Downey Unified
School District
Life Only

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INTRODUCTION

■ Notices

Notice Required for Residents of Texas/Aviso Para Residentes Del Estado De Texas

GREAT-WEST LIFE & ANNUITY
INSURANCE COMPANY
EXECUTIVE OFFICES -
8505 EAST ORCHARD ROAD
GREENWOOD VILLAGE, COLORADO 80111

IMPORTANT NOTICE

To obtain information or make a complaint

You may call Great-West's toll-free telephone number for information or to make a complaint at

1-800-537-2033

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance P.O. BOX 149104 Austin, TX 78714-9104 FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Great-West first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR PLAN

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja

Usted puede llamar al numero de telefono gratis de Great-West's para informacion o para someter una queja al

1-800-537-2033

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas P.O. BOX 149104 Austin, TX 78714-9104 FAX # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Great-West primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

UNA ESTA AVISO A SU POLIZA

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Coverage for Residents of Certain Other States

If you are a resident of a state other than California and the life insurance and accidental death & dismemberment insurance laws of the state in which you reside require the Plan to provide coverage in excess of what is described in this booklet, the Plan will be administered to comply with such law(s).

■ About This Plan

Downey Unified School District (the Employer) has established an Employee Welfare Benefit Plan. As of October 1, 2008, the Life Insurance and Accidental Death & Dismemberment (AD&D) benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the Life Insurance and AD&D benefit terms described in this booklet. The Plan may be amended from time to time.

If a booklet was issued to you under the Employer's prior plan, this is your new booklet. This new booklet replaces your old booklet in its entirety. If you were covered under the replaced booklet on the day before the effective date of the Plan, you will be covered under this booklet as of the date shown above.

If on the date shown above you are not Actively at Work, see "Will My Coverage Change?" in WHEN COVERAGE BEGINS & ENDS for details as to when a change in coverage will become effective.

The Life Insurance and AD&D benefits described in this booklet are fully insured by Great-West Life & Annuity Insurance Company

(referred to as Great-West or Company in this booklet), 8505 E. Orchard Road, Greenwood Village, CO 80111.

This booklet becomes your certificate of insurance for Life Insurance and AD&D benefits only if you complete the appropriate application forms and are approved for coverage by Great-West.

Defined terms are capitalized and have specific meaning with respect to Life Insurance and AD&D benefits, see GLOSSARY.

Plan Modification/Termination

The Employer may:

- change the contributions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY

This summary provides a general description of your Life Insurance and Accidental Death & Dismemberment benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

LIFE INSURANCE BENEFITS

All active full-time or permanent part-time Classified CSEA Employees working 20 hours or more per week who are not participating in the District sponsored Medical Plan	$25,000.00

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The amount of AD&D Benefit that an Employee may receive is based on a Principal Sum. The amount of the Principal Sum is equal to the amount of Standard Life Insurance.

AD&D Benefit for the Loss of:	**Amount Payable**
Life	Principal Sum
Both hands or both feet or sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand or one foot and sight of one eye	Principal Sum
One hand or one foot	1/2 of Principal Sum
Sight of one eye	1/2 of Principal Sum

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT

The amount of an Employee's Life Insurance and AD&D Benefit in effect at the time the Employee reaches age 65 will reduce by 35% at age 65, 55% at age 70, 70% at age 75, 80% at age 80 and 85% at age 85.

ELIGIBILITY

■ Eligible Employees

For the purpose of Life Insurance and Accidental Death & Dismemberment benefits, an eligible Employee is a person who is in the Service of the Employer who:

- is a resident of the United States or Puerto Rico; and
- is classified as a Classified CSEA (California School Employees Association) Employee.

Service

"Service" means work with the Employer on an active, full-time and full pay basis for at least 20.00 hours per week.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee in ELIGIBILITY will determine who is eligible for coverage under the Plan.

