location: MSR 340 Phone: (209) 664-6730 Email: rjones4@csustan.edu

CSU The California State University

2014 CalPERS Health Benefits Program

BASIC PLAN RATES

HEALTH PLAN	Enrolled Employee and Eligible Dependents	Plan Number	Total Monthly Premium	All Employee Groups (except Unit 6)		Unit 6	
				Amount Paid by CSU	Amount Paid by Employee	Amount Paid by CSU	Amount Paid by Employee
Anthem Blue Cross Select HMO California www.anthem.com/ca/calpershmo/ (855) 839-4524	Employee Only Employee + 1 Dependent Employee + 2 or more	181	$622.53 $1,245.06 $1,618.58	$622.53 $1,218.00 $1,559.00	**$0.00** **$27.06** **$59.58**	$622.53 $1,228.00 $1,579.00	**$0.00** **$17.06** **$39.58**
Anthem Blue Cross Traditional HMO California www.anthem.com/ca/calpershmo/ (855) 839-4524	Employee Only Employee + 1 Dependent Employee + 2 or more	180	$670.36 $1,340.72 $1,742.94	$642.00 $1,218.00 $1,559.00	**$28.36** **$122.72** **$183.94**	$647.00 $1,228.00 $1,579.00	**$23.36** **$112.72** **$163.94**
Blue Shield Access + California HMO www.blueshieldca.com/sites/calpersmember/home.sp 800-334-5847	Employee Only Employee + 1 Dependent Employee + 2 or more	141	$655.02 $1,310.04 $1,703.05	$642.00 $1,218.00 $1,559.00	**$13.02** **$92.04** **$144.05**	$647.00 $1,228.00 $1,579.00	**$8.02** **$82.04** **$124.05**
Blue Shield Access + EPO California **(Restricted to Colusa, Mendocino & Sierra Counties)** www.blueshieldca.com/sites/calpersmember/plans-benefits/home.sp 800-334-5847	Employee Only Employee + 1 Dependent Employee + 2 or more	191	$655.02 $1,310.04 $1,703.05	$642.00 $1,218.00 $1,559.00	**$13.02** **$92.04** **$144.05**	$647.00 $1,228.00 $1,579.00	**$8.02** **$82.04** **$124.05**
Blue Shield NetValue HMO www.blueshieldca.com/sites/calpersmember/home.sp 800-334-5847	Employee Only Employee + 1 Dependent Employee + 2 or more	042	$575.78 $1,151.56 $1,497.03	$575.78 $1,151.56 $1,497.03	**$0.00** **$0.00** **$0.00**	$575.78 $1,151.56 $1,497.03	**$0.00** **$0.00** **$0.00**
Health Net Salud y Mas California www.healthnet.com/portal/member/content/iwc/mysites/calpers/home.action (888) 926-4921	Employee Only Employee + 1 Dependent Employee + 2 or more	184	$515.87 $1,031.74 $1,341.26	$515.87 $1,031.74 $1,341.26	**$0.00** **$0.00** **$0.00**	$515.87 $1,031.74 $1,341.26	**$0.00** **$0.00** **$0.00**
Health Net SmartCare California www.healthnet.com/portal/member/content/iwc/mysites/calpers/home.action (888) 926-4921	Employee Only Employee + 1 Dependent Employee + 2 or more	185	$632.38 $1,264.76 $1,644.19	$632.38 $1,218.00 $1,559.00	**$0.00** **$46.76** **$85.19**	$632.38 $1,228.00 $1,579.00	**$0.00** **$36.76** **$65.19**

