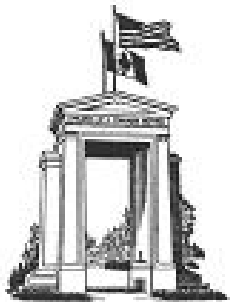

Blaine School District #503

Employee Benefit Guide

2017-2018 School Year

Important Open Enrollment Information

Open Enrollment Period: August 15th - September 29th, 2017

- Applications must be received by the Payroll Office no later than 4:00 pm on **September 29th** to be effective by the beginning of the plan year on November 1st.

Benefits Fair

Please plan on attending this one time event as this will be your only chance to meet with our insurance representatives to answer your questions or to get further information and details.

Date: Tuesday August 29th, 2017

Time: 7:30-8:40 am

Location: Blaine Middle / High School Cafeteria

975 H St

Blaine, WA 98230

The information herein is not a contract. It is a summary of the benefits available. It is not intended to be an all-inclusive description of Plan benefits, limitations or exclusions, and should not be used in lieu of a Plan book. Be sure to consult your Plan booklet, or consult with the insurance company representative before making your selection. If there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets prevail. Questions may be directed to Christine Anderson at (360) 322-0712, Lynn VanBuskirk at (360) 332-0710 or The Partners Group at 877-455-5640. This summary was printed on August 10, 2017. Any information not provided by that time or revisions by bargaining units or by insurers after this date could change or modify the information contained herein.

If you are unable to attend the Blaine School District Benefits Fair, many of our vendors will be attending the following Whatcom County School District benefits fairs.

Bellingham School District, Wednesday, August 16th, 2:00-6:00 pm
Bellingham High School
2020 Cornwall Ave
Bellingham, WA 98225

Ferndale School District, Wednesday, August 23th, 1:00-4:00 pm
Ferndale High School Cafeteria
5830 Golden Eagle Drive
Ferndale, WA 98248-0428

Lynden School District, Thursday, September 7th, 3:30-5:00 pm
Lynden High School Cafeteria
1203 Bradley Rd.
Lynden, WA 98264

Meridian School District, Tuesday, August 29th, 3:30-5:00 pm
Meridian High School
194 W. Laurel Rd.
Bellingham, WA 98226-9699

Mount Baker School District, Monday, August 28th, 2:30-5:00 pm
Mount Baker High School
4936 Deming Road
Deming, WA 98244-0095

Nooksack Valley School District, Thursday, August 31st, 2:30-5:30 pm
Nooksack Valley High School Commons
3326 E. Badger Road
Everson, WA 98247

PLEASE NOTE: A Premera Blue Cross representative will be attending the Bellingham and Ferndale benefits fairs ONLY.

A Willamette Dental representative will be attending the Bellingham, Blaine, Ferndale, Meridian, Mount Baker and Nooksack benefits fairs ONLY.

Welcome to Your Benefits!

Our District is proud to offer a comprehensive benefits package to its valued employees and their eligible family members. This package is designed to provide you with choice, flexibility and value.

This Benefits Guide will help you learn more about your benefits, review highlights of the available plans and make selections that best fit your lifestyle and budgetary needs. This information is also available on your District's website. In addition, you can contact the Human Resources Department or our Insurance Broker, The Partners Group for help in understanding your benefits. After enrollment, you will have access to insurance plan booklets that provide more detailed information on each of the programs you have selected.

Table of Contents

Enrolling or Making Changes to your Benefits

You may make changes to your benefit choices once a year during the open enrollment period. Outside of this period, you can add or drop dependents if there has been a qualifying event. Coverage will be effective for newborns on their actual date of birth. If you have been recently married, coverage becomes effective the 1st of the month after date of marriage.

You have the following time periods to enroll:

- 60 days from birth/adoption to add a child
- 30 days from date of marriage to add a spouse and stepchildren
- 30 days to add a spouse or children if there has been a loss of other group coverage
- 30 days to enroll dependents for voluntary benefits

Many of your benefits are on a pre-tax basis so the IRS requires you to have a qualified change in status in order to make changes to your benefits.

Types of Qualifying Events

- You get married or divorced
- You enter into a domestic partnership
- You have a child or adopt one
- An enrolled family member dies
- You (or your spouse) go on a leave of absence
- You waived coverage for yourself or your family member because of other coverage and that coverage is lost for qualified reasons

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may be able to enroll yourself or your dependents in our plans provided that you request enrollment within 30-60 days (depending on carrier) after your other coverage ends.

Unless one of the above Qualifying Events apply, you may not be able to obtain coverage under our insurance plans until the next open enrollment period.

Dropping Coverage

You may only drop coverage for yourself and/or dependents after open enrollment if there is a qualifying event as defined under Section 125. Please contact Human Resources/Payroll for additional information.

Dependents

Your legal spouse or domestic partner is eligible for coverage as well as any of your children (biological or step) up to age 26. Coverage is also available beyond age 26 for incapacitated children. Please see Human Resources for more information if you have questions on dependent eligibility.

Major Insurance Plan Changes for 2017-2018

State Allocation for Benefits

Employee benefits allocation depends on your bargaining group.

For All Regence Blue Shield Plans

- No benefit changes.
- The Regence Innova 1000 plan has been added.
- Premium rates increased 8.99%.

Kaiser Permanente - Traditional 250

- The Kaiser Permanente Traditional 250 plan has been discontinued.

Kaiser Permanente - Welcome 500 Plan

- The 4th quarter carryover will not apply.
- Acupuncture visits have been limited to 12 per calendar year. Additional visits are no longer available.
- Premium rates increased 10.69%.

Willamette Dental Group

- Composite (tooth colored) fillings will be covered on posterior (back) teeth.
- No change in premium rates.

Delta Dental of Washington, Formerly Washington Dental Service (WDS)

- No benefit changes.
- Premium rates decreased 2%.

Northwest Benefit Network

- No changes in plan benefits.
- Premium rates increased 2.12%.