Coverage will begin on the first day of the month coinciding with or next following the date you satisfy any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution; and
- Be Actively at Work on the eligibility date.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage.

Late applicants must provide the Company with Proof of Good Health at their own expense. Coverage for a late applicant will begin on the date the Company approves Proof of Good Health.

■ Will My Coverage Change?

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class the first day of the month coinciding with or next following the date the Member's class status changes.

If you are an active Employee and you are not Actively at Work when either of these changes occurs, the change in your coverage will not take place until you return to work with the Employer for one full day.

All claims will be based on the benefits in effect on the date the claim was incurred.

■ When Will My Coverage End?

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The date you are no longer eligible or the last day of the month coinciding with or next following the date your Service ends.
- The due date of the first contribution toward your coverage that the Employer fails to make.
- The date Loss of Residence occurs.

■ Can I Continue or Convert My Coverage If I Become Ineligible?

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

Continuation of Life Insurance during an Illness, Approved Leave of Absence or Temporary Layoff

If your Service ends due to Illness, Life Insurance will continue for 12 months after your Service ends.

If you are continuously covered under this provision and this group life policy terminates before you are eligible to qualify for coverage under the provision "What If I Become Disabled? (Waiver of Premium)", you must convert to an individual life insurance policy within 31 days in order to continue your life insurance.

If your Service ends due to approved leave of absence or temporary layoff, Life Insurance will continue for 31 days after the date your Service terminates.

Your coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

There is no continuation for AD&D benefits.

WHEN COVERAGE BEGINS & ENDS - Continued

Continuance of Life Insurance During a Labor Dispute

This provision applies only if your Employer contributes to the premium for your life insurance under a collective bargaining agreement.

If a labor dispute stops work, the group policy can stay in force for up to 6 months. During this time, you must pay the entire premium yourself. Life insurance will be continued subject to:

- the payment of premiums. The premium in effect for the group policy when work stopped will be used. Premiums are determined by your class;
- the collection of the premiums by the Employer or by the union. Premiums must be sent in a lump sum to Great-West by the due date; and
- Great-West's right to change the premium rate or to terminate the group policy.

Continuation of Coverage under Federal Laws and Regulations

If coverage would otherwise terminate under this Plan, you may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES and CONTINUATION OF COVERAGE - FMLA.

Conversion of Life Insurance Benefits

If all or part of your group term life insurance ends, you may apply for an individual life insurance policy.

Proof of Good Health is not required. You must apply for the life conversion coverage within 31 days after your life insurance coverage ends. You are entitled to written notice of your right to convert. If you do not receive written notice within 16 days of the date your coverage ends, the 31 days will be extended to the earlier of:

- 91 days after the date coverage ends; and
- 25 days after the date on which you receive written notice.

The policy will be one of Great-West's standard conversion policies and will not contain a disability benefit or an accidental death benefit. The amount of coverage chosen can never be more than your current amount of insurance. The amount of the premium will depend on your age and class of risk.

You are allowed 31 days to apply for the individual policy. If you die within this period, your beneficiary will receive a death benefit. The amount of this benefit will be the maximum amount of group term life insurance which you would have been eligible to convert under this provision.

However, if the amount of your insurance had been reduced during this 31-day period because of age or retirement, the death benefit will be the amount of your group term life insurance before the reduction. This death benefit is payable even if you had not applied for an individual policy.

Employee Conversion of Life Insurance Benefits

If the group policy is still in force, you may convert all or part of your insurance to an individual policy if your coverage ends. If your coverage reduces due to age or retirement you may convert up to the amount of the reduction.

If the group policy is terminated or amended you may convert your life insurance if all or part of your coverage ends. However:

- You must have been insured under the group policy for at least five consecutive years; and
- The amount of the individual policy will be the lesser of $2,000.00 and the current amount of your group term life insurance.

You may convert your coverage if you are:

- Totally Disabled; and
- not covered under the disability benefit;

on the date of discontinuance.