CSU The California State University

2014 CalPERS Health Benefits Program

BASIC PLAN RATES

HEALTH PLAN	Enrolled Employee and Eligible Dependents	Plan Number	Total Monthly Premium	All Employee Groups (except Unit 6)		Unit 6	
				Amount Paid by CSU	Amount Paid by Employee	Amount Paid by CSU	Amount Paid by Employee
Kaiser Permanente California http://my.kaiserpermanente.org/ca/calpers/ 800-464-4000	Employee Only Employee + 1 Dependent Employee + 2 or more	056	$661.61 $1,323.22 $1,720.19	$642.00 $1,218.00 $1,559.00	**$19.61** **$105.22** **$161.19**	$647.00 $1,228.00 $1,579.00	**$14.61** **$95.22** **$141.19**
Kaiser Permanente - Out of State http://my.kaiserpermanente.org/ca/calpers/ 800-464-4000	Employee Only Employee + 1 Dependent Employee + 2 or more	Codes vary by region	$917.20 $1,834.40 $2,384.72	$642.00 $1,218.00 $1,559.00	**$275.20** **$616.40** **$825.72**	$647.00 $1,228.00 $1,579.00	**$270.20** **$606.40** **$805.72**
PERS Care PPO www.anthem.com/ca/calpers 877-737-7776	Employee Only Employee + 1 Dependent Employee + 2 or more	278	$698.73 $1,397.46 $1,816.70	$642.00 $1,218.00 $1,559.00	**$56.73** **$179.46** **$257.70**	$647.00 $1,228.00 $1,579.00	**$51.73** **$169.46** **$237.70**
PERS Choice PPO www.anthem.com/ca/calpers 877-737-7776	Employee Only Employee + 1 Dependent Employee + 2 or more	222	$643.53 $1,287.06 $1,673.18	$642.00 $1,218.00 $1,559.00	**$1.53** **$69.06** **$114.18**	$643.53 $1,228.00 $1,579.00	**$0.00** **$59.06** **$94.18**
PERS Select PPO www.anthem.com/ca 877-737-7776	Employee Only Employee + 1 Dependent Employee + 2 or more	045	$594.95 $1,189.90 $1,546.87	$594.95 $1,189.90 $1,546.87	**$0.00** **$0.00** **$0.00**	$594.95 $1,189.90 $1,546.87	**$0.00** **$0.00** **$0.00**
PORAC PPO *Limited to dues paying members of the Peace Officers Research Assn of CA* http://porac.org/insurance-and-benefits/prudent-buyer-plan/ 877-542-0284	Employee Only Employee + 1 Dependent Employee + 2 or more	207	$634.00 $1,186.00 $1,507.00	$634.00 $1,186.00 $1,507.00	**$0.00** **$0.00** **$0.00**	N/A	**N/A**
Sharp Performance Plus California **(Restricted to San Diego County)** www.sharphealthplan.com/index.php/calpers/ (855) 995-5004	Employee Only Employee + 1 Dependent Employee + 2 or more	189	$562.14 $1,124.28 $1,461.56	$562.14 $1,124.28 $1,461.56	**$0.00** **$0.00** **$0.00**	$562.14 $1,124.28 $1,461.56	**$0.00** **$0.00** **$0.00**
UnitedHealthcare Alliance HMO California http://calpers.welcometouhc.com/ (877) 359-3714	Employee Only Employee + 1 Dependent Employee + 2 or more	187	$652.08 $1,304.16 $1,695.41	$642.00 $1,218.00 $1,559.00	**$10.08** **$86.16** **$136.41**	$647.00 $1,228.00 $1,579.00	**$5.08** **$76.16** **$116.41**

*This plan is restricted to employees in Unit 8, State University Police Association (SUPA) and requires membership.

Revised 8/26/2013

CSU The California State University

CSU VOLUNTARY LIFE, LONG TERM DISABILITY AND AD&D INSURANCE
2014 RATES

VOLUNTARY LIFE INSURANCE

Age Bracket	Employee Rate	Spouse/Registered Domestic Partner Rate	Coverage Amount Children Only	Monthly Amount/ Children
<25	$0.06	$0.05	$5,000	$0.69/month
25-29	$0.06	$0.05	$10,000	$1.38/month
30-34	$0.08	$0.07	$20,000	$2.75/month
35-39	$0.09	$0.09		
40-44	$0.10	$0.14		
45-49	$0.18	$0.24		
50-54	$0.30	$0.37		
55-59	$0.53	$0.64		
60-64	$0.66	$0.67		
65-69	$1.27	$1.17		
70-74	$2.06	$1.74		
75+	$2.06	$2.05		

Monthly rates based on cost per $1,000 of coverage. Eligible employees may apply for insurance coverage for themselves and spouses/registered domestic partners in increments of $10,000 from $10,000 to $200,000.
Refer to The Standard website, www.standard.com/mybenefits/csu, for increments in larger sums and specific criteria.