Medical Insurance

Comprehensive and preventive health care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Our District offers you a choice of a variety of plans and plan styles. All plans cover most of the same benefits but your out-of-pocket costs and network physicians vary. Please review the types of plans available, listed below, then review the highlights of what each plan covers on the following pages.

Preferred Provider Organization (PPO)

These type plans contact with a large number of providers. If you choose to receive your care through a preferred provider, the insurance company will pay a higher percentage of the charges. If you choose to receive your care through a non-preferred provider, then the insurance company will pay a lower percentage of the charges.

Your PPO plan options are available through Regence.

To find a preferred provider through Regence, visit www.wa.regence.com.

High Deductible Health Plan (QHDHP)

These type plans operate almost like the PPO plans. If you choose to receive care through a preferred provider, the insurance company will pay a higher percentage of the charges than if you receive care from a non-preferred provider. ***Unlike a PPO plan, the deductible must be satisfied before the QHDHP plan will pay for any care (except preventive care), including prescriptions. Also, unlike a PPO plan, if there is more than one person enrolled on your plan, the family deductible must be satisfied before the plan will pay benefits (except for preventive care) for any enrolled member.*** **However, a single member on family coverage will not pay more than $6,850 OOPM for annual cost sharing. When a single member on family coverage reaches the $6,850 OOPM, benefits will be paid at 100% of the allowed amount for that member.**

If you choose to elect the QHDHP, you may be eligible for a Health Savings Account (HSA). An HSA is a bank account that allows you to deposit funds, on a pre-tax basis, that can be used to pay for qualified medical expenses. If you choose the QHDHP, you may be eligible for an HSA however if you do not choose the HDHP, you are not eligible to participate in an HSA. Further information on QHDHP's and HSA's are located further in this guide.

Your HDHP plan option is available through Regence and is the HSA 2.0 plan.

To find a preferred provider through Regence, visit www.wa.regence.com.

Health Maintenance Organization (HMO)

These type plans provide you with managed benefits and usually a lower cost at the time of service. However, these plans require that you select a primary care provider (PCP) from their list of providers. Your primary care provider will either provider or coordinate all of your care except in the case of a medical emergency.

Your HMO plan option is available through Kaiser Permanente.

To find a Kaiser Permanente provider, visit www.kp.org.

Special Note about Hospitals and Emergency Rooms

E.R. physicians and the hospitals they practice in are not always participating with the same insurance companies. The physicians and hospitals are *usually* under separate contracts.

To receive the highest benefits your insurance provides it is a good idea to check your nearest ER and physician participation prior to needing these services. You may do this by calling your insurance company or checking their website.

Medical Plan Options

Plan	Regence WEIC Innova $500		Regence WEIC Innova $2,500	
Network	**Preferred Provider**	**Participating Provider**	**Preferred Provider**	**Participating Provider**
Medical Deductible	$500 person / $1,500 family		$2,500 person / $7,500 family	
Rx Deductible	None		$500	
4th Qtr. Carry Over	Applies		Applies	
Carrier Coinsurance	80%	60%	80%	60%
Medical Out of Pocket Max	$3,000 person / $9,000 family		$5,000 person / $10,000 family	
Rx Out of Pocket Max	Included in Medical		Included in Medical	
Office Visit *Primary/Specialist*	$15 copay (dw)	$30 copay (dw)	$30 copay (dw)	$45 copay (dw)
Preventive Care*	Covered in full		Covered in full	
Diagnostic Lab & X-Ray	Covered in full up to $500 per year then ded & coins		Covered in full up to $500 per year then ded & coins	
Advanced Diagnostic Imaging				
Emergency Care**	$75 copay + ded & coin		$75 copay + ded & coin	
Ambulance	Deductible & coinsurance		Deductible & coinsurance	
Hospital (Inpatient)	Deductible & coinsurance		Deductible & coinsurance	
Hospital (Outpatient)	Deductible & coinsurance		Deductible & coinsurance	
Spinal Manipulations	Deductible & coinsurance 10 manipulations PCY		$30 copay (dw) 10 manipulations PCY	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	60 visits PCY		25 visits PCY	
	Deductible & coinsurance		$30 copay (dw)	
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY		30 days PCY	
	Deductible & coinsurance		Deductible & coinsurance	
Prescriptions	**Generic / Brand / Non-Formulary - At Participating Pharmacies**			
Retail Cost Share	$5 / $20 / $40 (30 day supply)		$0 (dw) / $30 / $45 (30 day supply)	
Mail Order Cost Share	$10 / $40 / $80 (90 day supply)		$0 (dw) / $60 / $90 (90 day supply)	
Specialty Cost Share	$75 Copay through BriovaRx Only (30 day supply)		$75 Copay through BriovaRx Only (30 day supply)	
Life/AD&D Insurance	None			

*Preventive Services as defined by the Affordable Care Act
**Copay waived if admitted to hospital

Non participating providers are subject to ded & coin and may balance bill for services

To locate a Regence provider, visit www.wa.regence.com

(dw)= Deductible Waived
(PCY) = Per Calendar Year
Ded & coin = Deductible & Coinsurance Apply
OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

