Employee Benefit Guide

2016-2017 School Year

Important Open Enrollment Information

Open Enrollment Period: August 29th to September 30th, 2016

- August 29- September 30, 2016 for an effective date of November 1, 2016 for all lines of coverage.
- **You will need to fill out an enrollment form to enroll in a new United Healthcare medical plan. Forms must be turned in by September 30th, 2016.**
- WEA Select Dental Plans can be previewed beginning Aug 18th at http://resources.hewitt.com/wea.
- If you are currently enrolled in any WEA Select Dental Plan and do not wish to make any changes, you will automatically stay in your current plan.
- If you are a new hire or wish to make changes to your WEA Select Dental Plan, you will need to enroll using the online system or by calling the WEA Select Benefits Center at 1-855-668-5039.

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: Thursday, August 25th

Time: 12:30-3:30 pm

Location: Montesano High School

303 N Church St

Montesanto, WA 98563

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.

Dependents

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

Benefit Changes for the 2016-2017 School Year

Washington State Allocation

- State allocation for employee benefits will remain the same at $780.00.

WEA - Premera Blue Cross (Plan 2, Plan 3, EasyChoice, Plan 5, Basic and QHDHP)

The WEA Premera plans are being discontinued and are being replaced with similar plans from United Healthcare.

NEW PLANS - United Healthcare

- UHC Plan 2 (similar to Premera Plan 2).
- UHC Plan 3 (similar to Premera Plan 3).
- UHC Plan 5 (similar to Premera Plan 5).
- UHC Plan EasyChoice A & B (similar to Premera EasyChoice A & B).
- UHC Basic Plan (similar to Premera Basic Plan).
- UHC QHDHP Plan (similar to Premera QHDHP Plan).

WEA – Delta Dental of Washington

- Composite fillings will now be covered on any tooth.
- 1.5% rate decrease.

WEA - Willamette Dental

- No benefit changes.
- No rate changes.

NBN - Vision

- No benefit changes.
- Rate decreasing by $3.00 to $22.00.

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 United Healthcare

To find a preferred provider through United HealthCare, visit www.uhc.com.

Qualified 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.***

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 QHDHP, you are not eligible to participate in an HSA. Further information on QHDHP's and HSA's are located further in this guide.

Your QHDHP plan option is available through United HealthCare.

To find a preferred provider through United HealthCare, visit www.uhc.com

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 (Network)	United Healthcare Plan 2 Choice Plus Network		United Healthcare Plan 3 Choice Plus Network		United Healthcare Plan 5 Choice Plus Network	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$200 person / $600 family		$300 person / $900 family		$200 person/ $600 family	$350 per person $1,050 family
Rx Deductible	None		None		None	
4th Qtr. Carry Over	Full 4th Quarter applies		Full 4th Quarter applies		Full 4th Quarter Applies	
Carrier Coinsurance	80%	60%	80%	60%	90%	70%
Medical Out of Pocket Max	$1,700 person/ $5,100 family	$3,400 person / $10,200 family	$2,950 person/ $8.850 family	$5,900 person / $17,700 family	$700 person / $2,100 family	Unlimited
Rx Out of Pocket Max	Included in Medical		Included in Medical		Included in Medical	
Office Visit	$25 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin	$15 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Diagnostic Lab & X-Ray	Covered in full		Covered in full		Covered in full	
Advanced Diagnostic Imaging	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance	
Emergency Care**	$75 copay + ded & coin		$100 copay + ded & coin		$50 copay + ded & coin	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Inpatient)	$150 copay per admit then ded & coin	Ded & coin	$300 copay admit then ded & coin	Ded & coin	$150 copay per admit then ded & coin	Ded & coin
Hospital (Outpatient)	Surgery- $100 copay then ded & coin. All other services- Ded & coin	Ded & coin	Surgery- $150 copay then ded & coin. All other services- Ded & coin	Ded & coin	Deductible & Coinsurance	
Spinal Manipulations	$25 copay (dw)	Ded &coin	$30 copay (dw)	Ded & coin	$15 copay (dw)	Ded &coin
	Unlimited Manipulations		Unlimited Manipulations		Unlimited Manipulations	
Rehab - Outpatient (Speech, Massage, OT, PT)	45 visits for each type Unlimited visits for PT		45 visits for each type Unlimited visits for PT		45 visits for each type	
	$25 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin	$15 copay (dw)	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	Unlimited days		130 days PCY		60 days PCY	
	See Hospital Inpatient		See Hospital Inpatient		See Hospital Inpatient	
Prescriptions	**Tier 1 / Tier 2 / Tier 3 - At Participating Pharmacies**					
Retail Cost Share	$10 / $20 / $35 (31 day supply)		$15 / $25 / $40 (31 day supply)		$10 / $15 / $30 (31 day supply)	
Mail Order Cost Share	$15 / $30 / $45 (90 day supply)		$20 / $35 / $50 (90 day supply)		$15 / $30 / $60 (90 day supply)	
Tier 4 Cost Share	$50 copay (31 or 90 day supply)		$60 copay (31 or 90 day supply)		$50 copay (31 or 90 day supply)	
Life/AD&D Insurance	None					