VOLUNTARY LONG TERM DISABILITY

Age Bracket	Employee Rate (30-day elimination period)		Age Bracket	Employee Rate (90-day elimination period)
0-24	$0.25		0-24	$0.10
25-29	$0.28		25-29	$0.11
30-34	$0.30		30-34	$0.13
35-39	$0.33		35-39	$0.18
40-44	$0.45		40-44	$0.23
45-49	$0.60		45-49	$0.35
50-54	$0.73		50-54	$0.50
55-59	$0.93		55-59	$0.63
60-64	$0.95		60-64	$0.67
65-69	$0.98		65-69	$0.70
70+	$1.53		70+	$1.13

Monthly rates based on cost per $100 of coverage.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

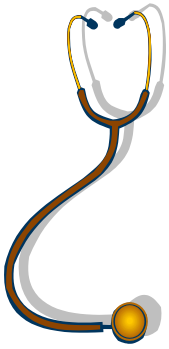
Employee Rate	Employee & Dependents
$0.019	$0.029

Monthly rates based on cost per $1,000 of coverage.

Example to calculate monthly rate: _____ (amount of coverage) ÷ $1,000 ×_____ (rate) = monthly cost

Voluntary Life, Long Term Disability and AD&D insurance plans are offered by The Standard. For more information and/or to enroll, refer to The Standard website, www.standard.com/mybenefits/csu. The voluntary benefit plans are available to CSU benefits eligible employees. Premiums for voluntary benefit plans are fully paid by the employee; CSU does not contribute.

Human Resources Benefits Fair



Thursday, September 26, 2013
Mary Stuart Rogers (MSR) 130
9:00 a.m. - 1:00 p.m.

(Registration is not required – just drop in)

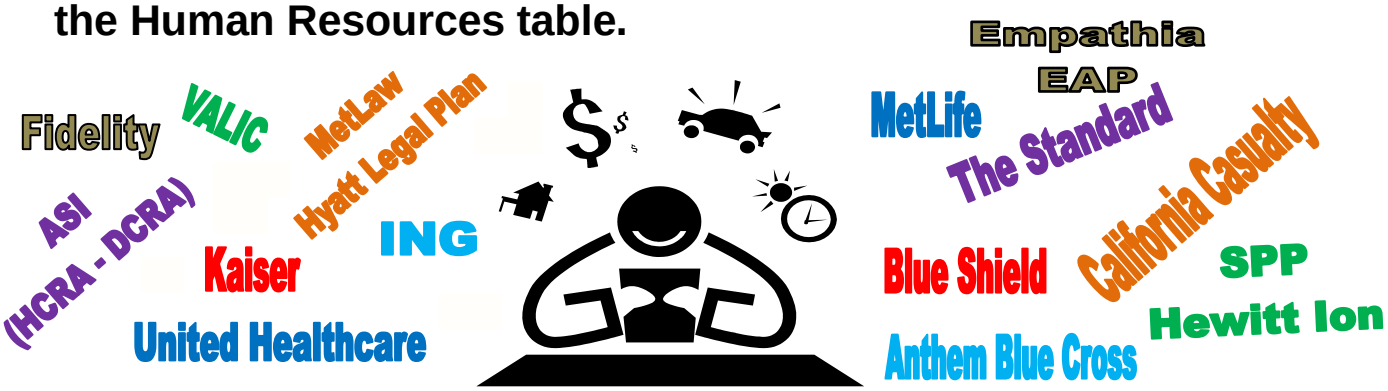
The Benefits Fair is brought to you by the CSU Stanislaus Office of Faculty Affairs and Human Resources to provide employees with an opportunity to learn about the many benefit programs available.

Did you know there will be four new HMO options for 2014?

Representatives from our various Health and Voluntary Plans will be here on September 26th to answer plan-specific questions.

The Benefits Team will be available to answer questions about the variety of benefits offered to you – i.e. medical, dental, vision, life insurance, voluntary plans, benefits elections, plan rates, retirement, etc.

Information regarding Open Enrollment will be available at the Human Resources table.



CALIFORNIA STATE UNIVERSITY, STANISLAUS

OFFICE OF THE VICE PRESIDENT FOR FACULTY AFFAIRS AND HUMAN RESOURCES

Benefits Worksheet

Please complete and return to the Office of Faculty Affairs and Human Resources, MSR340. You must enroll within 60 days from your date of hire to avoid a delay in coverage. You will be contacted when official enrollment forms are ready for your signature. **Failure to complete form in its entirety may hinder processing and cause a delay in enrollment.**

SECTION A — EMPLOYEE INFORMATION (*Please print*)