Medical Plan Options

Plan	Regence WEIC Engage 70		Regence WEIC HSA 2.0ł	
Network	**Preferred Provider**	**Participating Provider**	**Preferred Provider**	**Participating Provider**
Medical Deductible	$750 person / $2,250 family		$1,500 person, $3,000 familył	
Rx Deductible ***	None		None	
4th Qtr. Carry Over	Applies		Does NOT apply	
Coinsurance	70%	70%	80%	60%
Medical Out of Pocket Max	$5,750 person / $11,500 family		$5,000 person / $10,000 family	
Rx Out of Pocket Max ***	Included in Medical		Included in Medical	
Office Visit	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Preventive Care*	Covered in full		Covered in full	
Diagnostic Lab & X-Ray	Deductible and Coinsurance		Deductible and Coinsurance	
Advanced Diagnostic Imaging	Deductible and Coinsurance		Deductible and Coinsurance	
Emergency Care**	$75 copay + ded & coin		Deductible & coinsurance	
Ambulance	Deductible & coinsurance		Deductible & coinsurance	
Hospital (Inpatient)	Deductible & coinsurance		Deductible & coinsurance	
Hospital (Outpatient)	Deductible & coinsurance		Deductible & coinsurance	
Spinal Manipulations	Deductible & Coinsurance 10 manipulations PCY		Deductible & Coinsurance 10 manipulations PCY	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient **(Speech, Massage, OT, PT)**	50 visits PCY		25 visits PCY	
	Deductible & coinsurance		Deductible & coinsurance	
Rehab - Inpatient **(Speech, Massage, OT, PT)**	30 days PCY		30 days PCY	
	Deductible & coinsurance		Deductible & coinsurance	
Prescriptions	**Generic / Brand / Non-Formulary - At Participating Pharmacies**			
Retail Cost Share	$5 / $20 / $40 (30 day supply)		Deductible & Coinsurance (30 day supply)	
Mail Order Cost Share	$10 / $40 / $80 (90 day supply)		Deductible & Coinsurance (90 day supply)	
Specialty Drug Cost Share	$75 Copay through BriovaRx Only (30 day supply)		Deductible & Coinsurance through BriovaRx Only (30 day supply)	
Life/AD&D Insurance	None			

*Preventive Services as defined by the Affordable Care Act
**Copay waived if admitted to hospital
Non participating providers are subject to ded & coin and may balance bill for services

(dw)= Deductible Waived
(PCY) = Per Calendar Year
Ded & coin = Deductible & Coinsurance Apply

OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

łRegence HSA 2.0:, the deductible must be satisifed before benefits are payable. If more than one person is enrolled, the family deductible must be satisifed before benefits are payable for ANY enrolled person/HSA 2.0 Rx Ded does not apply to certain preventive drugs, women's contraceptives, or immunizations. A single member on family coverage will not pay more than $6,850 OOPM for annual cost sharing. When a single member on family coverage reaches the $6,850 OOPM, benefits will be paid at 100% of the allowed amount for that member.

To locate a Regence provider, visit www.wa.regence.com

Medical Plan Options

Plan	Regence WEIC Innova $1,000		Kaiser Permanente Welcome 500
Network	**Preferred Provider**	**Participating Provider**	**At a GHC facility/Provider only**
Medical Deductible	$1,000 person / $3,000 family		$500 person / $1,500 family
Rx Deductible	None		None
4th Qtr. Carry Over	Applies		Does not apply
Carrier Coinsurance	80%	60%	80%
Medical Out of Pocket Max	$5,000 person / $10,000 family		$2,000 person / $6,000 family
Rx Out of Pocket Max	Included in Medical		Included in Medical
Office Visit *Primary/Specialist*	$30 copay (dw)	$45 copay (dw)	Visits 1-4 - $20 copay (dw) Visits 5+ - $20 copay then ded & coin
Preventive Care*	100% (dw)	100% (dw)	100% (dw)
Diagnostic Lab & X-Ray	Covered in full up to $500 per year then ded & coins		Covered in full up to $500 per year then ded & coins
Advanced Diagnostic Imaging			
Emergency Care**	$75 copay + ded & coin		$100 copay + ded and coin
Ambulance	Deductible & coinsurance		80%
Hospital (Inpatient)	Deductible & coinsurance		80% deductible
Hospital (Outpatient)	Deductible & coinsurance		$20 copay (dw) then ded & coin
Spinal Manipulations	Deductible & coinsurance 10 manipulations PCY		10 manipulations PCY without prior authorization
Vision Care	Not Covered		One exam every 12 months
Rehab - Outpatient (Speech, Massage, OT, PT)	60 visits PCY		45 visits (PT, Speech, Massage, OT)
	Deductible & coinsurance		See Office Visit limits
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY		30 visits (PT, Speech, Massage, OT)
	Deductible & coinsurance		80%+ deductible
Prescriptions	**Generic / Brand / Non-Formulary - At Participating Pharmacies**		
Retail Cost Share	$10 / $25 / $50 (30 day supply)		$15 / $30 (30 day supply)
Mail Order Cost Share	$20 / $50 / $100 (90 day supply)		$30 / $60 (90 day supply)
Specialty Cost Share	$75 Copay through BriovaRx Only (30 day supply)		Subject to applicable retail copay through GHC Specialty Medication Pharmacy Only (30 day supply)
Life/AD&D Insurance	None		

*Preventive Services as defined by the Affordable Care Act
**Copay waived if admitted to hospital

Non participating providers are subject to ded & coin and may balance bill for services

To locate a Regence provider, visit www.wa.regence.com
To locate a Kaiser provider, visit www.kp.org/wa.

(dw)= Deductible Waived
(PCY) = Per Calendar Year
Ded & coin = Deductible & Coinsurance Apply
OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

High Deductible Health Plan and HSA Questions and Answers

How does the High Deductible Health Plan (HDHP) work?

- Unlike your other health plans that have co-pays for certain services that do not apply toward the deductible, on an HDHP, your deductible **must be met before** payments are provided for any services (except for Preventive Care) including prescriptions. If there is more than one person covered by your HDHP (spouse and/or child) the family deductible **must be met before** payments are provided for ANY person enrolled.

What is a Health Savings Account (HSA)?

- A Health Savings Account is a special bank account tied to your HDHP where you can put in money, on a pre-tax basis, to pay for "qualified medical expenses" such as prescriptions, services provided by your HDHP, dental plan and vision plan.

Who is eligible to participate in an HSA?

