



Snoqualmie Valley School District #410

A SUMMARY OF HEALTH AND WELFARE BENEFIT PLANS FOR THE 2010 – 2011 SCHOOL YEAR

Benefit Fair

September 9, 2010
2:30 p.m. – 7:00 p.m.
Mt. Si High School

Open Enrollment

September 1, 2010
Through
October 15, 2010

Applications are to be turned in to **Lori Becker** at the payroll office. To be effective by October 1st, your application must be received by **Lori** no later than September 15th. All applications must be received by October 15, 2010.

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. Please direct any questions to **Lori Becker at (425) 831-8014 or Baldwin Resource Group at (877) 455-5640**. This summary was printed on **August 25, 2010**. Any further 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 benefit related changes from last year are bolded within this summary.**
- **You can find this summary booklet on the district's website www.svsd410.org under Staff Resources, Nuts & Bolts, Payroll-Benefits.**

*Available to:
Certificated & Classified Employees for
2010 – 2011*

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A GUIDE ON HOW TO USE THIS BOOKLET

1. The State provides **\$745.00 (through September 30th, October 1, 2010 will be \$768.00)** per month for each full time (1.00 FTE) employee to pay for benefits offered by the school district. The **\$745.00** will be used in the September paycheck and the **\$768.00** will be used starting with your October paycheck. The benefits that can be purchased with this allocation are: **Medical Insurance, Dental Insurance, Vision Insurance, Long Term Disability Insurance and Life Insurance**. Each employee is also required to make a monthly contribution to the cost of medical care that the state provides to school district retirees; this is referred to as **Retiree Medical and equals \$62.48 monthly**.
2. In our district, each employee who receives this monthly allocation for benefits or some prorated share of that amount **is required to participate in Dental Insurance, Vision Insurance, Long Term Disability Insurance, Life Insurance and Retiree Medical**. You have a choice as to whether or not you want to sign up for Medical Insurance.
3. Currently employees can choose between two different Dental Plans and several different Medical Plans.
4. Our district does Benefit Allocation Pooling by Bargaining Groups so there is the opportunity to receive more than the **\$768.00** per month, depending upon the make-up and choices of your particular pool members. For now, consider the **\$768.00** as a minimum amount that a full-time employee receives. Each year in October, after all new enrollment forms are turned in, the district will re-calculate the pools and share the results with the Bargaining Units. You automatically receive any additional allocation created by pooling in your October payroll calculation. The pool then stays static between October and the following September.
5. In order to help you make your decision on which Dental and Medical Plan to choose, the following is an example of what a typical employee's decision process might look like:

Monthly Allocation = **\$745.00 (September) \$768.00 (October)**. (First step is to subtract **\$62.48** (will be prorated for part time employees) for Retiree Medical; subtract **\$22.50** for Vision Insurance; subtract **\$13.94** for Long Term Disability; subtract **\$9.50** for Life Insurance). This leaves **\$636.58 (September), \$659.58 (October)**. You must then choose one of two Dental Plan Options depending on what fits your needs best. If, for example, you choose the Willamette Plan, you would subtract \$77.45 from your remaining balance and have \$559.13 (September), \$582.13 (October) available to apply towards Medical Insurance (if you wanted to purchase Medical Coverage). Medical Coverage is not a mandatory benefit. You may choose not to enroll in a medical plan if you wish.

6. If you are changing your Dental Plan Coverage or Medical Plan Coverage from the previous year, or want to drop Medical Coverage all together, you must call Lori Becker and request the appropriate form. Paperwork must be completed to initiate these changes, otherwise you risk not having your request processed appropriately.

How to Select a Medical Plan

You have a choice of six different medical plans, which offer a variety of plan designs. Explanations of each plan design and plan names are listed as follows:

HEALTH MAINTENANCE ORGANIZATION (HMO) type plans provide you with managed benefits and usually at 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 PCP will then either provide or coordinate all of your care (except in the case of medical emergency).

HMO / Managed Care Plan Choices: *Group Health Traditional &, Group Health Deductible*

PREFERRED PROVIDER ORGANIZATION (PPO) type 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 very high percentage of the charges. If you choose to receive care through a non-preferred provider, then the insurance company will pay a lower percentage of the charges.

Preferred Provider Plan Choice: *Regence Blue Shield Premier, High & Innova \$500*

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) type plans have a high deductible, and require that the deductible is met prior to the insurance company making payment for any service except for preventive services. These plans are eligible to be paired with a Health Savings Account (HSA) that enables the member to pay for healthcare with pre-tax dollars. These plans are also PPO plans, which contract with a large number of providers. If you choose to receive your care through a preferred provider the insurance company will pay a very high percentage of the charges. If you choose to receive care through a non-preferred provider, then the insurance company will pay a lower percentage of the charges.

HDHP-HSA Plan Choice: *Regence Blue Shield HDHP-HSA Plan*

All enrollment forms have to be completed by 9-15-10 to be effective by 10-1-10 or 10-15-10 to be effective 11-1-10.

Emergency Room (E.R.) Physicians And Hospitals

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

RECOMMENDATION: To receive the highest benefits your insurance provides, during open enrollment, it is a good idea to check your nearest emergency room and physician participation prior to needing these services. You may do this by calling your insurance company or checking their website.

Special Enrollment Rights Description

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in a plan, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Unless the above applies, understand that you may not be able to obtain coverage under the group insurance plan until the next open enrollment period. Obtaining coverage in the future will be subject to administrative rules and laws in force at that time.

