FERNDALE
SCHOOL DISTRICT

...Making A Difference

Employee Benefit Guide

Administrative, Building Principals, and Classified Employees

2018-2019 School Year

Important Open Enrollment Information

Open Enrollment Period:

DUE DATES CLASSIFIED STAFF:

Online enrollment (Delta Dental, Willamette Dental) must be completed by 4:00 PM on Friday, September 28th using the Alight Portal (http://digital.alight.com/wea).

Enrollment forms (Kaiser Permanente, Premera) must be postmarked no later than 4:00 PM on Friday, September 28th.

Classified staff only:

- All benefit effective dates are November 1st.
- If you wish to either enroll in a new Premera plan or make changes to your existing plan, enrollment forms are required. To obtain an enrollment form please email Shelley.Carpenter@ferndalesd.org or visit our website at http://ferndalesd.org/human-resources/employee-benefits/.

September New Hires:

- Your medical selection must be received in the payroll department no later than September 10th via an enrollment form. Your dental selection must be made via the Alight Portal.

Benefit Fair

Please plan on attending the District Benefit Fair. If you are unable to attend during the date and time below, there are several other benefit fairs and information sessions happening in Whatcom County. Please refer to the next page for more information on these events.

Date: Wednesday, August 22nd 2018
Time: 1:00 PM - 4:00 PM
Location: Vista Middle School Cafeteria
6051 Vista Drive
Ferndale

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 your insurance committee representative listed later in this publication or The Partners Group at 1-877-455-5640. This summary was printed on August 1, 2018. 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.

Please Note: All plan changes have been outlined in bold.

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

Bellingham School District: Wednesday, August 22nd, 2:00 PM - 6:00 PM
Bellingham High School
2020 Cornwall Ave Bellingham, WA 98225

Blaine School District: Tuesday, August 28th, 7:30 AM - 8:30 AM
Blaine Middle School / High School Cafeteria
975 “H” St. Blaine, WA 98230

Lynden School District: Thursday, September 6th, 2:30 PM -5:00 PM
Lynden High School Cafeteria
1203 Bradley Rd. Lynden, WA 98264

Meridian School District: Tuesday, August 28th, 3:30 PM - 5:30 PM
Meridian High School
194 W. Laurel Rd. Bellingham, WA 98226-9699

Mount Baker School District: Monday, August 27th, 2:30 PM-5:00 PM
Mount Baker High School
4936 Deming Road Deming, WA 98244-0095

Nooksack Valley School District: Thursday, August 30th, 2:30 PM - 5:00 PM
Nooksack Valley High School Commons
3326 E. Badger Road Everson, WA 98247

Premera, Kaiser, Aetna, UHC Medical Plans Only: Monday, August 27th, 2:00-6:00 pm
Sehome High School – 2700 Bill McDonald Parkway, Bellingham, WA 98226

Premera Blue Cross and Kaiser Plans Only: Monday, September 17th, 3:30-6:00 pm
Fisher Elementary School – 501 N. 14th St, Lynden, WA 98264

Premera Blue Cross and Kaiser Plans Only: Tuesday, September 18th, 3:30-5:30 pm
Mt. Baker High School Commons - 4936 Deming Road, Deming, WA 98244

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 benefit package to its valued employees and their eligible family members. This package is designed to provide you with choice, flexibility, and value.

This Benefit 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 the District website. If you need assistance with understanding your benefits, the following contacts are available for you: The District's Benefit Specialist, Shelley Carpenter (ext. 9227), or our Insurance Broker, The Partners Group.

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

Qualifying for Benefits

Below is a chart indicating the basic benefits provided, by group, and the restrictions placed on qualifying for benefits.

Group	Basic Benefits	Restrictions
Prof Tech	Medical, Dental, Vision, Long-Term Disability	Less than 4 hours/day is not eligible
PSE	Medical, Dental, Vision	Less than 4 hours/day is not eligible
FAAA	Medical, Dental, Vision	Less than 4 hours/day is not eligible
Teamsters	Medical, Dental, Vision	Less than 4 hours/day is not eligible
SEIU	Medical, Dental, Vision	Less than 4 hours/day is not eligible
Principals/Program Directors	Medical, Dental, Vision, Long-Term Disability	None
Central Office Administrators	Medical, Dental, Vision, Long-Term Disability	None

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 benefit (may sign up post-tax).