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

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

To locate a UHC provider, visit www.uhc.com

Medical Plan Options

Plan (Network)	United Healthcare EasyChoice A Choice Plus Network		United Healthcare EasyChoice B Choice Plus Network	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$1,000 person/ $3,000 family	$2,000 person/ $6,000 family	$750 person/ $2,250 family	$1,500 person/ $4,500 family
Rx Deductible	None		None	
4th Qtr. Carry Over	Full 4th Quarter Applies		Full 4th Quarter Applies	
Carrier Coinsurance	80%	50%	75%	50%
Medical Out of Pocket Max	$4,000 person/ $8,000 family	None	$3,500 person/ $7,000 family	None
Rx Out of Pocket Max	Included in Medical		Included in Medical	
Office Visit	$15 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Not covered	Covered in full	Not covered
Diagnostic Lab & X-Ray	Covered in full	Ded & coin	Covered in full	Ded & coin
Advanced Diagnostic Imaging	Deductible & Coinsurance		Deductible & Coinsurance	
Emergency Care**	$100 copay + ded & coin		$150 copay + ded & coin	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Inpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Outpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Spinal Manipulations	$15 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin
	20 manipulations PCY		20 manipulations PCY	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits for each type		40 visits for each type	
	$15 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	60 days PCY		60 days PCY	
	Ded & coin		Ded & coin	
Prescriptions	**Tier 1 / Tier 2/ Tier 3- At Participating Pharmacies**			
Retail Cost Share	$5 / 30% / 30% (31 day supply)		$5 / $30 / $45 (31 day supply)	
Mail Order Cost Share	$10 / 25% / 25% (90 day supply)		$10 / $75 / $112 (90 day supply)	
Tier 4 Cost Share	30% (31 or 90 day supply)		30% (31 or 90 day supply)	
Life/AD&D Insurance	None			

*Preventive Services as defined by the Affordable Care Act

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Ded & coin = Deductible & Coinsurance Apply
OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