Summary of Benefit changes for 2010 – 2011

ALL Medical, Dental and Vision Plans:

- Children are eligible to be covered on the plan until age 26 regardless of student or marital status or financial dependence.

Regence BlueShield– (Premier, High, Innova \$750 & HSA 2.0)

Federally or State-mandated changes:

- Preventive services will be covered at 100% with no deductible or copayment. This applies to preventive services recommended by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.
- Overall lifetime dollar limits and lifetime dollar limits on essential benefits have been removed. However, a final definition of “essential benefits” has not yet been released by the U.S. Department of Health and Human Services.
- There is no longer a pre-existing conditions exclusion on coverage for enrollees up to age 19.
- The limits on Inpatient and Outpatient Mental Health Benefits have been removed per Federal Mandate.
- Chemical Dependency will be covered as any other benefit with no annual dollar limit.
- Lifetime maximum for Transplants will increase from \$250,000 to \$350,000

Benefit changes:

- **Premier PPO Plan: 17.3% Rate Increase**
- **High PPO Plan: 10.4% Rate Increase**
- **Innova \$500 PPO Plan: 14.5% Rate Increase**
- **HSA Plan: 13.7% Rate Increase**
- **FourFront PPO Plan** will now be called the **Innova \$500 Plan**

Premier Option PPO Plan

- Coinsurance at Participating Providers will be increased from 60% to 70%.
- Office visits at Participating Providers covered at 100% after \$35 copay. (Previously paid at 60%)
- Chiropractic Services will be covered with deductible and coinsurance.
- Coinsurance for Outpatient Mental Health Services at Preferred providers will change to 100% (Previously paid at 90%) and at Participating providers will change to 100%, (Previously paid at 60%) and the Deductible is Waived.

High Option PPO Plan

- Office visits at Participating Providers covered at 90% after \$35 copay. (Previously paid at 70% after \$20 copay)
- Office visits at Out-of-Network providers are subject to deductible and covered at 60%. (Previously paid at 70%)
- Coinsurance for Non-Professional Services at Preferred Providers will change to 80%. (Previously paid at 90%)
- Coinsurance for Non-Professional Services at Participating and out-of-network providers will change to 60%. (Previously paid at 70%)
- Out of Pocket Maximum will increase from \$1,000 to \$2,000 per Member / from \$2,000 to \$6,000 per Family
- Coinsurance for Outpatient Mental Health Services at Participating providers will change to 90% (Previously paid at 70%) and the Deductible is Waived for Preferred and Participating providers

FourFront PPO Plan (Now the Innova \$500 Plan)

- There is no longer a limit on the number of office visits, the deductible is waived for all office visits
- Office visits at Preferred Providers covered at 100% after \$20 copay. (Previously \$25 copay)
- Office visits at Participating Providers covered at 100% after \$35 copay. (Previously paid at 50%)
- Outpatient Lab & X-Ray at Participating and Out-of-Network Providers covered at 100% of allowable charges for the first \$500. (Previously paid at 50%)
- Coinsurance payment level for Participating and Out-of-Network Providers will be increased from 50% to 60%.

Group Health Cooperative

Federally or State-mandated changes:

- Preventive services will be covered at 100% with no deductible or copayment.
- Chemical Dependency - Inpatient and outpatient services are subject to the applicable inpatient or outpatient services cost share (as any other medical service). Acute detoxification covered as any other medical service.
- Mental Health – No day/visit limits apply. Services are subject to applicable inpatient or outpatient services cost share.
- Organ Transplant - Covered up to a lifetime maximum of \$350,000. Wait is credited for prior similar coverage.
- Dependents – State registered domestic partners will now be covered the same as spouses.
- Allergy Serum will now be covered as a standard medical benefit subject to office visit cost shares.
- **20.2% rate increase (traditional plan)**
- **20.2% rate increase (deductible plan)**

Washington Dental Service (WDS)

- Incentive Plan 1 will be called Plan A
- Annual Maximum will increase from \$1,750 to \$2,000 when a PPO provider is used
- **2.0% rate decrease.**

WEA - Willamette Dental

- No benefit changes
- **No rate increase.**

NBN Vision Plan

- Contact Lens allowance increased to \$225
- **No rate increase.**

CIGNA Disability

- **No rate increase.**

Voluntary Disability Plans

Changed carrier to Lincoln Financial Group from American Fidelity Assurance Company (AFA)

- No Benefit Changes
- **No rate increase.**

FSA / Section 125 PLAN and Health Savings Accounts (HSA)

Beginning January 1, 2011, over-the-counter drugs (with the exception of insulin) are not eligible expenses for reimbursement under a Section 125 plan or Health Savings Account unless you have a written prescription from a physician.