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

NOTE: If you are removing a dependent due to a qualifying event, you must inform payroll **within 30 days** of the qualifying event date. The effective date for the removal of coverage will be the first of the month following the qualifying event date.

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 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.

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 of plans contract 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 Premera.

To find a preferred provider through Premera, visit www.premera.com.

Qualified High Deductible Health Plan (QHDHP)

These type of 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 the Premera QHDHP plan.

Health Maintenance Organization (HMO)

These type of 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 provide 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/wa.

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)	Premera Blue Cross PPO 2		Premera Blue Cross PPO 3	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$300 person / $900 family		$500 person / $1,500 family	
Rx Deductible	None		None	
4th Qtr. Carry Over	Nov & Dec Only		Nov & Dec Only	
Carrier Coinsurance	80%	60%	80%	60%
Medical Out of Pocket Max	$2,000 person / $6,000 family	$3,400 person / $10,200 family	$3,000 person / $9,000 family	$5,900 person / $17,700 family
Rx Out of Pocket Max	Shared with Medical		Shared with Medical	
Office Visit *Primary/Specialist*	$25/$35 copay (dw)	$30/$40 copay (dw)	$30/$40 copay (dw)	$40/$50 copay (dw)
Preventive Care*	Covered in full	Coinsurance only	Covered in full	Coinsurance only
Diagnostic Lab & X-Ray	Deductible & Coinsurance		Deductible & Coinsurance	
Advanced Diagnostic Imaging	Deductible & Coinsurance		Deductible & Coinsurance	
Emergency Care**	$75 copay + ded & coin		$100 copay + ded & coins	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Inpatient)	$150 copay per day / $450 max PCY then ded & coin		$300 copay per day / $900 max PCY then ded & coin	
Hospital (Outpatient)	Surgery- $100 copay then ded & coin All other services- Ded & coin		Surgery- $150 copay then ded & coin All other services- Ded & coin	
Spinal Manipulations	$25 copay (dw)	$30 copay (dw)	$30 copay (dw)	$40 copay (dw)
	Unlimited Manipulations		Unlimited Manipulations	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	45 visits Unlimited visits for PT		45 visits Unlimited visits for PT	
	$35 copay (dw) PT: ded & coin	$40 copay (dw) PT: ded & coin	$40 copay (dw) PT: ded & coin	$50 copay (dw) PT: ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	120 days PCY		30 days PCY	
	See Hospital Inpatient		See Hospital Inpatient	
Prescriptions	**Generic / Preferred / Non - Preferred - At Participating Pharmacies**			
Retail Cost Share	$10 / $20 / $35 (34 day supply)		$15 / $25 / $40 (34 day supply)	
Mail Order Cost Share	$20 / $40 / $65 (100 day supply)		$30 / $50 / $70 (100 day supply)	
Specialty Cost Share	$50 copay through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)		$60 copay through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)	
Life/AD&D Insurance	$25,000 Term Life and AD&D for Employee Only			

*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 Premera provider, visit www.premera.com

Medical Plan Options

Plan (Network)	Premera Blue Cross EasyChoice A		Premera Blue Cross EasyChoice B	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$1,250 person/ $3,750 family	$2,000 person/ $6,000 family	$750 person/ $2,250 family	$1,500 person/ $4,500 family
Rx Deductible	$500		$250	
4th Qtr. Carry Over	Nov & Dec Only		Nov & Dec Only	
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	Shared with Medical		Shared with Medical	
Office Visit *Primary/Specialist*	$25/$35 copay (dw)	Ded & coin	$30/$40 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Not covered except Screenings-ded & coin	Covered in full	Not covered except Screenings-ded & coin
Diagnostic Lab & X-Ray	Paid in Full to $1,000 then Ded & Coin		Deductible & Coinsurance	
Advanced Diagnostic Imaging			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	$25 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin
	12 manipulations PCY		12 manipulations PCY	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits		45 visits	
	$35 copay (dw)	Ded & coin	$40 copay (dw)	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY		45 days PCY	
	Ded & coin		Ded & coin	
Prescriptions	**Generic / Preferred / Non - Preferred - At Participating Pharmacies**			
Retail Cost Share	$10 (dw) / 30% / 30% (30 day supply)		$5 (dw) / $30 / $45 (30 day supply)	
Mail Order Cost Share	$20 (dw) / 30% / 30% (90 day supply)		$10 (dw) / $75 / $112 (90 day supply)	
Specialty Cost Share	30% through Accredo or Walgreens Specialty Pharmacy only (30 day supply)		30% through Accredo or Walgreens Specialty Pharmacy only (30 day supply)	
Life/AD&D Insurance	$25,000 Life and AD&D for Employee Only			