To locate a UHC provider, visit www.uhc.com

Medical Plan Options

Plan (Network)	United Healthcare Basic Plan Choice Plus Network		United Healthcare QHDHP Plan Choice Plus Network	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$1,250 person/ $2,500 family	$2,500 person/ $5,000 family	$1,500 person/ $3,000 family†	$3,000 person/ $6,000 family†
Rx Deductible	$500		Subject to Medical Deductible	
4th Qtr. Carry Over	Full 4th Quarter Applies		Does NOT Apply	
Carrier Coinsurance	70%	50%	80%	50%
Medical Out of Pocket Max	$4,500 person/ $9,000 family	Unlimited	$4,000 person/ $6,850 family	Unlimited
Rx Out of Pocket Max	Included with Medical		Shared with Medical	
Office Visit	$30 copay (dw)	Ded & coin	Deductible & Coinsurance	
Preventive Care*	Covered in full	Not covered	Covered in full	Not covered
Diagnostic Lab & X-Ray	Covered in full	Ded & coin	Deductible & Coinsurance	
Advanced Diagnostic Imaging	Deductible & Coinsurance		Deductible & Coinsurance	
Emergency Care**	$200 copay + Ded & coin		Deductible & Coinsurance	
Ambulance	Deductible & coinsurance		Deductible & Coinsurance	
Hospital (Inpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Outpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Spinal Manipulations	$30 copay (dw)	Ded & coin	Deductible & Coinsurance	
	20 manipulations PCY		20 manipulations PCY	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits for each type		20 visits for each type	
	$30 copay (dw)	Ded & coin	Deductible & Coinsurance	
Rehab - Inpatient (Speech, Massage, OT, PT)	60 days PCY		60 days PCY	
	Deductible & Coinsurance		Deductible & Coinsurance	
Prescriptions	**Tier 1 / Tier 2 / Tier 3 - At Participating Pharmacies**			
Retail Cost Share	$15 / $30 / $45 (31 day supply)		Deductible & Coinsuarnce (31 day supply)	
Mail Order Cost Share	$15 / $60 / $90 (90 day supply)		Deductible & Coinsurance (90 day supply)	
Tier 4 Cost Share	30% (31 or 90 day supply)		Deductible & Coinsurance (31 or 90 day supply)	
Life/AD&D Insurance	None			

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

†UHC QHDHP, the deductible must be satisfied before benefits are payable. If more than one person is enrolled, the family deductible must be satisfied before benefits are payable for ANY enrolled person.
To locate a UHC provider, visit www.uhc.com

(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?

- You (and/or your employer) can contribute up to the Federal Annual Limit. For 2016, including employer contributions, it is $3,350 (individual) or $6,750 (family). The limit for 2017 stays at $6,750 (family) and increases to $3,400 (individual).
- 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 are 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 11/1/2016 and your dentist performed a crown on 9/5/2016, 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

You may choose to enroll in either of the dental plans below.

Under the Delta Dental 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 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, Flouride, 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
Orthodontics (Plan H - Adults & Children)	50% to $2,000 (lifetime maximum benefit)

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 1 (Group #W066)	
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%
Orthodontics (Plan 4 - Adult & Children)	Covered in full after a $15 per visit copay and a $1,500 orthodontia copay

Mandatory Vision Benefits

Our District provides its eligible employees with 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.

This plan covers you and your entire family (spouse, domestic partner and children up to age 26).

	Frequency	Panel Provider
Copayment for lenses/frames		$10.00
Exams	Once per calendar year	Paid in full*
Lenses (pair)	Once per calendar year	Paid in full**
Frames	Once per two calendar years	Paid in full***
Contacts -subnormal (in lieu of all other services, requires approval from NBN Claims)	Once per calendar year	Paid in full*
Contacts - elective (in lieu of all other hardware services)	Once per calendar year	$250 allowance towards the cost of fitting fee and lenses at an NBN provider

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

*When services are provided by a Northwest Benefit Network Provider.
**Paid in full means the cost of basic lenses are covered in full when service is provided by a panel provider.
***Paid in full means for the cost of frames covered by your Plan when provided by a panel provider. Your panel provider will inform you of which frames are covered and which frames will require out-of-pocket costs for you.

Obtaining services from a Panel Provider:

1. Log on to www.nwadmin.com or NWA's mobile app and use the NBN Vision Provider Locator feature to find an NBN eye care professional. It's also a good idea to verify your eligibility status online prior to receiving services.

2. 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. Need additional ID cards? You can print extras online at www.nwadmin.com.

3. Complete any paperwork your eye care provider may require.

4. After your services are complete, pay your NBN Vision provider any co-payments (if your plan requires them) 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:

If you decide to use the services of a vision care provider not in the NBN network, simply pay for your vision services and/or materials and send the itemized bill to NBN with a completed NBN Vision claim form. Claim forms are available online at www.nwadmin.com. You will be reimbursed according to the out-of-network schedule of benefits (see your plan booklet for details). Payment for your claim will typically be made within 10 – 14 business days from receipt of your claim.