**Snoqualmie Valley School District #410
Health Insurance Rate Changes 2010 – 2011
(Monthly Rates)**

<i>Medical</i>	<i>Option I Group Health Traditional HMO</i>	<i>Option II Group Health Deductible HMO</i>
<i>Subscriber</i>	\$522.23	\$403.06
<i>Subscriber & Spouse</i>	\$1,014.07	\$782.68
<i>Entire Family</i>	\$1,221.51	\$942.74
<i>Subscriber & Child(ren)</i>	\$729.72	\$563.19
<i>Dep. child eligibility age</i>	26	26

<i>Medical</i>	<i>Option III Regence Blue Shield PPO Premier (\$10K Life Included)</i>	<i>Option IV Regence Blue Shield PPO High (\$10K Life Included)</i>	<i>Option V Regence Blue Shield Innova \$500 PPO (\$10K Life Included)</i>	<i>Option VI Regence Blue Shield HSA \$1,500* (\$10K Life Included)</i>
<i>Subscriber</i>	\$679.50	\$609.25	\$569.40	\$537.67
<i>Subscriber & Spouse</i>	\$1,320.59	\$1,183.96	\$1106.74	\$926.28
<i>Entire Family</i>	\$1,592.03	\$1,427.27	\$1,334.25	\$1,090.82
<i>Subscriber & Child(ren)</i>	\$950.94	\$852.56	\$796.91	\$702.21
<i>Dep. child eligibility age</i>	26	26	26	26

*Option VI HSA Plan: Your premium dollars include a monthly contribution of \$125 towards your HSA

<i>Dental</i>	<i>WDS Dental Plan A w/Ortho B</i>	<i>Willamette Dental Plan 1 w/Ortho 6</i>	<i>NBN Vision</i>
<i>Entire Family</i>	\$125.40	\$77.45	\$22.50
<i>Dep. child eligibility age</i>	26	26	26

<i>Life & AD&D</i>	<i>CIGNA \$50,000</i>
<i>Subscriber</i>	\$9.50

<i>Disability (Long Term)</i>	<i>CIGNA</i>
<i>Subscriber</i>	\$13.94

2010 – 2011 State Allocation (for all covered benefits) = \$768.00 for full time employees. From the State Allocation come the following premiums: Retiree Medical (**\$62.48**), Dental, Disability, Life & Vision (shown above). The amount remaining, depending on the pooling outcome goes toward medical premiums.

It is recommended that all employees read this rate sheet. Because of rate increases this year, you may now have payroll deduction costs or your current costs may increase with your present medical plan.

OPTION I
Group Health Cooperative Traditional
(Group Number 00687)

Eligible Health Care Providers	Must use Group Health Cooperative or Group Health Cooperative designated providers.
Definition of Dependent Child	Child(ren) from birth to their 26th birthday.
Annual Deductible	No annual deductible, calendar year
Coinsurance (Benefit) Level	100% for most services.
Out of Pocket Maximum	Once you have paid \$2,000 (Individual) / \$4,000 (Family), most coinsurance benefits will be covered at 100% of allowable charges thereafter
Physician Office Calls	\$15 co-pay per office visit. Hearing exams covered as medically necessary.
Preventive Care Services	Covered in full including well baby care, well adult visits, following adult/child schedules.
Chiropractic Services	Self referrals to a GHC provider for manipulative therapy of the spine covered up to a maximum of 10 visits per Member per calendar year with a \$15 co-pay per visit.
Prescription Drug Co-payment Retail (30 day supply)	Most drugs ^(*) , including contraceptives obtained from GHC: \$15 – generic \$15 – brand
Mail Order (90 day supply)	\$5 discount per month for mail order = 90 day supply = \$30
Ambulance Services	GHC initiated hospital to hospital ground transfers are covered in full; Non-emergent ground/air to facility transfers are covered at 80%.
Emergency Room	\$75 co-pay per ER visit. Waived if admitted. Members must notify GHC within 24 hours if admitted.
Hospital Inpatient Services	Covered in full.
Inpatient Surgery	Covered in full.
Outpatient Surgery	\$15 co-payment then covered in full.
Diagnostic Lab & X-Ray	Covered at 100% for all covered services. Preauthorization required for high-end radiology services.
Mental Health Inpatient	Covered in full <u>at a GHC approved mental health care facility when authorized in advance by GHC.</u>
Mental Health Outpatient	\$15 co-payment then covered at 100% of allowable charges when authorized in advance by GHC.
Vision Care	<u>One routine eye exam covered once every 12 months.</u> \$15 co-payment then covered at 100% of allowable charges.
Maximum Lifetime Benefit	Unlimited
Life / AD&D Insurance	N/A

OPTION II
Group Health Cooperative Deductible Plan
(Group Number 1146900)

Eligible Health Care Providers	Must use Group Health Cooperative or Group Health Cooperative designated providers.
Definition of Dependent Child	Child(ren) from birth to their 26th birthday.
Annual Deductible	\$500 per person / \$1,500 per family per calendar year, with carryover provision.
Coinsurance (Benefit) Level	After the applicable calendar year deductible has been met, services are paid at 80% for most services.
Out of Pocket Maximum	Annual out-of-pocket limit is \$2,000 individual / \$6,000 family. Does not include Deductible
Physician Office Calls	After calendar year deductible has been satisfied, \$20 co-pay then covered at 80%. Hearing exams covered as medically necessary.
Preventive Care Services	Covered in full , including well baby care, well adult visits, following adult/child schedules. Calendar year deductible <u>does not</u> apply.
Chiropractic Services	<u>Self-referral to 10 visits per member per calendar year by GHC providers.</u> After calendar year deductible has been satisfied, \$20 co-pay, then covered at 80%.
Prescription Drug Co-payment Retail (30 day supply)	Most drugs ⁽¹⁾ , including contraceptives obtained from GHC: \$15 – generic \$30 – brand
Mail Order (90 day supply)	Covered at \$30 co-pay for generic / \$60 co-pay for brand name drugs for each ninety (90) day supply or less.
Ambulance Services	GHC initiated hospital to hospital ground transfers are covered in full; Non-emergent ground/air to facility transfers are covered at 80%. Deductible Waived.
Emergency Room	\$75 co-pay per visit (waived if admitted). Patient must notify Group Health Cooperative within 24 hours. Deductible and 80% coinsurance applies.
Hospital Inpatient Services	Covered at 80%, after the calendar year deductible has been satisfied.
Inpatient Surgery	Covered at 80%, after the calendar year deductible has been satisfied.
Outpatient Surgery	After calendar year deductible has been satisfied, \$20 co-pay then covered at 80%.
Diagnostic Lab & X-Ray	After calendar year deductible has been satisfied, covered at 80% for covered services. Preauthorization required for high-end radiology.
Mental Health Inpatient	After calendar year deductible has been satisfied, covered at 80% <u>at a GHC approved mental health care facility when approved in advance by GHC.</u>
Mental Health Outpatient	After calendar year deductible has been satisfied, \$20 co-pay then covered at 80% when approved in advance by GHC.
Vision Care	Routine eye exam covered in full once per calendar year, subject to a \$20 co-pay.
Maximum Lifetime Benefit	Unlimited
Life / AD&D Insurance	N/A