You are eligible to convert your life insurance benefits on the same basis as an Employee whose Service ends while the group policy is in force. You must become Totally Disabled while covered under this Plan. The amount of the conversion policy will be:

- your current amount of group term life insurance; less
- any amount for which you are eligible under any group policy issued to the Employer within 31 days of the date of discontinuance.

"Date of discontinuance" means the date:

- the group policy terminates; or
- the company by which you are employed is no longer an affiliated company of the group policyholder.

Conversion of AD&D Benefits

Conversion coverage is not available for AD&D benefits.

■ Can Coverage Be Reinstated?

If your coverage ended because of termination of your Service, it will be reinstated on the date you return to work with the Employer. You must return within 12 month(s) to be reinstated.

On the date you return to work, coverage will be on the same basis as that provided for any other active Employee as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

See USERRA RIGHTS AND RESPONSIBILITIES for information about reinstatement of coverage upon return from leave for military service.

Reinstatement When Coverage Ends Due to Loss of Residence

Coverage for an Employee whose coverage ended due to Loss of Residence will be reinstated on the day after completing 30 consecutive days of Work in the United States. You must return to the United States within three months of the date the Loss of Residence occurred to be reinstated. Coverage will be on the same basis as that being provided for any other active Employee on the date coverage is reinstated. However, any restrictions on the coverage that were in effect before reinstatement will continue to apply.

LIFE INSURANCE BENEFITS

■ Standard Life Insurance

If you die from any cause while covered under the life insurance Plan, your amount of standard life insurance will be paid to your beneficiary. The amount is shown in the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY.

■ How Do I Name a Beneficiary?

A beneficiary is the person who will receive payment of the life insurance amount if you die. You should name a beneficiary when you first apply for insurance. Unless legally restricted, you can change the beneficiary at any time by giving written notice. The beneficiary's consent is not required unless the designation of the beneficiary is irrevocable.

Naming or changing a beneficiary must be in writing, signed by you and filed with your Employer.

If a named beneficiary dies before you, the amount of the life insurance that beneficiary would have received will be paid to any remaining named beneficiaries who survive you, unless you have specified otherwise on your application or state law does not allow this.

When there are two or more named beneficiaries the life insurance will be divided in equal shares, unless you have specified otherwise.

Subject to state law, if no named beneficiary survives you or if you have not named a beneficiary, the amount of insurance will be paid to your surviving spouse; if none, then to your surviving child or children; if none, then to your surviving parent or parents; if none, then to your surviving brothers or sisters; if none, then to your estate.

■ How Will Benefits Be Paid?

Proof of death must be sent to Great-West. Great-West will pay the amount of insurance (the death benefit) to the beneficiary.

- If any person has incurred expenses related to your last Illness or death, Great-West can deduct up to $500.00 from the death benefit to pay the person who incurred these expenses.
- The life insurance will be paid to the beneficiary. Prior to your death, you may elect to have your life insurance paid to your beneficiary in any manner to which Great-West agrees.
- If you do not elect an optional payment method prior to your death, then after your death the beneficiary may elect to have the life insurance paid to him or her in any manner to which Great-West agrees.

Payments will not be made more than once a year unless each payment is at least $25.00.

■ What If I Become Disabled? (Waiver of Premium)

After you have been Totally Disabled for 9 consecutive months, insurance for yourself may be continued without further premium payment. To qualify for this benefit:

- You must become Totally Disabled while insured under this life insurance Plan;
- Your Total Disability must continue without interruption for at least 9 months;
- You must be under age 60 when you become Totally Disabled;
- You must send proof of your Total Disability to Great-West within 12 months of the start of the disability.

If you were continuously covered under the provision "Continuation of Life Insurance During an Illness, Approved Leave of Absence or Temporary Layoff" when you qualified for this disability waiver of premium benefit, you will be notified of the date when you will no longer be required to pay life insurance premium.