- Anyone covered by an HDHP, however, you or your enrolled spouse cannot be covered under another medical plan unless that plan is also an HDHP.
- If you are no longer covered by an HDHP, or you enroll in Medicare, you can no longer contribute funds to an HSA but you can use the remaining funds toward eligible expenses.
- You cannot participate in an HSA if you can be claimed as a dependent on another person's tax return.
- As this is a bank account, you must be eligible to open a bank account. This process may include a credit check.

Can I have an HSA and a Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA)?

- Any person covered by an HDHP **cannot** have an FSA or HRA **including VEBA** unless it is a **non-medical** FSA or HRA such as a daycare reimbursement FSA or a "limited purpose" non-medical FSA.
- If your spouse has an FSA that could cover your medical expenses, you **cannot** participate in an HSA.

How much can I contribute to my HSA?

- Your current premium dollars includes a monthly contribution of $125 towards your HSA.
- You (and/or your employer) can contribute up to the Federal Annual Limit. For 2017, including employer contributions, it is $3,400 (individual) or $6,750 (family). For 2018, the limit increases to $3,450 (individual) and to $6,900 (family).
- If you are over age 55, contributions may include an additional $1,000 per calendar year.
- Married couples with two separate HSAs are limited to a total of $6,750 between the two accounts if one has an HDHP with employee & dependents enrolled.
- Contributions to your HSA are deducted from your paycheck on a pre-tax basis and deposited by your employer.

How do I use my HSA?

- Most HSAs come with a debit card attached to the account. Use or provide this card at time of service/purchase to use the funds in your HSA.
- You may also provide receipts for eligible expenses to your HSA administrator for reimbursement if you do not use your HSA debit card.

High Deductible Health Plan and HSA Questions and Answers continued

Important Things to Be Aware of About your HDHP and HSA

- The HSA is a bank account, in your name, that belongs to you. If you leave your employer, the account goes with you and you can continue to use it for qualified medical expenses. Any monthly banking fees for the HSA are your responsibility and will be deducted directly from your HSA.
- Over-the-Counter medications are not a qualified medical expense under an HSA.
- Any use of HSA funds for a non-qualified medical expense is subject to a 20% tax penalty and applicable income taxes. You should keep all your receipts for purchases made with your HSA in case you are audited by the IRS.
- You cannot use HSA funds for any item or service provided prior to your effective date on your HDHP. For example, if your HDHP was effective 11/1/2017 and your dentist performed a crown on 9/5/2017, you cannot use HSA funds on this service.
- Unlike an FSA, you can only use the funds that have already been deposited in your HSA. If you receive a bill for $400 for services but only have $200 in your HSA available, you can only use $200.
- You can use your HSA funds for qualified medical expenses for any tax dependent even if they are not covered by your HDHP. You cannot, however, use your HSA funds for qualified medical expenses for someone who is not a tax dependent (e.g. a child over the age of 26.)
- All deductibles on your HDHP reset January 1st of each calendar year. There is no carry forward of deductibles met in the prior year. If you enroll in an HDHP on November 1, your medical expenses will be subject to the entire annual deductible for the remainder of the calendar year and will reset on January 1.

This is just a brief overview of HSAs and HDHPs and is not inclusive of all tax laws. More information can be found at www.treasury.gov , and on IRS Publication 969 and 502 or by consulting your tax professional

Saving Money on Your Medical Costs

Health care costs can be expensive. You can help keep your costs down for yourself and for everyone enrolled under our plans by making wise choices.

Use The Emergency Room for Emergencies Only

If you have a life threatening emergency, contact 911 or go to an emergency room but if your condition is not life threatening or a medical emergency, use an urgent care facility or see your doctor. Urgent Care facilities are significantly cheaper than emergency rooms and generally only require a small co-pay for their use.

Select Generic Prescription Drugs When Available

If a generic drug is available and will work for you, select the generic. Generic drugs are considerably less expensive for you and our insurance plan. Some plans, like the Premera EasyChoice plans, include a separate deductible for prescriptions that is waived if you select generic drugs.

Choose to Receive Care from a Preferred (In-Network) Provider on Your PPO Plan.

To make sure you are receiving the maximum coverage possible, ask if the physician or the medical facility whose services you want to use is in your plan's "preferred provider" network. Always be sure to ask, if you are being referred for any services, that you are being referred to a preferred provider. While your hospital or physician may be a preferred provider, the lab they use or refer you to for tests may not be and you will be responsible for a greater percentage of the charges as a result.

Participate in the Flexible Spending Account

Our Flexible Spending Account (FSA), described under the Voluntary Benefits section of this guide, allows you to pay many of your out-of-pocket expenses such as deductibles, co-pays, co-insurance, non-covered health care costs and dependent care with before-tax dollars. The FSA allows you to spread these costs over the year as just a portion of your annual election is deducted from each paycheck.

Mandatory Dental Benefits

For All District Employees

If you are a new hire or wish to make changes, you will need to enroll using the online system or by calling the WEA Select Benefits Center at 1-855-668-5039.

Dental benefit eligible employees must enroll in either of the dental plans below.

Under the Delta Dental of Washington Incentive Plan, you may receive care from any dentist. However, if you receive care from a preferred provider dentist, your out-of-pocket expenses will be lower and your maximum plan year benefit will be higher.

To find a Delta Dental of WA provider go to www.deltadentalwa.com/wea.

Delta Dental of WA Incentive Plan A (Group #186)	
Plan Year Maximum (Nov 1 - Oct 31)	$1,750 per person (Non-PPO providers) $2,000 per person (PPO providers)
Preventive Services (Exams, X-Rays, Cleanings, Fluoride, Sealants)	70% - 100% Incentive
Restorative Services (Fillings, Oral Surgery, Endo, Perio)	70% - 100% Incentive
Onlays, Crowns	70% - 100% Incentive
Major (Dentures, Bridges, Partials & Implants)	50%
Temporomandibular Joint Disorder	50% up to $1,000 Annual Maximum $5,000 Lifetime Maximum
Orthodontia (Plan E)	$1,250 Lifetime Max for Each Dependent Child

During your 1st benefit year on this plan, 70% of covered benefits are paid. This advances by 10% annually (on November 1) **providing you use the program at least once each benefit year to a maximum of 100%. Failure to use the program once each benefit year causes your benefit level to drop by 10% but never lower than 70%. Each eligible employee creates their own percentage level. Percentage levels do not affect the 50% level on allowable prosthetics (dentures and bridges) and orthodontics.