☐ **Faculty** ☐ **Staff**

☐ **New Enrollment** ☐ **Add Dependent(s)** ☐ **CSU Transfer Employee**

☐ **Open Enrollment** ☐ **Delete Dependent(s)** ☐ **Change Plans**

Name _____ **Zip Code** _____ **Employee CMS ID # *** _____

***CMS ID # is required – located on CMS Self Service Page: Self Service>Time Reporting>Employee Balance Inquiry.**

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Domestic Partnership Marriage Date: _____ Declaration/Marriage Date: _____

Contact Number _____ **Campus Ext** _____ **Email** _____

SECTION B — ENROLLMENT DETAILS (skip this section if selecting Open Enrollment)

Department _____ **Hire/Rehire Date** _____ **Position** _____

Reason for Enrollment or Change: ☐ Newborn/Child ☐ Marriage ☐ Other _____ ☐ Loss/Gain of Outside Coverage ☐ New Hire ☐ Rehire ☐ Divorce (provide ex-spouse mailing address in space below)

Date of Event: _____

_____

_____

Are you transferring from or currently working for a CalPERS / State agency? ☐ **Yes** ☐ **No**

If yes, Agency Name _____ **Date coverage ends** _____

SECTION C — ENROLLMENT SELECTIONS: HEALTH/DENTAL COVERAGE or FLEX CASH

I elect to join the following health plan (choose one):

PPO Plans:
(Anthem Blue Cross)
☐ PERS Select
☐ PERS Care
☐ PERS Choice
☐ PORAC
(Police Officers only)

HMO Plans:

☐ Kaiser ☐ Blue Shield Access Plus ☐ Blue Shield NetValue*
☐ United Healthcare ☐ Anthem Traditional ☐ Anthem Select
☐ Sharp**** ☐ Health Net Salud Y Mas** ☐ Health Net Smartcare***

* = Not available in Merced County; ** = Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego only;
*** = Los Angeles, Orange, Riverside, San Bernardino, San Diego only; **** = San Diego Only;

I elect to join the following dental plan (choose one):

☐ Delta Dental (PPO) ☐ Delta Care USA (HMO)* Delta Care Dental Office Choice: _____

***It is employee responsibility to ensure office accepts new patients and must provide dental office #. See list of providers online at:** www.deltadentalins.com/csu/

I elect to enroll in the Flex Cash: ☐ **Health** ($128.00) ☐ **Dental** ($12.00) ☐ **Both** ($140.00) ***(Check one)***

You **must** provide a completed Flex Cash Authorization form to complete enrollment.

If your health/dental coverage is through your spouse, please list their Social Security Number _____

You must provide a copy of proof of enrollment in alternative health/dental plan.

Alternative Medical Insurance Company _____ Group Number _____

Alternative Dental Insurance Company _____ Group Number _____

If electing Flex Cash, please list qualifying spouse/domestic partner information in Section E.

NOTE: Vision coverage is an automatic enrollment.

COMPLETE REVERSE SIDE

SECTION D — DEPENDENT INFORMATION *(please print)*

Please list all eligible dependents you wish to have covered under the appropriate sections below and indicate whether you want each dependent on medical, dental or both.

- If **enrolling a spouse**, a copy of the marriage certificate and social security number is mandatory.
- If **enrolling a Domestic Partner**, a copy of the Declaration of Domestic Partnership, Statement of Liability, and social security number is mandatory.
- If **enrolling a child**, a copy of the birth certificate and social security number is mandatory.
- If **deleting a spouse** due to divorce, a copy of divorce final judgment is mandatory.
- Affidavit of Eligibility if enrolling dependents **OTHER THAN** spouse, domestic partner, natural/adopted child, or stepchild is mandatory.

Dual coverage in a CalPERS sponsored health plan is not allowed. To enroll in CSU coverage, you will need to cancel the other CalPERS sponsored health plan.

Please answer the following questions:

Is your Spouse/Domestic Partner currently on a medical plan through CalPERS? ☐ **Yes** ☐ **No** ☐ **N/A**

If yes, please list the Agency he/she is working for: _____

Are you/your dependent(s) being cancelled from this coverage? ☐ **Yes** ☐ **No**

If yes, effective date of cancellation: _____

SECTION E — ELIGIBLE DEPENDENT INFORMATION **(skip this section if no dependent changes for open enrollment)**

Below, list ALL eligible dependents (including self), and their Social Security Numbers. Copies of marriage certificate or domestic partnership declaration, and/or dependent children's birth certificates are REQUIRED at the time of enrollment.