If you obtain services or eyewear 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 Vision Benefits continued

Lens Extras

The following lens extras are covered by your NBN Vision Plan when a network provider is used:

Generic Flat Top Multi Focal	Blended	Progressive**
Oversize blanks	Prism Segs	Slab Off
Laminated	Double Segs	Pink 1 & 2 Tints
Sun Tints	Glass Photochromatic Lite Shades	Glass Photocromatic Dark Shades
Other Tints	Anti-Reflective Multi Layer	Color Coat
Scratch Coat	Anti-Reflective + Scratch Coat**	

The following lens extras are available but the costs for these are the responsibility of the patient:

Plastic Photochromatic**	Edge Coat	Special Lens Edge Treatments

Hi-Index** (extra thin, light weight lenses) are covered by your NBN Vision plan only when necessary under the terms of the plan.

**If covered, plan pays for standard or basic styles. Patient pays the difference in cost of “premium” progressives, “premium” photochromatic, “premium” anti-reflective + scratch coat and “premium” hi-lens extras.

Mandatory Long Term Disability Insurance

All **Certificated and Administrative Staff** working a minimum of 17.5 hours per week will be covered by our District’s Long Term Disability Policy provided by Cigna and paid for by the District. 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 $5,000/month
Minimum Benefit Amount	10% of your maximum benefit or $100, whichever is greater.
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.

Employee Assistance Program

CIGNA's Life Assistance[SM] Program helps all covered members and their immediate family members (living in their household) to better balance their work and personal lives with access to online tools, in-person behavioral health assistance and live telephonic counseling - 24 hours a day, seven days a week.

This program focuses on providing consultation, information, success planning and referral to resources for a variety of concerns including:

Adoption (includes online resources)	**Parental Care**	**Summer Care**
Pet Care (includes online resources)	**Parenting**	**Legal Services**
Child Care (includes online resources)	**Special Needs**	**Financial Information**
Senior Care (includes online resources)	**Education** (includes online resources)	

Research and up to 3 qualified referrals within 12 business hours (6 for emergencies)

This program's unique advantages include:

- **Proactive Outreach** – Important outreach features promote usage of Cigna's Life Assistance[SM] program when you need it most. Outreach includes reminders throughout the length of the issue.
- **Emphasis on Personal Interaction** – Cigna's Life Assistance[SM] offers 24 hour live, telephone access to Cigna's licensed behavioral clinicians and up to three, free face to face behavioral counseling sessions with independent specialists when needed.
- **Extensive Network of Behavioral Health Resources** – Cigna Behavioral Health's network of more than 54,000 contracted licensed behavioral health clinicians provide prompt, local access to support.
- **Comprehensive Life Event Services** – Your EAP program offers information and referrals on a wide variety of topics such as finding qualified child care, summer care, senior care facilities, research and information on education programs, adoption, and financial information plus a 30-minute free legal consultation for most legal issues.
- **Unique Health Rewards® Program** – Cigna's Life Assistance[SM] includes Healthy Rewards®, which offers discounts (up to 60%) on a range of health and wellness related services and products including discounts on Jenny Craig, smoking cessation programs, chiropractic care, fitness club memberships, hearing and vision care, massage therapy, acupuncture, pharmacy, vitamins and more.
- **Assessment and Counseling** – Up to three (3) in-person counseling sessions for you and your family members for assessment, problem solving and referral to resources.

To access online resources visit: www.cignabehavioral.com/cgi

To contact a Cigna licensed behavioral clinician call 1-800-538-3543

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 sick pay or vacation pay. 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 Benefit Eligible Employees**
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	60, 90, 120, or 180 days (varies by plan)

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 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

SB-26240-0713

Voluntary Life Insurance

Optional group term life insurance is available for you and your family from Cigna. This is available to all permanent employees working a minimum of .5 FTE under the age of 70. Your spouse is eligible for coverage up to age 70 as well as dependent children up to age 19, or up to age 26 if they're a full-time student. Please note the below rates are subject to change each November.