*Preventive Services as defined by the Affordable Care Act
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(dw)= Deductible Waived
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Ded & coin = Deductible & Coinsurance Apply
OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

To locate a Premera provider, visit www.premera.com

Medical Plan Options

Plan (Network)	Premera Blue Cross Basic	Premera Blue Cross QHDHP	
Network	**In Network**	**In Network**	**Out of Network**
Medical Deductible	$2,100 person/ $4,200 family	$1,750 person/ $3,500 family†	$3,000 person/ $6,000 family†
Rx Deductible	$750 person/ $1,500 family	Subject to Medical Deductible	
4th Qtr. Carry Over	Nov & Dec Only	Does NOT Apply	
Carrier Coinsurance	70%	80%	50%
Medical Out of Pocket Max	$6,600 person/ $13,200 family	$5,000 person/ $10,000 family	Unlimited
Rx Out of Pocket Max	Shared with Medical	Shared with Medical	
Office Visit *Primary/Specialist*	$35/$50 copay (dw)	Ded & coin	Ded & coin
Preventive Care*	Covered in full	Covered in full	Not covered except Screenings-ded & coin
Diagnostic Lab & X-Ray	Ded & coin	Ded & coin	Ded & coin
Advanced Diagnostic Imaging	Ded & coin	Ded & coin	Ded & coin
Emergency Care**	$200 copay + Ded & coin	Ded & coin	
Ambulance	Deductible & coinsurance	Ded & coin	
Hospital (Inpatient)	Ded & coin	Ded & coin	Ded & coin
Hospital (Outpatient)	Ded & coin	Ded & coin	Ded & coin
Spinal Manipulations	$35 copay (dw)	Deductible & Coinsurance	
	12 manipulations PCY	12 manipulations PCY	
Vision Care	Not Covered	Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits	15 visits PCY	
	$50 copay (dw)	Ded & coin	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY	30 days PCY	
	Ded & coin	Ded & coin	Ded & coin
Prescriptions	**Generic / Preferred / Non- Preferred - At Participating Pharmacies**		
Retail Cost Share	$15 / $30 / $50 (30 day supply)	Ded & coin (30 day supply)	
Mail Order Cost Share	$30 / $60 / $100 (90 day supply)	Ded & coin (90 day supply)	
Specialty Cost Share	30% through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)	20% through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)	
Life/AD&D Insurance	$25,000 Term Life and AD&D for Employee Only		

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

†Premera 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 Premera provider, visit www.premera.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 (Network)	Kaiser Permanente Welcome 500
Network	**At a KP Facility/Provider Only**
Medical Deductible	$500 person / $1,500 family
Rx Deductible * **	None
4th Qtr. Carry Over	Does not apply
Coinsurance	80%
Medical Out of Pocket Max	$2,000 person / $6,000 family
Rx Out of Pocket Max* **	Included in Medical
Office Visit	Visits 1-4 : $20 copay (dw) Visits 5+: $20 copay then ded & coin
Preventive Care*	100% (dw)
Diagnostic Lab & X-Ray	Covered in full up to $500 per year then ded & coins
Adv. Diagnostic Imaging	
Emergency Care**	$100 copay + ded & coin
Ambulance	80%
Hospital (Inpatient)	Deductible & Coinsurance
Hospital (Outpatient)	$20 copay (dw) then ded & coin
Spinal Manipulations	10 manipulations PCY without prior authorization
	One exam every 12 months
Vision Care	45 visits (PT, Speech, Massage, OT)
Rehab - Outpatient (Speech, Massage, OT, PT)	See Office Visit limits
	30 days (PT, Speech, Massage, OT)
Rehab - Inpatient (Speech, Massage, OT, PT)	Deductible & Coinsurance
	See Hospital Inpatient
Prescriptions	**Generic / Brand / Non-Formulary At Participating Pharmacies**
Retail Cost Share	$15 / $30
Mail Order Cost Share	$30 / $60
Specialty Drug Cost Share	Subject to applicable retail copay through KP Specialty Medication Pharmacy Only
Life/AD&D Insurance	None