Add/ Delete	Name	Birth Date	Relation	Gender		Please Check One			Social Security Number
		On File	Self			☐ Medical	☐ Dental	☐ Both	Already on file.
				☐ M	☐ F	☐ Medical	☐ Dental	☐ Both	
				☐ M	☐ F	☐ Medical	☐ Dental	☐ Both	
				☐ M	☐ F	☐ Medical	☐ Dental	☐ Both	
				☐ M	☐ F	☐ Medical	☐ Dental	☐ Both	
				☐ M	☐ F	☐ Medical	☐ Dental	☐ Both	
				☐ M	☐ F	☐ Medical	☐ Dental	☐ Both	
				☐ M	☐ F	☐ Medical	☐ Dental	☐ Both	

If there is a change in your assignment and you are no longer eligible for health benefits, they will be canceled. You will be responsible for any services rendered while ineligible for benefits.

If enrolled in FlexCash and you no longer meet the criteria for this benefit, you will be responsible for any resulting overpayment.

For more information please review your Benefits Confirmation of Elections form that will be issued with the finalization of the Official Benefits Enrollment.

I understand that my effective date of enrollment is the 1st day of the month following my month of eligibility. I may see multiple deductions in subsequent months after enrollment, to cover any arrears in benefits payments, depending on the enrollment processing dates.

_____ _____

Signature **Date**

NOTE: Your share of the health plan premium (if any) is paid from pre-tax dollars through the Tax Advantage Premium Plan (TAPP). You will be automatically enrolled in the TAPP. Check the following box if you elect to NOT participate in TAPP. ☐

CSU The California State University

DEPENDENT CARE/HEALTH CARE REIMBURSEMENT ACCOUNT PLANS ENROLLMENT AUTHORIZATION

Please type or print clearly with ballpoint pen. Return completed form to campus Benefits Officer.

SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

1. TYPE OF ENROLLMENT (Check appropriate box)	2. SOCIAL SECURITY NO.	3. MARITAL STATUS
☒ OPEN ENROLLMENT ☐ NEW ENROLLMENT ☐ CHANGE DUE TO PERMITTING EVENT (i.e., Change in Status) ☐ CANCELLATION	4. NAME (first) (initial) (last)	☐ Married ☐ Single

5. REIMBURSEMENT PLAN ELECTIONS: To establish a Dependent Care (DCRA) and/or Health Care Reimbursement Account (HCRA), enter the amount you want to have deducted EACH month on a pre-tax basis from your pay warrant. **The minimum monthly pre-tax deduction amount for each account is $20.00, up to a maximum of $208.33 for HCRA ($2,500 annual maximum) and $416.66 for DCRA ($5,000 annual maximum), as allowed by the Plan.**

For HCRA participants only: If you are interested in obtaining a FSA Debit Card, you must submit a completed "FSA Debit Card Request" form to ASIFlex. If you request the FSA Debit Card, a separate debit-card fee will be deducted directly from your HCRA account by ASIFlex as a one-time, lump sum amount (i.e., $12.00 if your enrollment begins in January, and the amount is prorated if enrollment begins after January). Therefore, your available benefit under the HCRA will be reduced by this debit-card fee. You can adjust your annual HCRA election amount to include the debit-card fee and thereby obtain a higher HCRA benefit; however, your maximum monthly HCRA pre-tax deduction amount cannot exceed $208.33.

Benefit Deduction Item (Pre-Tax)	6. DED/ORG Code	7. Monthly Deduction Amount	SCO Use Only
Dependent Care Reimbursement Account (DCRA) Employee Initial here ___ Please note: This plan is for eligible dependent day care related expenses only	380- 027	A. $ _____	
Health Care Reimbursement Account (HCRA) Employee Initial here ___ Please note: This plan is for eligible health care related expenses only	378- 027	B. $ _____	

8. Coverage Statement

I UNDERSTAND THAT MY ENROLLMENT INTO THE DEPENDENT CARE AND/OR HEALTH CARE REIMBURSEMENT ACCOUNT PLAN(S) IS FOR ONE PLAN YEAR AT A TIME – MY ENROLLMENT WILL NOT AUTOMATICALLY RENEW. IF I WISH TO CONTINUE ENROLLMENT FOR THE NEXT PLAN YEAR, I MUST RE-ENROLL ANNUALLY DURING OPEN ENROLLMENT.