The Willamette Dental plan is an Exclusive Provider Organization plan. In order to access benefits provided by these plans you need to see an authorized provider. If you obtain care from a non-authorized provider, you will not receive any benefits provided by these plans.

You must receive services from a Willamette provider in order to receive coverage.

To find a Willamette provider, go to www.willamettedental.com.

Willamette Dental	
Plan Year Maximum (Nov 1 - Oct 31)	No annual max
Preventive (Exams, X-Rays, Cleaning etc.)	$15 copay then covered at 100%
Restorative Services (Fillings, Extractions, etc.)	$15 copay then covered at 100%
Major Care (Crowns, Dentures, Partials Bridges, etc.)	$50 copay plus a $15 copay per visit, then covered at 100%
Temporomandibular Joint Disorder	$1,000 Annual Max Benefit $5,000 Lifetime Max Benefit
Nightguards	$15 copay then covered at 100%
Orthodontia (Plan 1 - Children Only)	$1,500 orthodontia copay then covered at 100%

Mandatory Vision Benefits

Plan Year/Rates Renew November 1

Our District provides its eligible employees working a minimum of **17.5 hours per week** vision care coverage through Northwest Benefit Network (NBN). This plan allows you to use any licensed provider. However, if you use an NBN panel provider, your benefits are greater, your out of pocket costs are less and payment is made directly to the provider. Please refer to the table below to find out how often you are eligible for services and what benefits are provided. There is no co-payment required on materials or eye exams for either Panel (Participating) or Non-Panel Providers. Many benefits obtained from Panel Providers are covered at 100%, with a few of the exceptions listed below. For Non-Panel Providers, members pay all charges and are reimbursed up to the allowances listed below under "Non-Panel Providers". Either contacts or glasses may be obtained in a benefit period—not both. Children are eligible from birth to age 26.

	Frequency †	NBN Panel Providers	Non-Panel Providers
Eye Exam	Every year	100%	$35
Single Vision Lenses	Every year	100% *	$30
Bifocal Lenses	Every year	100% *	$40
Trifocal Lenses	Every year	100% *	$45
Progressive Lenses	Every year	100% **	$40
Lenticular Lenses	Every year	100% *	$90
Continuous Blend	Every year	100% **	$40
Lens Coating, Tints, Oversize	Every year	Some covered	Not covered
Frames	Every 2 years	100% ***	$30
Elective Contacts	Every year	$175 ****	$90
Necessary Contacts	Every year	100%	$200

PLEASE NOTE: Your benefits are tracked from service date to service date; there is no "grace period."

* Lenses necessary to correct the visual acuity of the patient are fully covered. Specialized lenses, special features and "extras" may not be covered.
** Standard grades of 'continuous blend' lenses are covered.
*** Plan pays 100% of a selection of frames; subscriber pays additional amount for more expensive frames.
**** $175 contacts allowance is for the exam, fitting and lenses combined, in lieu of all other services for 365 days.
† Every Year = 365 consecutive days. Every 2 Years = 730 consecutive days.

Kaiser Permanente offers coverage for eye exams. Kaiser Permanente subscribers can maximize their NBN contact allowance by billing their eye exam to Kaiser Permanente.

Obtaining services from a Panel Provider:

Register on www.nwadmin.com to locate a panel provider and access your account.

Present your NBN Vision ID card when you arrive for your appointment. Failure to tell your NBN eye care professional that you have NBN Vision eye care coverage could result in significant out-of-pocket expenses. Additional ID cards can be printed online at www.nwadmin.com. Complete any paperwork your eye care provider may require. The panel provider will go over what services are covered by your plan. After your services are complete, pay your NBN Vision provider any required co-payments and/or charges for any uncovered items you elected to receive. NBN will pay the panel provider directly for professional services and eyewear covered under your NBN Vision Plan.

Obtaining reimbursement for services at a Non-Panel Provider:

Send in your itemized statement and NBN claim form to the NBN claims office. NBN will process your claim and reimburse you directly in accordance with the non-panel schedule of benefits.

If you obtain services or eyeware before you are eligible, you will be responsible for all charges incurred. If a non-covered lens extra or a frame that exceeds the plan allowance is ordered, you are responsible for the additional costs including any fees. All claims must be submitted within 365 days from the date of service to be considered for payment. There will be additional patient responsibility if a premium version of a covered item is ordered as the plan only covers standard styles of lens extras.

This is a summary only of the benefits of the plan. Actual benefits are based upon the plan agreement which may contain plan details not specified in this plan summary. Register at www.nwadmin.com to review your past claims history, eligibility status, plan documents, print a claim form and more.

Mandatory Long Term Disability Insurance

All employees working a minimum of **17.5 hours per week** will be covered by our District's Long Term Disability Policy provided by Cigna. This plan provides financial assistance if you are not able to return to work due to a qualified disabling condition. Plan benefits are below.

Benefits begin paying at:	After the 90th day of disability
Benefit Amount	60% of your gross monthly income up to $6,000/month
Benefits stop paying at:	Your Social Security Normal Retirement Age (if disabled before age 65) If disabled after age 65, benefits end based on age when disabled. See plan documents for schedule.
Restrictions	Mental Illness/Drug & Alcoholism is covered only for 24 months

There are other benefits and restrictions on these benefits. Please review the Plan Summary for details.

Mandatory Life Insurance

All District Employees are eligible for $30,000 of Life insurance coverage through CIGNA. If you leave the District, convertibility to an individual policy is available. At age 70, benefit reduces by 50%.