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

Major Insurance Plan Changes for 2018-2019

State Allocation for Benefits

- State allocation for employee benefits will increase to $843.97. The Retiree Medical Carve out amount will increase from $64.39 to $71.08.

Kaiser Permanente - Welcome 500 Plan

- No benefit changes.
- Premium rates increased 10.43%.

All Regence Blue Shield Plans Have Been Discontinued

Premera Blue Cross Plans

- Heritage Plus PPO 2: Premium rates decreased 8.85-9.08% depending upon dependent enrollment tier.
- NEW PLAN: Heritage Plus PPO 3.
- NEW PLAN: Heritage Plus EasyChoice A.
- NEW PLAN: Heritage Plus EasyChoice B.
- NEW PLAN: Heritage Plus Basic Plan.
- NEW PLAN: Heritage Plus QHDHP HSA Plan.
- EviCore prior authorization for outpatient rehabilitation, including massage, has been removed from all plan options.

Delta Dental of Washington

- The annual maximum increased to $2,300 when a Delta Dental PPO dentist is used and to $2,000 when a Delta Dental Premier dentist is used.
- Cost shares and the annual maximum will be eliminated for children ages 14 and under.
- Premium rates *decreased* by 1.8%.

Willamette Dental Group

- No benefit changes.
- Premium rates increased 5.8%.

Northwest Benefit Network (Vision)

- No benefit changes.
- No change in premium rates.

Cigna (LTD)

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

American Fidelity - Voluntary Disability Plans

- No benefit changes.
- No changes in premium rates.

High Deductible Health Plan and HSA Questions and Answers

How does the Qualified High Deductible Health Plan (QHDHP) work?

- Unlike your other health plans that have co-pays for certain services that do not apply toward the deductible, on a QHDHP, 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 QHDHP (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 QHDHP where you can put in money, on a pre-tax basis, to pay for "qualified medical expenses" such as prescriptions, services provided by your QHDHP, dental plan and vision plan.
- Ferndale School District uses American Fidelity to manage your HSA account.

Who is eligible to participate in an HSA?

- Anyone covered by a QHDHP, however, you or your enrolled spouse cannot be covered under another medical plan unless that plan is also a QHDHP.
- If you are no longer covered by a QHDHP, 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 2018, including employer contributions, it is $3,450 (individual) or $6,900 (family). For 2019, the limits increase to $3,500 (individual) and $7,000 (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 $6,900 ($7,000 for 2019) 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.

Important Information Regarding your QHDHP 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 QHDHP was effective 11/1/2018 and your dentist performed a crown on 9/5/2018, 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 QHDHP. 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 QHDHP 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 QHDHPs 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 plans. Some 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

All eligible employees, except Teamsters, must choose to 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)	$2,000 per person (Delta Premier providers) $2,300 per person (Delta 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

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).

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 (Group #W005)	
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%

Mandatory Vision Benefits

Our District provides its eligible employees, except Teamsters, 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.

This plan covers you and your entire family (spouse, domestic partner and children up 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 lens 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 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 Long Term Disability Insurance

All Prof Tech & Administrative staff working **20 or more 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 $5,000/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.

Employee Assistance Program

This is mandatory coverage for all employees paid for by the District.