I hereby agree to have my monthly pay reduced on a pre-tax basis by the amount(s) specified above. I understand that IRS regulations require that my monthly pre-tax deductions authorized by this form are irrevocable during this plan year, unless I experience an allowable "change in status event," as defined in these regulations and described in the Dependent Care and/or Health Care Reimbursement Account brochure(s).

This reduction in pay is effective with the December pay period (January pay warrant), unless this is a mid-year enrollment, and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the CSU contribute the amounts from my pay warrant to the Reimbursement Account(s) that I have specified on this form. **I also agree to pay the $1.00 monthly administrative fee through payroll deduction on a post-tax basis. The $1.00 monthly administrative fee is charged per Plan.**

Each Plan Year begins on January 1 and ends December 31. I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective dates of my participation in the Plan(s) through the end of the Plan Year, or the following 2 ½ month grace period extension (January 1 – March 15) if I am enrolled in the Plan(s) through December 31. All reimbursement requests for the current Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Health Care Reimbursement Account(s) after that date will be forfeited.

I have read the above statements and agree to the terms and conditions of the Dependent Care and/or Health Care Reimbursement Account(s) Plan(s) as specified on this form and described in the applicable brochure(s).

Employee's Signature: ▶	Date Signed: ▶

FOR CAMPUS USE ONLY

9. Effective Date of Action	10. Employee CBID	11. Permitting Event Date			12. Permitting Event Code
Day -1-	Select	09 Mo	16 Day	2013 Year	00

13. Remarks:	14. Agency Code	15. Unit Code	16. Campus Name
	271		CSU-Stanislaus

17. Authorized Campus Signature

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the CSU HCRA and/or DCRA Plan(s).

Print Name: Rose Jones

E-mail address: rjones4@csustan.edu

Signature: ▶

18. Date Received:	19. Telephone Number: (209) 664-6730

DISTRIBUTION: ORIGINAL - State Controller's Office COPY – Campus COPY W/PRIVACY NOTICE – Employee

REV. 08/2012 – Plan Year 2013 or later

The California State University
DEPENDENT CARE/HEALTH CARE REIMBURSEMENT ACCOUNT PLANS
ENROLLMENT AUTHORIZATION
(REV. 08/2012) (REVERSE)

PRIVACY NOTICE

The Information Practice Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the program administrator, for the purposes of identification and account processing.

It is mandatory to furnish all information requested on this form except for employee's gender and marital status, which may be furnished on a voluntary basis. Failure to provide the mandatory information may result in the DCRA and/or HCRA enrollment action(s) not being processed or being processed incorrectly.

The State Controller's Office requires the employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the Claims administrator. Copies of the Dependent Care/Health Care Reimbursement Account Plan(s) Enrollment Authorization Form(s) are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Dependent Care and/or Health Care Reimbursement Account Plan(s) Enrollment Authorization forms upon request. The official responsible for the maintenance of the forms is: Chief of Personnel/Payroll Operations Bureau, State Controller's Office, P. O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.

Benny

Your card for Better Benefits!

The FSA Benny Card is a great benefit and provides a convenient method to pay for out-of-pocket medical expenses for you, your spouse or registered domestic partner[1] and/or any tax dependents. Here's how the FSA Benny Card works:

Where can the cards be used?

Per IRS regulations, the FSA Debit Card can only be used at Health Care Providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Control System.

1) **Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The FSA debit card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).

2) **Inventory Control System Restriction:** The IRS also allows a card to be used at retail stores that have an FSA Inventory Control System in place that only allows FSA-eligible items to be paid for with your FSA debit card. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The card will work at these stores, even if the MCC does not indicate it is a health care provider. A list of stores with this system in place now (and some expected in the future) is available online, at www.asiflex.com/debitcards. Purchases at these stores should never require follow-up documentation!!

The IRS has stringent regulations regarding appropriate use of the Benny Card, as far as where the card can be used, and when follow-up documentation is required (use of the card DOES NOT eliminate all of the paperwork).

Documentation is not required when the transaction:

- Matches a co-pay or up to five times the highest for the health plan you have elected through your employer;
- Occurs at a retail outlet that has implemented the Inventory Control System; or
- Is for recurring expenses for the exact same amount at the same provider and have been substantiated once via a paper claim.

Documentation is required when the debit card:*

- Is used to pay for your spouse's or registered domestic partner's[1] co-payments on a non-CSU plan;
- Is used to pay for your deductible or co-insurance expense, even if these expenses are through your employer's plan; and
- Does not meet any of the three allowed auto-substantiation methods listed above

* IRS regulations require that you provide documentation when requested to confirm that what you are paying for is an eligible expense.