If you have converted to an individual policy because this group life policy terminated or the continuation benefit ended during your qualifying period, you must surrender it. See the provision "Conversion of Life Insurance Benefits" in WHEN COVERAGE BEGINS & ENDS. All premiums paid for the individual policy after you have been Totally Disabled for 9 months will be returned. If you die during this 9 month period, the amount of insurance will be paid under either this life insurance Plan or the individual policy but *not* under both.

If you qualify for this disability waiver of premium benefit, you must send proof of the continuance of your Total Disability to Great-West when requested.

The amount of life insurance continued will be the amount in effect under this Plan on the date you became disabled. However, the amount of insurance may reduce or terminate due to age or retirement according to the provisions of the Plan that were in effect on the date you became Totally Disabled.

This life insurance Plan does not have to be in force at the time of death for life insurance to be paid.

Your disability waiver of premium benefit will terminate:

- On the date you recover from your Total Disability; or
- If you do not send Great-West proof of the continuance of your Total Disability when requested.

■ Is the Amount of My Insurance Reduced As I Grow Older?

Your amount of standard life insurance will be reduced according to the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY - REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT.

■ Life Insurance Benefits If Terminally Ill

Any Accelerated Benefit that you receive may be treated as taxable income and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

If you are terminally ill, you may apply to receive a portion of your life insurance as an Accelerated Benefit. In order to do this, you must be covered under this Plan and you must give Great-West satisfactory proof of having a Qualifying Medical Condition.

Qualifying Medical Condition means you are terminally ill, with a life expectancy of 24 months or less. In considering a request for an Accelerated Benefit, Great-West at its expense, may require that you be examined by a Doctor of its choice.

To apply for an Accelerated Benefit you must:

- contact your Employer for the appropriate application form; and
- send your application to Great-West along with a statement from your Doctor certifying the Qualifying Medical Condition.

  For purposes of this benefit, the Doctor cannot be:
  - yourself; or
  - a person who is part of your immediate family (your parent, spouse, sibling or child); or
  - a person who lives with you.

The request for an Accelerated Benefit must be made by the terminally ill insured person. However, if he or she is legally incapacitated or a minor child, the request must be made by a person with legal authority to act on the insured person's behalf.

You may request an Accelerated Benefit of up to 50% of the amount of your life insurance to a maximum of $100,000.00. The minimum Accelerated Benefit is $1,000.00.

The amount of the Accelerated Benefit available to you will be based on the amount of life insurance coverage provided to you by Great-West under this Plan when you request the Accelerated Benefit.

For any life insurance scheduled to be reduced within 36 months of the date of application for the Accelerated Benefit, the amount of the Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid in a lump sum and is available only one time while covered by Great-West. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, Great-West will not ask you for a refund of the Accelerated Benefit. However, your amount of life insurance will be reduced as described below.

After payment of the Accelerated Benefit, the amount of your life insurance coverage under this Plan will be reduced by the amount of the Accelerated Benefit. If the Accelerated Benefit amount is equal to or exceeds the amount of life insurance in force at the time of your death, no additional amounts of life insurance will be payable upon your death.

Anyone approved for an Accelerated Benefit may also be approved for disability waiver of premium. (See "What If I Become Disabled? (Waiver of Premium)") Anyone already on disability waiver of premium when approved for an Accelerated Benefit, will continue on premium waiver.

No Accelerated Benefit will be paid if:

- All or part of your insurance must be paid to your children or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
- You are married and live in a community property state, unless you provide us with a signed statement from your spouse consenting to payment of the Accelerated Benefit.
- You have made an assignment of all or part of your life insurance, unless you provide Great-West with a signed statement from your assignee consenting to payment of the Accelerated Benefit.
- You have filed for bankruptcy, unless you provide Great-West with written approval from the bankruptcy court for payment of the Accelerated Benefit.
- You have previously received an Accelerated Benefit while covered under this Plan.