Health Promotion Northwest (HPN) of St. Joseph Hospital is the District's EAP provider. Utilizing the EAP is completely confidential. HPN offers up to four sessions of counseling/social work assistance to any employee, as well as the members of an employee's household. Below is a non-exhaustive list of topics the EAP may be able to assist with:

Stress	Relationships	Referral for brief legal consultation
Depression	Parenting	
Grief & loss	Co-worker conflict	Financial problems
Substance abuse	Health problems	Anger management

You can receive EAP services in-person, over the phone, or via email. For more information, or to schedule an appointment, please contact Health Promotion Northwest:

1-800-244-6142

www.peacehealth.org/whatcom/eap

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 and Long Term Disability/Salary Insurance

Our district offers its eligible employees Short and Long 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 or long term disability. This plan includes offsets that will subtract any other sources of income, such Social Security. These plans do not offset income received for the first 30 days (Short Term Disability) or 60 days (Long Term Disability). Injury or sickness arising out of or in the course of any occupation for wage or profit for which you are entitled to Workers' Compensation will not be covered under the benefits listed below.

Voluntary Short Term Disability

Eligible Class	**Prof Tech/DO Administrators, FEA Members, Principals and Program Directors**
AmFi Brochure #	SB-25071 - 0717
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 66 2/3rd % 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.

Voluntary Long Term Disability

Eligible Class	**Administrative, Support Staff & Clerical Employees**
AmFi Brochure #	SB-293320717
Benefit Amount	Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month
Benefit Period	To your normal Social Security Retirement Age

Eligible Class	**Non-Clerical Classified Employees**
AmFi Brochure #	SB-25658
Benefit Amount	Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month
Waiting Period	15 days for injury / 15 days for sickness
Benefit Period	To your normal Social Security Retirement Age

This plan has limitations and exclusions. 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 plans.

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.

Voluntary Life Insurance

Optional group term life insurance is available for you and your family from Unum through the WEA.

Minimum $10,000 of death benefit to a $150,000 maximum. Up to $50,000 of coverage is guaranteed with no health evidence required for employees. Optional coverage is available for spouses, not to exceed 50% of the employee amount (subject to health evidence). $2,000 per child up to age 26, $1,000 per child less than six months of age.

To learn more about this coverage, you may contact the District office at (360) 383-9227, or the WEA Select Benefits Center at 855-668-5039**.**

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 earnings 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, increasing 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 "Section 125 Medical Premium Election" form to the Payroll Department by September, 28th 2018. 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 period.

To take advantage of either or both of the Flexible Spending Accounts, you must meet with the American Fidelity representative and complete an election form prior to **November 30th, 2018**. Employees currently participating in either of the Flexible Spending Accounts and plan to continue participation for the 2018/2019 school year need to submit a new election form each year. American Fidelity will be scheduling appointments in November 2018. All employees will need to see the American Fidelity Representative as no manual forms will be accepted.

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 75 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.

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.

An employee will be required to reimburse Ferndale School District for employer paid group insurance premiums during unpaid FMLA if they terminate employment less than 30 days after returning to work. This condition applies unless the termination is a result of at least one of the following:

- A continuation, recurrence or onset of a serious health condition.
- Other circumstances as defined by the Family and Medical Leave Act of 1993.

For specific questions, contact Human Resources @ (360) 383-9206 or Heidi Lindsay @ (360) 383-9202 in Human Resources or contact the Department of Labor for a copy of the FMLA law.

COBRA and 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 and Vision Insurance- Dental and vision insurance may be continued under COBRA. This coverage 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 the District’s Benefit Specialist: *Shelley Carpenter, Ferndale School District, (360) 383-9227.*

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 $18,500 if you are under age 50 and $24,500 if you are over age 50 for 2018.

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: 1-800-547-6657 (Mon-Fri 8:00-5:00pm)

Email: dcpinfo@drs.wa.gov

Mail: PO BOX 48380 Olympia, WA 98504-0931

Shared Sick Leave Qualifications

What qualifications are required to receive shared leave?