Action Required:

- Enroll in the CSU Health Care Reimbursement Account (HCRA)
- Complete the Flexible Spending Plan Debit Card Request Form and send it to ASIFlex
- Enjoy the convenience of your new Benny Card!

ASIFlex

Contact ASIFlex with Questions:

Phone: (800) 659-3035
Email: asi@asiflex.com
Web: www.asiflex.com

[1] You may claim reimbursement for expenses paid for your registered domestic partner if your registered domestic partner is a dependent.

The California State University

ASIflex

FLEXIBLE SPENDING PLAN (FSA) DEBIT CARD REQUEST FORM

Please type or print clearly with ballpoint pen.

The fields in the shaded areas below are required. If any shaded field is left blank, the FSA Debit Card will not be issued.

CAMPUS:	SOCIAL SECURITY NUMBER:	FULL NAME (LAST, FIRST, MIDDLE)		
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:
DAYTIME PHONE:	HOME PHONE:	E-MAIL ADDRESS:		DATE OF BIRTH:

CSU HEALTH PLAN ENROLLMENT:	CSU DENTAL PLAN ENROLLMENT:	CSU VISION PLAN ENROLLMENT:
I AM ENROLLED IN THE FOLLOWING CALPERS HEALTH PLAN: ☐ BLUE SHIELD HMO (ACCESS, NETVALUE, ADVANTAGE) ☐ KAISER PERMANENTE ☐ PORAC ☐ PERS CHOICE/PERS SELECT ☐PERSCARE	I AM ENROLLED IN THE FOLLOWING CSU DENTAL PLAN (ALSO INDICATE PLAN LEVEL): ☐ DELTACARE USA: ☐ BASIC ☐ ENHANCED ☐ DELTA DENTAL PPO: ☐ BASIC ☐ ENHANCED I ☐ ENHANCED II	☐ I AM ENROLLED IN THE CSU VISION PLAN (VSP)

The FSA Debit Card is optional to you, and is only for Health Care Reimbursement Account (HCRA) Plan participants. If you want to receive an FSA Debit Card (aka "FSA Benny Master® Card"), you have to complete this application. If you do not wish to request the FSA Debit Card, you will access your HCRA funds by filing claims and ASIFlex will reimburse you by direct deposit or check.

If you request the FSA Debit Card, a separate, $1.00 per month administrative fee will be deducted directly from your HCRA account by ASIFlex as a one-time, lump sum amount (i.e., $12.00 if your enrollment begins in January, and the amount is prorated if enrollment begins after January). Therefore, your annual HCRA election amount will be reduced by an amount equal to or less than $12.00. You can adjust your annual HCRA election to include the one-time fee only if your monthly HCRA deduction amount does not exceed $208.33.

Upon receipt of this completed form, two (2) debit cards, both in your name, will be issued on your behalf. The cards will be mailed to your home address approximately two weeks from ASIFlex's processing of this form. There is a $5.00 charge for additional or replacement cards.

When using the FSA Debit Card, ALWAYS select the "credit" option when you present the card at a merchant or a provider, even though the card is referred to as a "debit card." There is no PIN number associated with this FSA debit card.

It is important to note that there will be times when you will be required to **submit substantiating documentation for some debit card transactions.** ASIFlex will notify you when follow-up documentation (i.e., detailed statement of services, etc.) is required. **If you do not provide the requested documentation in the timeframe stated in your notification, your card will be deactivated.**

PLEASE NOTE: If you use the Benny Card during the FSA Grace Period (January 1 - March 15th) and have funds remaining in your HCRA, card transactions will automatically be applied to available funds from the previous plan year and transactions that exceed your available balance from the previous plan year will have the excess applied to available funds from the new plan year. If you do not choose to re-enroll in the HCRA, your card WILL continue to be active with prior year funds for the entire grace period. For any questions or concerns, please contact ASI at (800) 659-3035 or email your questions to asi@asiflex.com

I hereby state that the above information is accurate, to the best of my knowledge. Additionally, I certify that the FSA debit card will only be used to purchase eligible medical care-related (i.e., health, dental, vision, etc.) expenses, as defined in Code §213(d) of the Internal Revenue Code and that I will not seek reimbursement from any other source for the expenses paid for with the FSA debit card. I also acknowledge that if I do not provide requested documentation in a timely fashion, my card will be deactivated, in accordance with Federal regulations.