■ Other Information About Life Insurance

Absolute Assignment

You can transfer all your rights of ownership in your life insurance. This is known as absolute assignment. Great-West is not responsible for the validity or effect of any assignment.

To assign your life insurance, notify your Employer, who will contact Great-West for an assignment form. Great-West will not recognize an assignment until the original assignment form has been noted at its Executive Offices.

Collateral Assignment

You cannot assign your insurance as collateral for a loan.

Proof of Age

Before benefits are paid, Great-West may request proof of age. An adjustment may be made if:

- The Member's age was misstated; and
- A different premium rate would have been charged for the person's true age.

The difference between the premiums actually paid, and those that should have been paid, will be calculated. Any difference will be paid:

- By your Employer to Great-West, if the age was understated; and
- By Great-West to your Employer, if the age was overstated.

AD&D BENEFITS

Your AD&D benefits are payable if you are Injured while covered under this AD&D Plan and suffer a loss:

- Within 90 days of the Injury; and
- As a result of the Injury.

The amount of AD&D benefits that you may receive is based on a Principal Sum. The amount of your Principal Sum is equal to the amount of your Standard Life Insurance. (See "Standard Life Insurance" in LIFE INSURANCE BENEFITS.) Great-West will pay all or part of the Principal Sum according to the AD&D Benefit shown in the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY.

Only one of the amounts, the largest, will be paid for all Injuries that result from any one accident.

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

If you die, the benefit will be paid to the beneficiary you name for life insurance. If you suffer any other loss, the benefit will be paid to you.

To claim AD&D benefits, written proof of loss must be sent to Great-West as soon as reasonably possible. In any case, the proof required must be given no later than 15 months from the date of loss unless the claimant was legally incapable of doing so.

Your amount of AD&D Principal Sum is subject to the same age-based reductions as your life insurance.

AD&D BENEFIT LIMITATIONS

No amount will be payable for any loss caused by or in connection with:

- Intentionally self-inflicted Injury.
- War or any act relating to war.
- Any form of disease.
- Physical or mental infirmity.
- The medical or surgical treatment of a disease or infirmity.
- Suicide.
- Ptomaine poisoning.
- Bacterial infections.
- Commission of a felony.

CLAIMS & LEGAL ACTION

■ How To File Claims

A claim for benefits may be filed by a Member, beneficiary or Authorized Representative. An *Authorized Representative* means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission and appeals.

All claim forms include instructions on how to complete and submit a claim. Claim forms may be requested from the Plan Administrator. Complete and accurate claim information is necessary to avoid claim processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

Disability Waiver of Premium Benefits

To apply for disability waiver of premium benefits, the Plan Administrator, Member and the Member's Doctor must complete the Waiver of Premium Disability Claim Report. The Plan Administrator will submit the report to Great-West for processing.

Claims for which determination of disability is involved will be processed within 45 days of the date received by Great-West. If a decision cannot be made within this time period for reasons beyond the control of the Plan, the Member will be notified of:

- the reasons for the delay;
- any information needed to perfect the claim; and
- the date by which a decision is expected.

The Member will have 45 days from the date the notice is received to provide the requested information. If the requested information is not provided within this time period, the Member should consider the claim to be denied.

This denial will be reconsidered if the information is subsequently received. If the necessary information is received within the 45-day period, a decision will be made within 30 days of the date the information is received, unless a decision still cannot be made. If this is the case, the above notification process will be repeated within the 30-day decision period.

The Member will again have 45 days from receipt of the notice to provide the requested information. If the information is received within the 45-day period, a decision will be made within 30 days of the date the information is received, unless the Member agrees to a longer period of time.

Life Insurance and Accidental Death & Dismemberment Benefits

For life insurance and accidental death claims, the beneficiary must request a claim form from the Plan Administrator, complete the form and return it with the certified proof of death to the Plan Administrator, who will submit to Great-West for processing.