OPTION III

K-12 REGENCE BLUESHIELD PREMIER PLAN (Group Number 10001011)

Eligible Health Care Providers	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence's allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.	
Dependent Child Definition	Child(ren) from birth to their 26th birthday.	
Annual Deductible (PCY = Per Calendar Year)	\$100 (Individual) / \$300 (Family) PCY– Combined between Category 1 and 2 Network & Non-contracted Providers	
	Category 1 – Preferred Providers	Category 2 – Participating Providers
Coinsurance (Benefit) Level	90%	70%
Out of Pocket Maximum (PCY = Per Calendar Year)	Once you have paid \$1,000 (Individual) / \$3,000 (Family) PCY, benefits will be covered at 100% of allowable charges thereafter. (Does not include deductible or co-payments)	
Physician Office Calls	\$20 Co-pay then covered at 100%; Deductible waived.	\$35 Co-pay then covered at 100%; Deductible waived.
Preventive Care Services	Covered at 100% (no dollar limit); Deductible waived.	Covered at 100% (no dollar limit); Deductible waived.
Chiropractic Services	Subject to deductible then covered at 90%. No co-pay.	Subject to deductible then covered at 70%. No co-pay.
Prescription Drug Co-payment	<u>At Participating Pharmacies</u>	<u>At Participating Pharmacies</u>
Retail (30 day supply)	\$5 – formulary generic \$20 – formulary brand \$40 – non-formulary	\$5 – formulary generic \$20 – formulary brand \$40 – non-formulary
Mail Order (90 day supply)	\$10 – formulary generic \$40 – formulary brand \$80 – non-formulary	\$10 – formulary generic \$40 – formulary brand \$80 – non-formulary
Ambulance Services	Subject to deductible, then covered at 90%.	Subject to deductible, then covered at 90%.
Emergency Room Co-payment	\$75 Co-pay per ER visit then subject to deductible and covered at 90%. Co-pay waived if admitted.	
Hospital Inpatient Services	Subject to deductible then covered at 90%	Subject to deductible then covered at 70%
Inpatient Surgery	Subject to deductible then covered at 90%	Subject to deductible then covered at 70%
Outpatient Surgery	Subject to deductible then covered at 90%	Subject to deductible then covered at 70%
Diagnostic Lab & X-Ray	Covered at 100% for outpatient. Deductible Waived.	Covered at 100% for outpatient. Deductible Waived.
Mental Health Inpatient Services	Subject to deductible, then covered at 90% (no day limit)	Subject to deductible, then covered at 70% (no day limit)
Mental Health Outpatient Services	Covered at 100%; Deductible waived. (no visit limit)	Covered at 100%; Deductible waived. (no visit limit)
Vision Care	Not Covered.	
Maximum Lifetime Benefit	Unlimited	
Life / AD&D Insurance	\$10,000 – Decreasing at age 65, employee only.	

*Regence Plans include Life/AD&D Insurance : \$10,000 – Decreasing at age 65, employee only.

OPTION IV

K-12 REGENCE BLUESHIELD HIGH OPTION PREFERRED (Group Number 10001011)