A district classified or certificated employee is eligible to receive donated leave if:

- The employee suffers from, or has a relative or household member suffering from an extraordinary or severe illness, injury, impairment or physical or mental condition which has caused, or is likely to cause, the employee to:
  - Go on leave-without-pay status; or
  - Terminate his/her employment;
- The employee's absence and the use of shared leave are justified; (the employee is on an approved qualifying leave)
- The employee has depleted, or will shortly deplete, his/her vacation and/or sick leave reserves;
- The employee has abided by district rules regarding sick leave use; and
- The employee has diligently pursued and been found to be ineligible to receive industrial insurance benefits.

Who may share their leave?

- Employees who have accrued more than 22 days of sick leave may share sick leave. Employees may donate any amount of vacation while maintaining a balance of 10 days.

Can employees from one bargaining group share their leave with an employee from another bargaining group?

- Yes.
- **Leave, Share questions? Contact Human Resources @ (360) 383-9206 or Heidi Lindsay @ (360) 383-9202 in Human Resources.**

Insurance Contact Information

Carrier Name	Coverage	Group/ Policy #	Phone Number	Website
Premera	Medical	4012394	800-932-9221	www.premera.com/wea
Kaiser Permanente	Medical	Welcome - 1147400	888-901-4636	www.kp.org/wa
Delta Dental of WA	Dental	186	800-554-1907	www.deltadentalwa.com
Willamette Dental	Dental	W005	855-433-6825	www.willamettedental.com
Northwest Administrators	Vision	WS	800-732-1123	www.nwadmin.com
Cigna	Life/Long Term Disability	N/A	800-362-4462	www.cigna.com
American Fidelity	Salary Insurance / Flexible Spending Account	N/A	866-576-0201	www.americanfidelity.com
Health Promotion Network	Employee Assistance Program	N/A	800-244-6142	www.peacehealth.org/whatcom/eap
Dept. of Retirement Systems	Retirement	N/A	800-547-6657	www.drs.wa.gov
VEBA Service Group		N/A	888-828-4953	www.veba.org

District Contact Information

Human Resources	**Heidi Lindsay**	**360-383-9202**
Human Resources	**John Fairbairn**	**360-383-9223**
Payroll Benefits	**Shelley Carpenter**	**360-383-9227**

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

Emily Austin
The Partners Group
Phone: 1-877-455-5640
eaustin@tpgrp.com

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 **Human Resources** or **The Partners Group at (877) 455-5640.** This summary was printed on August 1, 2018. 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.

Notes

Monthly Insurance Rates for 2018-2019

MEDICAL	Premera EasyChoice A	Premera EasyChoice B	Premera Plan 2	Premera Plan 3	Premera Basic	Premera QHDHP*
Employee Only	$711.09	$711.09	$1,056.60	$965.95	$573.93	$707.92
Employee & Spouse	$1,292.70	$1,292.70	$1,934.76	$1,768.99	$1,042.48	$1,183.83
Employee & Child(ren)	$943.78	$943.78	$1,411.09	$1,290.13	$761.35	$898.32
Family	$1,549.14	$1,549.14	$2,319.74	$2,121.20	$1,249.02	$1,376.32

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

MEDICAL	Kaiser Permanente Welcome 500
Employee Only	$753.96
Employee & Spouse	$1,441.80
Employee & Child(ren)	$1,146.93
Family	$1,833.60

DENTAL/ VISION/LTD (Admin, PSE, Prof Tech, SEIU, FAAA)	Delta Dental of WA Incentive Plan A	Willamette Dental	Vision NBN	Long Term Disability Cigna (Admin & Prof Tech only)
Rate	$99.79	$82.95	$24.00	$12.98

Dental and Vision 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. Long Term Disability rate is for employee only coverage.

DENTAL/ VISION (Teamsters)	Dental Plan G	Vision NBN
Rate	$87.50	$14.90

Dental and 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.

2018-2019 State Allocation = **$843.97** for full time employees (varies depending on pooling outcome). From the above state allocation, Dental & Vision and Long Term Disability are deducted. Also, a Washington State health care reform bill enables retirees and disabled school employees to purchase health care insurance from the state Health Care Authority (HCA). In order to support the K-12 retiree health care plan, school districts are required to forward the HCA **$71.08** per month per full time employee from the State's monthly health benefit allocation.

Please Note: For Exclusions, Limitations and Clarifications, see the individual plan booklets. This comparison is not a contract.