To apply for accelerated benefits, the Plan Administrator, Member and the Member's Doctor must complete the Accelerated Living Request form. The Plan Administrator will submit the form to Great-West for processing.

For accidental dismemberment and loss of sight claims, the Member must request a claim form from the Plan Administrator, complete the form and return it with the accident or police report to the Plan Administrator, who will submit to Great-West for processing.

Life insurance and accidental death & dismemberment claims will be processed within 40 days of the date received by Great-West. If a claim decision cannot be made within the initial 40-day period because of special circumstances, Great-West may request an extension of up to 40 days. Before the end of the initial 40-day period, Great-West will notify the Member or beneficiary in writing of the reason(s) for the extension, whether additional information is required and why this information is needed, and the date that Great-West expects to make a claim decision. Claim decisions will not exceed the above time frames unless the beneficiary agrees to a longer period of time. Once the decision is made, Great-West will either pay the allowable amount of insurance to the beneficiary(ies) or send written notice of benefits denied.

CLAIMS & LEGAL ACTION - Continued

■ If A Claim Is Denied

If benefits are denied, in whole or in part, Great-West will send the Member or beneficiary a written or electronic notice within the established time periods described in "How To File Claims". The denial may be appealed as described below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits.

If the denial involves a disability claim, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available upon request and at no charge.

Appeal of a Disability Waiver of Premium Claim Denial

After receiving notice of a claim denial, in whole or in part, the Member, the Member's beneficiary, provider or other Authorized Representative can appeal by submitting a written request to the address shown on the adverse determination letter within:

- 180 days of the date the notice of denial of the initial claim is received; or
- 60 days of the date the notice of the initial appeal decision is received.

In connection with the review, the Member has the right to:

- review and request copies of relevant documents, free of charge; and
- submit issues and comments in writing; and
- have a representative act on his or her behalf in the appeal.

The appeal will be reviewed by an individual who was not involved in the prior adverse determination and who is not a subordinate of the individual who made the prior determination. If the prior determination was based on medical judgment, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted and identified.

The decision on the appeal will be made within 45 days of the date the appeal is received. If special circumstances require it, the time period may be extended up to an additional 45 days provided that within the initial 45-day review period the Member is informed of the special circumstances and the date a decision is expected. If the special circumstances include the need for additional information from the Member in order for a decision to be made, the necessary information will be requested. The Member will have 45 days from the date the request is received to provide the information. If the requested information is not provided within this time period, the appeal may be denied. If the additional information is received within the 45-day period, a decision on the appeal will be made within 45 days of the date the information is received, unless the Member agrees to a longer period of time.

In the case of an adverse decision of an appeal, the notice of the decision will include the information described above for a claim denial.

Two appeals are required.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is provided. Voluntary reviews must be requested within 60 days of the date the notice of the appeal decision is received.

There are no voluntary appeal rights following the required appeal process when the denial was based on medical judgment.

The Member may request information regarding voluntary appeal procedures.

CLAIMS & LEGAL ACTION - Continued

If you or your beneficiary have contacted the Plan Administrator and/or the Company to resolve any issues related to your benefits but are still unsatisfied, you or your beneficiary may contact the California Department of Insurance at the following address and telephone number:

Department of Insurance
Consumer Service Division
300 S. Spring Street
Los Angeles, California 90013
In-State 800-927-4357
Out-of-State 213-897-8921

Appeal of a Life Insurance or Accidental Death & Dismemberment Claim Denial

After receiving notice of a claim denial, in whole or in part, the Member, beneficiary, or Authorized Representative can appeal a claim denial by submitting a written request to the address shown on the adverse determination letter within 60 days of the date the denial notice is received.

An appeal includes the right to review and request copies of relevant documents, free of charge, and to submit issues and comments in writing.

The appeal request should include the following information:

- The name of the Member, Employee and the deceased; and
- The Member's group plan number and claim number, as shown on the adverse determination letter; and
- Any relevant information in support of the appeal.