Employee Assistance Program

Health Promotion Network (EAP) is a voluntary and confidential, professional assessment and referral program for employees and the members of their household. Dependent upon the counselor's assessment of the situation, up to 4 visits can be available at no cost to the employee. The EAP offers assessments and referral sessions, short-term counseling, and 24-hour emergency consultation services. It is staffed by trained and licensed professionals.

The EAP line is 800-244-6142 or 360-788-6565.

Voluntary Benefits

Our District offers a variety of voluntary benefits to eligible employees on the following pages. *Please be aware that these benefits cannot be paid for from monies from your state allocation*.

Voluntary Short Term Disability/Salary Insurance

Our district offers its eligible employees Short Term Disability/Salary insurance through American Fidelity. This policy is designed to provide you with a cash benefit in the event you suffer a qualified short term disability. This plan includes offsets that will subtract any other sources of income, such as Social Security. This plan will not offset income received from sick pay for the first 30 days. Injury or sickness arising out of or in the course of any occupation for wage or profit for which you are entitled to Worker's Compensation will not be covered under the benefits listed below.

Eligible Class	**All Classes**
AmFi Brochure #	SB-30485
Benefit Amount	Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month
Waiting Period	0 days for injury / 7 days for sickness (benefits begin on 8th day for sickness)
Benefit Period	90 days

These plans include a limitation to offset with other sources of income. Participants will be eligible to receive up to 70% of their monthly earnings, which includes other income received, such as sick pay (after 30 days) or unemployment compensation. Injury or Sickness arising out of or in the course of any occupation for wage or profit for which you are entitled to Worker's Compensation will not be covered under this plan.

The above information does not constitute a contract. It only highlights some general information. These products contain limitations, exclusions, and waiting periods. Please be sure to consult the appropriate WEA Select American Short-Term brochure for a summary of the plan's rates, specific benefits, limitations, exclusions, and elimination period information before making your selection. The brochure is available in the human resource department and/or through an American Fidelity Assurance Company representative at 1-866-576-0201 between 8:00 AM and 5:00 PM or via the Internet at www.americanfidelity.com.

An American Fidelity representative will be on site the last week in September in order to enroll or make changes for the benefit year beginning October 1, 2017.

AFLAC Supplemental Insurance

Employees have the opportunity to select supplemental insurance coverage through AFLAC. Most policies can be paid on a pre-tax basis through payroll deduction. AFLAC provides supplemental insurance policies to help with medical and living expenses associated with serious injuries or illnesses. Policy benefits are paid directly to you, unless assigned, regardless of any other coverage you may have. Benefits cannot be reduced because of other insurance. Also, payroll rates may be retained upon retirement or job change. AFLAC policy lines include: Personal Short Term Disability, Accident, Intensive Care, Cancer Expense, Life Assurance, Dental and Personal Recovery (a policy for heart attacks, strokes and more).

NOTE: Not all benefits available in every district. Contact Elena Johnson at (360) 676-4848 for more information.

Section 125 Plan / Flexible Spending Account

Section 125 Plan enables participating employees to reduce their income tax liability by setting aside pre-tax dollars from their earning to pay for out-of-pocket premiums, health care, and dependent care costs.

American Fidelity Assurance Company:

There are three ways to save by participating in the Section 125 Plan – by pre-taxing eligible insurance premiums, by participating in the Dependent Day Care Flexible Spending Account (Dependent Day Care FSA), and by participating in the Health Flexible Spending Account (Health FSA). Consider the following reasons to participate:

- Tax Advantages – Participating in the Section 125 plan helps you lower the amount you pay in taxes and thereby, increase your take-home pay.
- Control – You decide how much to put into the Flexible Spending Accounts.
- Out-of-Pocket Medical / Dental Expenses –You can pre-tax eligible medical and dental expenses, such as orthodontia, copayments, and deductibles. You must have a medical practitioner's prescription on file in order to be reimbursed for over-the-counter drugs and medicines. .
- Dependent Care Expenses – The Dependent Day Care FSA reimburses for certain eligible dependent care costs (e.g., daycare) with pre-tax dollars and thus reduces your taxable income. .

The eligible insurance plans available under Section 125 include dental, health, and vision insurance. These benefits will automatically be pre-taxed under the plan. If an employee does not want to participate in this plan, they must sign and return a "Premium Payment Plan Refusal" form to Lynn VanBuskirk. Elections made under the Section 125 plan must remain in place for the length of the plan year unless the employee experiences an allowable election change event mid-plan year (consult your employer for more details). An employee cannot change or revoke their Health FSA election during the contract year. Cancellation or changes for this account are allowed only during the next annual open enrollment period.

To take advantage of either or both of the Flexible Spending Accounts, you must complete an election form and return it to the payroll office prior to 9/30/2017. Employees currently participating in either of the Flexible Spending Accounts also need to submit a new election form for October 2017 through September 2018 to the payroll office. You must complete the appropriate election form with the American Fidelity Representative who will be scheduling appointments the last week of September, 2017. All employees participating in the plan need to submit an application for 2017/18. All employees will need to see the American Fidelity Representative as no manual forms will be accepted.

Grace Period: The Health FSA allows for a 70 day grace period immediately following the end of each plan year. During the grace period, unused account balances remaining from the previous plan year may be used to reimburse eligible medical expenses incurred during the grace period. The plan also allows for a 90 day runoff period after the end of the plan year during which the participant can submit eligible Health FSA or Dependent Day Care FSA claims incurred during the preceding plan year (and, for the Health FSA, the grace period) for reimbursement.

Voluntary Long Term Care Insurance

Medical plans provide little to no coverage for long term care, from home care to nursing home care. The District offers you the opportunity to purchase permanent long term care insurance through UNUM Insurance Company at low group rates and you may keep the plan beyond retirement. Long term care insurance provides you with benefits to pay for care when you cannot take care of yourself and need services either in your own home, an assisted living facility or a convalescent care facility. This can include short or long term rehabilitative care, which is very expensive. The coverage is available to all benefit eligible employees, spouses, parents and grandparents. Employees, who enroll within 30 days of eligibility, are guaranteed acceptance regardless of medical conditions. You may also enroll any year during open enrollment with medical underwriting for acceptance. All other family members require medical underwriting. This is a very flexible plan, which allows you to purchase the amount and type of coverage that makes sense for you and your family. Monthly premium depends on your age and the amount purchased.