Eligible Health Care Providers	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence's allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.	
Dependent Child Definition	Child(ren) from birth to their 26th birthday.	
Annual Deductible (PCY = Per Calendar Year)	\$200 (Individual) / \$600 (Family) PCY – Combined between Category 1 and 2 Network & Non-contracted Providers	
	Category 1 – Preferred Providers	Category 2 – Participating Providers
Coinsurance (Benefit) Level	80%	60%
Out of Pocket Maximum (PCY = Per Calendar Year)	Once you have paid \$2,000 (Individual) / \$6,000 (Family) PCY, benefits will be covered at 100% of allowable charges thereafter. (Does not include deductible or copayments)	
Physician Office Calls	\$20 Co-pay then covered at 90%. Deductible waived.	\$35 Co-pay then covered at 90%. Deductible waived.
Preventive Care Services	Covered at 100% ; (no dollar limit); Deductible waived.	Covered at 100% ; (no dollar limit); Deductible waived.
Chiropractic Services	Subject to deductible then covered at 80% . No co-pay.	Subject to deductible then covered at 60% . No co-pay.
Prescription Drug Co-payment	<u>At Participating Pharmacies</u>	
Retail (30 day supply)	\$5 – formulary generic \$20 – formulary brand \$40 – non-formulary	\$5 – formulary generic \$20 – formulary brand \$40 – non-formulary
Mail Order (90 day supply)	\$10 – formulary generic \$40 – formulary brand \$80 – non-formulary	\$10 – formulary generic \$40 – formulary brand \$80 – non-formulary
Ambulance Services	Subject to deductible, then covered at 80% .	Subject to deductible, then covered at 80% .
Emergency Room Co-payment	\$75 Co-pay per ER visit then subject to deductible and covered at 80% . Co-pay waived if admitted.	
Hospital Inpatient Services	Subject to deductible then covered at 80%	Subject to deductible then covered at 60%
Inpatient Surgery	Subject to deductible then covered at 80%	Subject to deductible then covered at 60%
Outpatient Surgery	Subject to deductible then covered at 80%	Subject to deductible then covered at 60%
Diagnostic Lab & X-Ray	Covered at 90% for outpatient. Deductible Waived.	Covered at 90% for outpatient. Deductible Waived.
Mental Health Inpatient Services	Subject to deductible, then covered at 80% (no day limit)	Subject to deductible, then covered at 60% (no day limit)
Mental Health Outpatient Services	Covered at 90%; Deductible Waived. (no visit limit)	Covered at 90%; Deductible Waived. (no visit limit)
Vision Care	Not Covered.	
Maximum Lifetime Benefit	Unlimited	
Life / AD&D Insurance	\$10,000 – Decreasing at age 65, employee only.	

*Regence Plans include Life/AD&D Insurance : \$10,000 – Decreasing at age 65, employee only.

OPTION V

K-12 REGENCE BLUESHIELD INNOVA \$500 OPTION PREFERRED (Group Number 10001011)

Eligible Health Care Providers	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence's allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.	
Dependent Child Definition	Child(ren) from birth to their 26th birthday.	
Annual Deductible (PCY = Per Calendar Year)	\$500 (Individual) / \$1,500 (Family) PCY –Combined between Preferred Network & Participating/Recognized Providers	
	Category 1 – Preferred Providers	Category 2 – Participating Providers
Coinsurance (Benefit) Level	80%	60%
Out of Pocket Maximum (PCY = Per Calendar Year)	Once you have paid \$2,500 (Individual) / \$7,500 (Family) PCY, benefits will be covered at 100% of allowable charges thereafter. (Does not include deductible or co-payments)	
Physician Office Calls	\$20 co-pay then covered at 100% of allowable charges; Deductible waived.	\$35 co-pay then covered at 100% of allowable charges; Deductible waived.
Preventive Care Services	Covered at 100% of allowable charges. (No dollar limit)	Covered at 100% of allowable charges. (No dollar limit)
Chiropractic Services	<u>Maximum of 10 visits per calendar year.</u> Subject to deductible, then covered at 80%	<u>Maximum of 10 visits per calendar year.</u> Subject to deductible, then covered at 60%
Prescription Drug Co-payment (PCY = Per Calendar Year)	<u>At Participating Pharmacies</u>	<u>At Participating Pharmacies</u>
Retail (30 day supply)	\$5 – formulary generic	\$5 – formulary generic
	\$20 – formulary brand	\$20 – formulary brand
	\$40 – non-formulary	\$40 – non-formulary
Mail Order (90 day supply)	\$10 – formulary generic	\$10 – formulary generic
	\$40 – formulary brand	\$40 – formulary brand
	\$80 – non-formulary	\$80 – non-formulary
Ambulance Services	Subject to deductible, then covered at 80%.	Subject to deductible, then covered at 80%.
Emergency Room Co-payment	\$75 Co-pay per ER visit then subject to deductible and covered at 80%. Co-pay waived if admitted.	
Hospital Inpatient Services	Subject to deductible then covered at 80%	Subject to deductible then covered at 60%
Inpatient Surgery	Subject to deductible then covered at 80%	Subject to deductible then covered at 60%
Outpatient Surgery	Subject to deductible then covered at 80%	Subject to deductible then covered at 60%
Diagnostic Lab & X-Ray (PCY = Per Calendar Year)	First \$500/year PCY outpatient is covered at 100% of allowable charges. Deductible waived.	First \$500/year PCY outpatient is covered at 100% of allowable charges. Deductible waived.
	Above \$500/year benefits are subject to deductible then covered at 80%	Above \$500/year benefits are subject to deductible then covered at 60%
	Subject to deductible, then covered at 80% (no day limit)	Subject to deductible, then covered at 60% (no day limit)
Mental Health Outpatient Services	Subject to deductible, then covered at 80% (no visit limit)	Subject to deductible, then covered at 60% (no visit limit)
Vision Care	Not Covered.	
Maximum Lifetime Benefit	Unlimited	
Life / AD&D Insurance	\$10,000 – Decreasing at age 65, employee only.	

*Regence Plans include Life/AD&D Insurance : \$10,000 – Decreasing at age 65, employee only.