The appeal will be reviewed by an individual who was not involved in the prior adverse determination and who is not a subordinate of the individual who made the prior determination. If the prior determination was based on medical judgment, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted and identified.

The decision on the appeal will be made within 60 days of the date the appeal is received. If special circumstances require it, the decision may be extended up to an additional 60 days provided the Member or beneficiary is informed of the special circumstances within the initial 60-day review period.

Two appeals are required.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is provided. Voluntary reviews must be requested within 60 days of the date the notice of the appeal decision is received.

There are no voluntary appeal rights following the required appeal process when the denial was based on medical judgment.

The Member or beneficiary may request information regarding voluntary appeal procedures.

If you or your beneficiary have contacted the Plan Administrator and/or the Company to resolve any issues related to your benefits but are still unsatisfied, you or your beneficiary may contact the California Department of Insurance at the following address and telephone number:

Department of Insurance
Consumer Service Division
300 S. Spring Street

Los Angeles, California 90013
In-State 800-927-4357
Out-of-State 213-897-8921

■ Other Information a Member Needs to Know

Incontestability

After the Plan has been in force for 2 years, its validity can only be contested due to non-payment of premiums. During the first 2 years a Member is covered under this Plan, only a written statement signed by the Member can be used to contest the validity of the coverage. After the Member's coverage has been in force for 2 years during the Member's lifetime, no statement by the Member can be used to contest the validity of the Member's coverage.

Proof of Claim

Send written claim to Great-West as soon as reasonably possible. A written claim must be submitted no later than 15 months from the date the claim is incurred, unless the claim can not be filed for legal reasons.

Benefit Payments

The death benefit will be paid to the beneficiary(ies).

Legal Actions

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Physical Examinations

The Company, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary.

Autopsy

The Company may have an autopsy performed unless prohibited by law.

GLOSSARY

Actively at Work

Employment on an active and full-time basis at the Employer's usual place of business.

Doctor/Physician

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if:

- He or she performs a service within the scope of his or her license; and
- State law requires such practitioner to be covered.

Employee

See ELIGIBILITY.

Employer

- DOWNEY UNIFIED SCHOOL DISTRICT.

Hospital

An institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, unless required by state law, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Illness

An Injury, a sickness, a disease, a bodily or mental disorder or pregnancy. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

Loss of Residence

Being outside the United States for more than 60 days. However, a Member will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States:

- On vacation;
- To study; or
- To conduct business for your Employer;

For a period of up to, but not exceeding, 60 continuous days.

Member

An Employee.

Plan

The Life Insurance and AD&D benefits described in this booklet.

Proof of Good Health

Written evidence that the person meets Great-West's general underwriting standards. Such evidence includes but is not limited to medical evidence.

Service

See ELIGIBILITY.

GLOSSARY - Continued

Totally Disabled and Total Disability

Being under the care of a Doctor and prevented by Illness from working for pay or profit in any job for which you are or may become suited by reason of education, training or experience.

You and Your

An Employee.

USERRA RIGHTS AND RESPONSIBILITIES

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service.

"Uniformed Service" means the performance of active duty in the Uniformed Services under competent authority which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

Continued Life Insurance Benefits

If you are covered under the Employer's Plan for life insurance and the Plan includes continuation of life insurance benefits for an approved leave of absence, then you are eligible for this continuation when you take a leave for Uniformed Service. Continuation of such coverage is subject to the same conditions, limitations and payment provisions that apply to continuation of life insurance benefits for any other approved leave of absence. No continuation is available for AD&D benefits.

Reinstatement of Coverage

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

CONTINUATION OF COVERAGE - FMLA

If the Employer approves your FMLA leave pursuant to the Family and Medical Leave Act of 1993 (as amended) (FMLA), coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If you have questions about FMLA leave, see the Plan Administrator.