For more information, please contact Lynn VanBuskirk at (360) 332-0710 OR you may contact the plan administrator directly: Terry Wood at Lehmann/Wood & Associates, Inc. at 800.696.1939 or www.lehmannwood.com.

Helpful Information

The information on the following pages is presented for your information. If you have any questions on this information, please contact Human Resources.

Family Medical Leave Act of 1993 (FMLA)

The Federal Family Medical Leave Act (FMLA) was signed into law in February 1993. The law guarantees up to 12 weeks of unpaid leave each year to workers who need time off for the birth or adoption of a child, to care for a spouse or immediate family member with a serious illness, or who are unable to work because of a serious health condition. Employees are eligible if they worked for a covered employer for at least one year and for 1,250 hours over the previous 12 months.

The FMLA is an employer law; it covers employers with 50 or more employees and affects many job-related rights of employees. Among other things, this law also affects the health benefit plans maintained by employers who are required to comply. Employers are required by FMLA to continue to provide group health benefits at the same level and under the same conditions as if the employee had continued to be actively at work. A person who fails to return from an FMLA leave may be entitled to continuation of coverage under COBRA. For specific questions, contact the personnel department or contact the Department of Labor for a copy of the FMLA law..

Continuation of Coverage

If you leave the District, certain insurance coverages, which have been provided, may be continued. Should you decide to continue coverage, continuation will become effective when your current plan normally would have terminated. For additional information please refer to your plan booklet.

GROUP MEDICAL INSURANCE - Medical insurance may be continued under COBRA. It is also convertible to a guaranteed individual policy. The benefits of the policy will vary and are usually less than provided by your group policy. Other medical plans are available on an individual basis.

GROUP DENTAL/VISION INSURANCE - Dental and/or Vision insurance may be continued under COBRA. This is not convertible to individual policies.

Federal law requires most group health plans maintained on behalf of 20 or more employees to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain cases. A “group health plan” includes any employer-provided medical, dental, vision care, or prescription drug coverage. If you or a qualifying family member wish to provide notice of any required events affecting your COBRA coverage, or have any questions about COBRA, please contact your employer representative Lynn VanBuskirk, Blaine School District, (360) 332-0710.

School Employees Retirement Systems

If you have questions regarding your retirement information under PERS/SERS/TRS, please contact:

Department of Retirement Systems

800-547-6657

www.drs.wa.gov

Healthy Kids Now through Apple Health

Infants through teenagers may be eligible to receive free or low cost health insurance in Washington State. Many families qualify and don’t know it. These programs are flexible and cover kids in many types of households. This program covers a full range of services that all children need to stay healthy. For more information, please contact or visit:

Apple Health Hotline

1-877-KIDS-NOW

www.insurekidsnow.gov

Washington State Deferred Compensation Program (DCP)

The Deferred Compensation Program (DCP) helps you save for retirement on a pre-tax basis, offering the options you need to develop a personal investment strategy. With DCP, you authorize your employer to postpone or defer a part of your income, before taxes are calculated, and have that money invested in your DCP account. Both the income you save and the earnings on your investments grow tax-deferred to add to your future retirement and Social Security benefits.

With DCP, you decide how much money you want deducted from each paycheck. That can be as little as $360 per year or as much as the annual legal maximum of $18,000 if you are under age 50 and $24,000 if you are over age 50 for 2017.

How does Deferred Compensation Work?

With DCP, you may elect to defer a portion of your salary until retirement or separation from service. Automatic payroll deduction makes savings easy as the amount you choose to defer is taken from your gross income before taxes. For example, if you are in the 15% tax bracket, for every $100 you earn, you keep only $85 because $15 is withheld for federal income taxes. If you elect to defer $100 into a DCP, your take home pay is only reduced by $85 because the $100 is deferred before taxes are calculated. When deciding how much to save, consider adding that extra income to your deferral amount. It can have a significant impact at the time you retire.

Should you have any questions or would like more information on the Washington State Deferred Compensation Program, contact the DCP at:

Phone: 1-888-327-5596 (Mon-Fri 8:00-5:00pm)

Email: dcpinfo@drs.wa.gov

Mail: PO BOX 40931 Olympia, WA 98504-0931

Workers Compensation & Occupational Safety and Accident Prevention Program

The Blaine School District is an insured employer through the Washington State Department of Labor & Industries. Our occupational safety and accident prevention program applies to any work-related injury or illness. If you sustain a work-related injury, the following steps are to be followed:

- Immediately report any injury (treated or untreated) to your supervisor and complete the Accident Report Form.
- The Return to Work Release Form is to be completed by the doctor and returned to the District Claims Manager prior to returning to work.
- If time loss is required or transitional work possible a Physical Capacities Evaluation is to be completed by the doctor and returned to the District Claims Manager prior to returning to work.

Obtain the Washington State Fund Report of Industrial Injury or Occupational Disease Form from the doctor and mail to the State. The employer portion is mailed to the district for completion of “Employer Information”.

The Blaine School District’s Return to Work Program is a team effort involving the injured employee, immediate supervisor, district safety officer, claims manager, personnel administrator and doctor. Should you become injured, it is important that you return to employment as early as it is medically safe for you to do so. We will stay in contact with you and your doctor to keep up to date on your recovery process. We have developed transitional duty assignments for employees who are unable to return to their normal duties while recovering from their injuries. Medical studies show that transitional work speeds the healing process.

The Blaine School District has a sick leave buy back process. Should you receive compensation from the State Fund for time off work due to an injury, bring it to the Payroll Office to buy back a portion of your sick leave.