OPTION VI

K-12 REGENCE BLUESHIELD HDHP-HSA PLAN (Group Number 10001011)

Eligible Health Care Providers	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence’s allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.	
Dependent Child Definition	Child(ren) from birth to their 26th birthday.	
Annual Deductible (PCY = Per Calendar Year)	\$1,500 (Individual) / \$3,000 (Family) PCY– Combined among category 1, 2 and 3 Providers. Prior to benefits being paid out for any family member, the deductible must be met. The family deductible applies with the subscriber and one or more dependents are enrolled.	
	Category 1 – Preferred Providers	Category 2 – Participating Providers
Coinsurance (Benefit) Level	80%	60%
Out of Pocket Maximum (PCY = Per Calendar Year)	Once you have paid \$5,000 (Individual) / \$10,000 (Family) PCY, benefits will be covered at 100% of allowable charges thereafter. (Does include deductible) For family coverage, the family OOP must be met before coverage is paid at 100%	
Physician Office Calls	80% subject to deductible	60% subject to deductible
Preventive Care Services	100% deductible waived	100% deductible waived
Chiropractic Services	80% subject to deductible	60% subject to deductible
Prescription Drug Co-payment Retail (30 day supply)	80% subject to deductible Deductible waived for generic and formulary preventive drugs for asthma, diabetes, high blood pressure, high cholesterol and tobacco addiction	80% subject to deductible Deductible waived for generic and formulary preventive drugs for asthma, diabetes, high blood pressure, high cholesterol and tobacco addiction
Mail Order (90 day supply)		
Ambulance Services	80% subject to deductible	80% subject to deductible
Emergency Room Co-payment	80% subject to deductible	
Hospital Inpatient Services	80% subject to deductible	60% subject to deductible
Inpatient Surgery	80% subject to deductible	60% subject to deductible
Outpatient Surgery	80% subject to deductible	60% subject to deductible
Diagnostic Lab & X-Ray	80% subject to deductible	60% subject to deductible
Mental Health Inpatient Services	80% subject to deductible (no day limit)	60% subject to deductible (no day limit)
Mental Health Outpatient Services	80% subject to deductible (no visit limit)	60% subject to deductible (no visit limit)
Vision Care	Not Covered.	
Maximum Lifetime Benefit	Unlimited	
Life / AD&D Insurance	\$10,000 – Decreasing at age 65, employee only.	

*Regence Plans include Life/AD&D Insurance : \$10,000 – Decreasing at age 65, employee only.

HDHP-HSA PLAN QUESTIONS AND ANSWERS

How does the High Deductible Health Plan (HDHP) and Health Savings Account (HSA) work?

On the HDHP, the deductible must be met prior to Regence Blue Shield making payment for any service, except for Preventive Care. All services including prescriptions must be paid for in full until the Deductible is met. You can use the funds in your HSA to pay for services and prescriptions. Once the Deductible is met, you are responsible for Coinsurance including Prescription Drugs. **If there is family coverage, the entire family deductible must be met prior to Regence Blue Shield making payment.**

Procedure:

1. When going to the doctor or a pharmacy for a prescription, **always** present your Regence Blue Shield Medical Insurance card at the time of service.
2. Your doctor will then bill Regence Blue Shield, or the Pharmacy will apply your insurance information to the prescription. Regence Blue Shield will process the claim, applying the charges to the deductible. If you go to a participating doctor or pharmacy, any discounts Regence Blue Shield has negotiated will apply and will reduce your out of pocket costs. You will also receive an Explanation of Benefits (EOB) from Regence Blue Shield, which will explain what your responsibility is and how much of the charges have been applied to your deductible.
3. You can now pay the provider with your HSA debit card. Many providers will bill you and provide space on the bill for you to write in your HSA debit card number to pay for the charges. If a provider or pharmacy (such as Costco) do not allow credit card payments, you will need to submit your receipt for reimbursement. (Note: although the HSA card is a debit card, it can only be run as a credit card. There is no pin number, and therefore the card cannot be run as a debit card.)

Contributions:

Your premium dollars include a monthly contribution of \$125 towards your HSA. You can also contribute to your HSA up to the federal annual limit. The total allowed contributions for 2010, *including the contributions made through your monthly premiums*, is \$3,050 for an individual, or \$6,150 for a family. These additional contributions will be deducted from your paycheck on a pre-tax basis. Snoqualmie Valley School District will allow you to change the amount of your additional contributions on a quarterly basis.

Distributions:

The HSA contributions through your premium dollars are intended to cover your annual deductible. Any time you go to the doctor or fill a prescription before your deductible is met, you can use the funds from your HSA. In addition, you are allowed to use your HSA for any "qualified medical expense" for medical, dental, vision, or other items that are allowed according to IRS Publication 502. For example, if you have a child who will need braces, you are allowed to contribute to your HSA with pre-tax dollars to pay for the braces. **Beginning January 1, 2011, over-the-counter drugs (with the exception of insulin) are not eligible expenses unless you have a written prescription from a physician.**