	Employee	**Spouse**	**Dependent Children**
Coverage options (until age 70)	The lesser of 5x your annual base salary or $300,000 in units of $10,000	The lesser of $300,000 or the amount of employee coverage in units of $10,000	14 days old to age 19 (Under age 25 if full time student) $5,000 or $10,000 (Children from live birth to 6 months is limited to $500)

	Age	**Rate per $1,000**	**Age**	**Rate per $1,000**
Monthly Cost	Under 30	$.06	50-54	$.42
	30-34	$.07	55-59	$.65
	35-39	$.10	60-64	$.88
	40-44	$.17	$65-69	$1.46
	45-49	$.28	Children	$1.50/$5,000 $3.00/$10,000

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 Shannon Meservey by 9/16/2016. 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 12/9/2016. Employees currently participating in either of the Flexible Spending Accounts also need to submit a new election form for 2017 to the payroll office.

Carryover: The Health FSA allows up to $500 of unused contributions to be carried over to the next plan year. This amount will be added to any contributions you elect for the next plan year. The plan 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 for reimbursement. Any amount over $500 remaining at the end of the runoff period will be forfeited.

To take advantage of the Flexible Spending Accounts, you must complete the appropriate election form with the American Fidelity Representative. All employees participating in the plan need to submit an application for 2017. All employees will need to see the American Fidelity Representative as no manual forms will be accepted.

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.

COBRA and Continuation of Coverage

If you or a qualifying family member have any questions about notices provided to you by your employer or questions about COBRA please contact:

Shannon Meservey, Payroll Department
Montesano School District
302 N. Church St.
Montesano, WA 98563-2500

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 2016.

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

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 Sheila Baker in the Business Office.
Your committee members are:

Sheila Baker	Dan Thomas
Lori Bialkowsky	Kenny Strong - The Partners Group
Tina Niels	Jennifer Spencer - The Partners Group
Shannon Meservey	

Insurance Contact Information

Carrier Name	Coverage	Group/ Policy #	Phone Number	Website
United Healthcare	Medical	TBD	800-357-0978	www.uhc.com
Delta Dental	Dental	186	800-554-1907	www.deltadentalwa.com
Willamette Dental	Dental	W066	855-433-6825	www.willamettedental.com
Cigna	Life/Long Term Disability	SGD600136	800-362-4462	www.cigna.com
Northwest Administrators	Vision	AN	800-732-1123	www.nwadmin.com
American Fidelity	Flexible Spending Account	N/A	866-576-0201	www.americanfidelity.com
American Fidelity	Voluntary Short Term Disability	N/A	866-576-0201	www.americanfidelity.com

District Contact Information

Payroll Department	**Shannon Meservey**	**360-249-1234**

If you need assistance or have questions on any of your benefits, you can always call Payroll or contact our Insurance Broker.

Kenny Strong (kstrong@tpgrp.com) or Jennifer Spencer (jspencer@tpgrp.com)
The Partners Group
Phone: 1-877-455-5640

The information herein is not a contract. It is a brief 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. Please direct any questions to **Payroll** or **The Partners Group at (877) 455-5640.** This summary was printed on August 24, 2016 . Any further information, revision by bargaining units or by insurers after this date could change or modify the information contained herein.

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 2016-2017

MEDICAL	UHC Plan 2	UHC Plan 3	UHC Plan 5	UHC EasyChoice A & B	UHC Basic Plan	UHC QHDHP *
Employee Only	$889.41	$784.91	$1040.21	$573.59	$522.93	$576.05
Employee & Spouse	$1627.68	$1436.47	$1998.81	$1041.68	$949.29	$943.13
Employee & Child(ren)	$1187.40	$1047.95	$1419.27	$760.82	$693.48	$722.89
Family	$1951.36	$1722.19	$2407.91	$1248.03	$1137.24	$1091.60

*Your UHC QHDHP plan premiums include a $125 monthly contribution to your HSA.

DENTAL	Delta Dental of WA Incentive Plan A with Ortho Plan H	Willamette Dental with Ortho Plan 4
Composite/Family Rate	$123.90	$89.45

Dental 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.

VISION	NBN Vision
Composite/Family Rate	$22.00

Vision plan rates are composite rated just like our dental plans. The rate is the same if it's just a single employee enrolled or an employee and his/her family.

2016-2017 State Allocation = **$780.00** for full time employees. From the above state allocation, Dental & Vision are deducted. The amount remaining, depending on pooling outcome, may be applies towards your medical premiums. **Please Note:** For Exclusions, Limitations and Clarifications, see the individual plan booklets. This comparison is not a contract.