Insurance Committee

Your insurance committee is made up of elected representatives from our district. The Committee reviews all the plans available to us from our Insurance Broker and advises District leadership on the benefits offered to employees.

If you are interested in participating on this committee, please contact Human Resources. Your committee members are:

Russell Carleton	BEA member needed
Lynn VanBuskirk	Christine Anderson

Insurance Contact Information

Carrier Name	Coverage	Group/Policy #	Phone Number	Website
Regence Blue Shield	Medical	60017856	888-367-2112	www.wa.regence.com
Kaiser Permanente	Medical	Welcome - 1055600	888-901-4636	www.kp.org/wa
Delta Dental of WA	Dental	186	800-554-1907	www.deltadentalwa.com
Northwest Administrators	Vision	WS	800-732-1123	www.nwadmin.com
Cigna	Life/Long Term Disability	SGD0600401	800-362-4462	www.cigna.com
Cigna	"Additional" Employee Assistance Program	N/A	800-538-3543	www.cignabehavioral.com
Health Promotion Network	Employee Assistance Program	N/A	800-244-6412 360-788-6565	www.peacehealth.org/whatcom/eap
American Fidelity	Flexible Spending Account Voluntary Disability	N/A	866-576-0201	www.afadvantage.com
VEBA Service Group	Health Reimbursement Plan	N/A	800-422-4023	www.veba.org
AFLAC	Supplemental Insurance	N/A	360-676-4848	
Dept. of Retirement Systems			800-547-6657	www.drs.wa.gov
Unum/Lehmann Wood	Long Term Care	N/A	800-696-1939	www.lehmannwood.com/school/blaine_index.htm

District Contact Information

Human Resources	Christine Anderson	360-332-0712	canderson@blainesd.org
Payroll	Lynn VanBuskirk	360-332-0710	lvanbuskirk@blainesd.org

If you have any questions regarding your benefits please contact the numbers above or you can contact our Insurance Consultant:

The Partners Group
Emily Austin
877-455-5640 x 311 or eaustin@tpgrp.com

Glossary of Terms

Advanced Diagnostic Imaging – Diagnostic services such as CAT scans, MRIs, and PET scans.

Allowed charges – Services rendered or supplies furnished by a health provider that qualify as covered expenses and for which insurance coverage will pay in whole or in part, subject to any deductible, coinsurance or table of allowances included within the plan design.

Benefit Period – The period designated for application of deductibles or specific types of benefits, after which, the deductible must be satisfied again before the benefits are again available.

Coinsurance – A provision under which the enrollee and the carrier each share a percentage of the cost of a covered service. A typical coinsurance arrangement is 80% / 20%. This means the carrier will pay 80% of the eligible charges and the enrollee will pay 20%.

Copayment - Generally used to refer to a fixed dollar amount the enrollee pays to the provider at time of service.

Deductible – The amount of out-of-pocket expenses that must be paid for services by the covered person before the carrier will begin to pay benefits. Please note that your medical deductible is run on a calendar year basis.

Explanation of Benefits (EOB) – A description sent to you by your carrier that describes what benefits were paid for a particular claim.

Family Deductible – A deductible that is satisfied by the combined expenses of all family members. For example, a program with a $200 deductible may limit its application of the deductible to a maximum of three deductibles ($600) for the family regardless of the number of family members enrolled. Under a High Deductible Health plan, the full family deductible must be satisfied before benefits are payable under anyone enrolled if there is more than one person enrolled.

Maximum Benefit – The largest dollar amount or number of visits a plan will pay towards the cost of a specific benefit or overall care.

Open Enrollment – A period in which you have an opportunity to make changes in your benefit selections or a period when uninsured individuals can obtain coverage without presenting evidence of insurability (health statements).

Out-of-Pocket Expenses - Those health care expenses for which the enrollee is responsible. These include deductible, coinsurance, copayments and any costs above the amount the insurer considers usual and customary or reasonable (unless the provider has agreed not to charge the enrollee for those amounts).

Out-of-Pocket Maximum – The amount that the enrollee must pay for deductibles, coinsurance and copayments in a defined period (usually a calendar year) before the insurer covers all remaining eligible expenses at 100%.

Specialty Medication – Medications that treat serious health condition such as cancer and rheumatoid arthritis. They are complex and expensive, and may require intensive monitoring.

Monthly Insurance Rates for 2017-2018

MEDICAL	Regence WEIC Engage 70	Regence WEIC Innova 500	Regence WEIC Innova 1000	Regence WEIC Innova 2500	Regence WEIC HSA 2.0*
Employee Only	$655.72	$862.77	$767.86	$624.48	$710.56
Employee & Spouse	$1,171.42	$1,656.18	$1,473.97	$1,115.64	$1,249.09
Employee & Child(ren)	$968.96	$1,344.72	$1,196.80	$922.84	$1,037.68
Family	$1,484.69	$2,138.12	$1,902.90	$1,414.00	$1,576.20

*HSA 2.0 plan premiums include a $125 monthly contribution to your Health Savings Account.

MEDICAL	Kaiser Permanente Welcome 500
Employee Only	$682.78
Employee & Spouse	$1,305.67
Employee & Child(ren)	$1,038.65
Family	$1,660.49

DENTAL	Delta Incentive w/ Ortho E	Willamette Dental Plan 1 w/Ortho 1
Composite/Family Rate	$112.60	$87.85

EAP	Health Promotion Network
Composite/Family Rate	$2.09

VISION	NBN Vision
Composite/Family Rate	$24.00

Dental, vision and EAP plan rates are composite rated. The rate is the same if it's just a single employee enrolled or an employee and his/her family.

State Mandated Retiree Benefit

A Washington State health care reform bill enables retirees and disabled school employees to purchase health care insurance from the state Health Care Authority. In order to support the K-12 retiree health care plan, school districts are required to forward to the Health Care Authority **$64.07** per month per full time employee.