Important facts about your HSA

- The HSA is an account in your name that belongs to you. If you leave Snoqualmie Valley School District, the account goes with you, and you can continue to use the account for qualified medical expenses.
- If you use HSA funds for anything that is not a qualified medical expense, there is a 10% tax penalty, and you must report the amount to the IRS as regular income. You should keep all receipts for purchases made with your HSA card, to prove the purchases were a qualified medical expense in case you are audited by the IRS.
- If you choose to go to a pharmacy that participates with the IIAS system, charges will be auto-adjudicated at the time of purchase. (a list of participating merchants is available at www.sig-is.org)
- You cannot use your HSA funds for any item or service prior to your effective date on the plan. For example, if your plan was effective 10/1/10 and dentist performed a crown for you on September 5, 2010, and your portion is \$400 of the cost of the crown, you cannot use your HSA funds for this service.
- **Any person covered under the HDHP cannot participate in a Flex-Spending Account (FSA), unless it is a non-medical FSA, such as a dependent care reimbursement FSA.**
- You or your spouse cannot be covered under another medical plan if they are on the Snoqualmie Valley School District HDHP unless the other plan is also an IRS qualified HDHP. If a spouse is covered by Snoqualmie Valley School District, and is also covered by their employer with a non-HDHP plan, they must decide to choose only one of the Medical plans.
- You can use HSA funds for qualified medical expenses for any dependent, even if they are not covered by the Snoqualmie Valley School District Health Plan. However, you cannot use HSA funds for qualified medical expenses for someone who is not a dependent according to the IRS, for example, a child who is over age 26.
- If you are no longer covered by a High Deductible Health Plan, or you enroll in Medicare, you cannot continue to contribute to the HSA, but you can continue to use the funds to pay for qualified medical expenses.

**MANDATORY BENEFITS
DENTAL INSURANCE
(2 options)**

OPTION #1:

WEA - WASHINGTON DENTAL SERVICE PPO:

Group No.: #0186

Family coverage (dependents to age 26) for all eligible employees.

Brief Description of Incentive Dental Plan A:

Preventive (Exams, X-rays, Cleaning, Fluoride, Sealants)	70% - 100% Incentive*
Restorative (Fillings, Oral Surgery, Endo & Perio)	70% - 100% Incentive*
Onlays, Crowns	70% - 100% Incentive*
Major (Dentures, Bridges, Partials and Implants)	50%
Temporomandibular Joint Disorder (TMJ)	50% up to \$1,000 Annual Maximum Benefit \$5,000 Lifetime Maximum Benefit
Annual Maximum Benefit (September 1 – August 31)	\$1,750 per person per Benefit Year if a non-PPO provider is utilized. \$2,000 per person per Benefit Year if a Delta Dental PPO provider is utilized.
Orthodontics (Plan B – Children only)	50% to \$1,000 (lifetime maximum benefit)

***HOW THE INCENTIVE PLAN WORKS:**

This plan encourages regular dental care. During the first Benefit Year on the plan, 70% of covered benefits are paid. This advances by 10% annually (on September 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 level to drop by 10% points below the last level of payment, but never below the original 70%. Each eligible employee and dependent creates his or her own percentage point level. Percentage point levels do not affect the established constant 50% payment level for the cost of allowable prosthetics (dentures, bridges, and implants) and orthodontics.

You may select a licensed dentist. Tell your dentist you are covered by WDS program **Group #0186**.

If your dentist is a member dentist, your claims will be submitted directly to Washington Dental Service and no more than the filed fee can be charged. Washington Dental Service member dentists are reimbursed based on negotiated, pre-approved fees. Employees are not held responsible for amounts charged in excess of the member dentists' approved fees. This translates to lower out-of-pocket costs – and no surprises. Your benefit dollars will go further if you seek services from a **Delta Dental PPO** dentist. If you visit a Delta Dental PPO dentist, you will be able to take advantage of a higher annual plan maximum. Starting October 1, 2010, your dental benefit plan maximum will increase to \$2,000 if you select a Delta Dental PPO dentist. Delta Dental Premier dentists are members of our traditional fee-for-service plan, but they are not part of the Delta Dental PPO network.

If you choose to see a dentist who is not a member of Washington Dental Service, you are responsible for having the dentist complete and sign claim forms. It will also be up to you to ensure that the claims are sent to Washington Dental Service. Claim payments will be based on actual charges or Washington Dental Service's maximum allowable fees for nonparticipating dentists, whichever is less. You will be responsible for any balance remaining. Please be aware that Washington Dental Service has no control over nonparticipating dentists' charges or billing procedures.

OPTION #2:

WEA-WILLAMETTE DENTAL:

Group No.: #W410

Family coverage (dependents to age 26) for all eligible employees.

Brief Description of Managed Dental Care Plan I:

Annual Maximum Benefit (Oct. 1, 2010 – Sept. 30, 2011)	No annual maximum
Preventive (Exams, X-rays, Cleaning, etc.)	Covered in full after a \$15 copay (per visit)
Restorative (Fillings, Extractions, etc.)	Covered in full after a \$15 copay (per visit)
Major Care (Crowns, Dentures, Partials, Bridges, etc.)	Covered in full after a \$50 copay for crowns, bridges and dentures, plus a \$15 per visit copay
Implants	See benefit booklet for specific co-pays
Temporomandibular Joint Disorder (TMJ)	\$1,000 Annual Maximum Benefit \$5,000 Lifetime Maximum Benefit
Nightguards	Covered in full after a \$15 copay (per visit)
Orthodontics (Plan 6 – employees, spouse, children)	Covered in full after a \$15 copay (per visit) & a \$2,000 orthodontia copay

Services must be provided by network providers in order to receive coverage.

MANDATORY BENEFITS (continued) VISION PLAN

Northwest Benefit Network:

Family coverage: Your spouse and children **to age 26** for all vision eligible employees. No card needed; prior to your appointment, get an NBN form from your building secretary or payroll office. You can view a list of the NBN network providers at www.nwadmin.com.