Visit the CSU Systemwide Benefits Portal at: www.calstate.edu/hr/benefitsportal for additional information.

Employee's Signature: ▶	Date Signed: ▶

The application must be sent directly to ASIFlex. Please fax application to: 1-877-879-9038 or Mail to: ASIFlex, P O Box 6044, Columbia, MO 65205-6044

REV. 09/12

The California State University
FLEXCASH PROGRAM ENROLLMENT AUTHORIZATION

Please type or use ball point pen, print clearly. Return completed form to campus Benefits Officer.

C

SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

1. TYPE OF ENROLLMENT (Check appropriate box)
   - ☐ ANNUAL/OPEN ENROLLMENT
   - ☐ NEWLY ELIGIBLE ENROLLMENT
   - ☐ CHANGE DUE TO PERMITTING EVENT
   - ☐ CANCELLATION

2. SOCIAL SECURITY NO.

3. MARITAL STATUS ☐ Married ☐ Single

4. NAME (first) (initial) (last)

5. PLAN ELECTIONS – Refer to the FlexCash Brochure for cash option election information.

Cash Option Type	Monthly Payment	Instructions for Completing Cash Option Elections
A. Cash in lieu of medical insurance	$	If you are electing the cash option in lieu of medical insurance, enter the monthly cash amount in item A, otherwise enter "none."
B. Cash in lieu of dental insurance	$	If you are electing the cash option in lieu of dental insurance, enter the monthly cash amount in item B, otherwise enter "none."
C. Plan Code **381-001**	Monthly Total $	In Item C enter the total monthly cash option amount (sum of the amounts entered in items A and B).

6. Statement of Other Medical and/or Dental Coverage

This section **must be completed** if you choose cash instead of your own CSU medical and/or dental insurance plans.

I certify that I am covered by another non-CSU medical and/or dental plan(s). I certify that I will maintain coverage in this medical and/or dental insurance plan(s) on an ongoing basis and I agree to notify my campus Benefits Officer within 60 days if I lose coverage under the medical and/or dental insurance plan(s).

Alternative Coverage	
A. Medical insurance carrier's name	Policy Number
B. Dental insurance carrier's name **Name Of Dental Carrier**	Policy Number

Complete this section ONLY if your "other" non-CSU medical and/or dental insurance coverage is through your spouse's (or domestic partner's*) plan(s).

Spouse's (or domestic partner's*) SSN: _____

I have reviewed the FlexCash Brochure describing the CSU's optional FlexCash Plan, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that regulations under the IRS Code require that my benefit choices authorized by this form are irrevocable during this plan year unless I experience an allowable "family status change event" as defined in these regulations or other permitting events as described in the FlexCash brochure. I understand that my FlexCash enrollment in lieu of medical and/or dental coverage will continue from year to year until I complete a new FlexCash Enrollment Authorization form to change or cancel FlexCash enrollment.

I have read and agree to the terms and conditions of the FlexCash Program as outlined on this form and in the FlexCash Brochure.

Employee's Signature: ►

Date Signed: ►

FOR CAMPUS USE ONLY

7. Effective Date of Action — Mo | Day -1- | Year

8. Employee CBID **E99**

9. Permitting Event Date — Mo | Day | Year

10. Permitting Event Code **01**

11. Health Form Attached? (HBD12) ☐ Yes ☐ No

12. Dental Form Attached? (STD 692) ☐ Yes ☐ No

13. Agency Code

14. Unit Code

15. Campus Name

16. Remarks:

17. Authorized Campus Signature

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the CSU FlexCash Program.

Signature: ►

18. Date Received:

19. Telephone Number:

*Employees who obtain "alternative" non-CSU coverage through a domestic partner are **not** required to submit proof of registration through the Secretary of State process to enroll in the FlexCash Program.

DISTRIBUTION: **ORIGINAL** - State Controller's Office **COPY** – Campus **COPY**- Employee (with privacy notice)

PRIVACY NOTICE

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Information requested on this form is used by the State Controller's Office and the program administrator for the purposes of identification and account processing.

It is mandatory to furnish all information requested on this form except for marital status, which may be furnished on a voluntary basis. Failure to provide the mandatory information may result in the enrollment elections not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Copies of the FlexCash Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Enrollment Authorization forms upon request. The official responsible for the maintenance of the forms is: Chief of Personnel/Payroll Services Division, State Controller's Office, Post Office Box 94250, Sacramento, California 94250-5878.