Frequency of Service:

Exams	Once each 365 days*
Lenses (pair)	Once each 365 days*
Frames	Once each 365 days*
Contact Lenses-subnormal (in lieu of exam, lenses & frames)	Once each 365 days*
Contact Lenses-elective (in lieu of exam, lenses & frames)	Once each 365 days*

Coverage:

Exams	Paid in Full†
Lenses	Paid in Full**†
Frames	Paid in Full***†
Contact Lenses-subnormal (in lieu of exam, lenses & frames) (Subnormal vision contacts requires prior approval from NBN claims office)	Paid in Full†
Contact Lenses-elective (in lieu of exam, lenses & frames)	\$225.00 allowance toward the cost of the exam, fitting fee and lenses†

To receive this allowance, you must be eligible for examination and lenses (glasses) at the time services for contact lenses begin.

Co-payment for lenses/frames/exams: \$0.00

* These time frames are strictly enforced (i.e., to the day). **There are no "grace periods"**

** Paid in full means the cost of basic lenses is covered in full. See below for covered extras.

*** Paid in full means for the frames selection covered by your Plan, not all frames

† When services are rendered by a Northwest Benefit Network Provider. See benefit booklet for Non-Network benefits.

Lens Extras:

	<i>Covered When Necessary</i>
Hi-Index (<i>Special thinning of lenses</i>) ****	<i>Covered by NBN Plan</i>
Generic Flat Top Multi-focal (<i>Basic lined bifocal or trifocal</i>)	<i>Covered by NBN Plan</i>
Blended (<i>Blend lenses together so you don't see a hard line</i>)	<i>Covered by NBN Plan</i>
Progressive **** (<i>Blends lenses together so you don't see a hard line</i>)	<i>Covered by NBN Plan</i>
Lenticular	<i>Covered by NBN Plan</i>
Oversize Blanks (<i>Oversized lenses</i>)	<i>Covered by NBN Plan</i>
Prism Segs (<i>Specific cut to the lenses</i>)	<i>Covered by NBN Plan</i>
Slab Off (<i>Specific cut to the lenses, thinning out the edges</i>)	<i>Covered by NBN Plan</i>
Laminated (<i>Special lens fabrication process</i>)	<i>Covered by NBN Plan</i>
Double Segs (<i>bifocal on top and bottom</i>)	<i>Covered by NBN Plan</i>
Pink 1 & 2 Tints	<i>Covered by NBN Plan</i>
Sun Tints	<i>Covered by NBN Plan</i>
Glass Photochromatic Lite Shades (e.g., <i>Photogrey Extra</i>)	<i>Covered by NBN Plan</i>
Glass Photochromatic Dark Shades (e.g., <i>Photosun</i>)	<i>Covered by NBN Plan</i>
Plastic Photochromatic (e.g., <i>Transitions</i>) ****	<i>Patient Responsibility</i>
Other Tints (<i>Solid, Gradient, Mirror (glass only), U.V., Polaroid</i>)	<i>Covered by NBN Plan</i>
Anti-Reflective Multi Layer	<i>Covered by NBN Plan</i>
Color Coat	<i>Covered by NBN Plan</i>
Edge Coat	<i>Patient Responsibility</i>
Scratch Coat	<i>Covered by NBN Plan</i>
Special Lens Edge Treatments	<i>Patient Responsibility</i>
Anti-Reflective + Scratch Coat – Basic Types (e.g., <i>Crizal</i>) ****	<i>Covered by NBN Plan</i>

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

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 allowable is ordered, you are responsible for the additional costs, including any fees. **Non-panel claims must be submitted within one (1) year 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; the plan covers Standard styles of lens extras. **Please note:** 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 summary. Please contact NBN at (800) 732-1123 if you have any questions about the plan benefits and/or your eligibility status or you can register online at www.nwadmin.com to review your past claims history, eligibility status, view your plan brochure and print a claim form and more.

MANDATORY BENEFITS (continued)

GROUP LIFE INSURANCE

CIGNA:

Eligible Class:

Benefit:

Benefit Reductions:

Life Group No.: FLX961436

AD&D Group No.: OK961530

Mandatory coverage for all eligible employees.

\$50,000 flat. AD&D included.

@ Age 65 drops to 67% of \$50,000

@ Age 70 drops to 45% of \$50,000

LONG TERM DISABILITY INSURANCE

CIGNA:

Eligible Class:

Benefit Amount:

Waiting Period:

Benefit Period:

LTD Group No.: LK961141

Mandatory coverage for all eligible employees.

60% of your monthly income to a max. of \$5,000 / month.

Greater of 60 days or accumulated sick leave.

The later of the maximum benefit period or SSNRA; own occupation period for plan duration; mental /nervous related disabilities have a 24-month limitation.

VOLUNTARY BENEFITS

(The following voluntary products are not endorsed by the Snoqualmie Valley School District, but are offered as benefit enhancements.)

OPTIONAL LIFE INSURANCE

CIGNA:

Description:

Eligibility:

Group No.: FLX961436

Optional inexpensive group term life insurance for you & your family.

All permanent employees working a minimum of .5 FTE under age 70.

Your spouse if under the age of 70. Your dependent children if between the ages live birth to under age 19 years, 26 if a full-time student and you are covered.

Coverage Ends:

At age 70.

Benefits:

Employee coverage – you may apply for insurance in \$10,000 increments (minimum \$10,000) to a maximum of \$300,000, or five times your annual base salary whichever is the lesser amount.

Spouse Coverage – your spouse may apply for insurance in \$10,000 increments (minimum of \$10,000), to a maximum of \$300,000 or the amount of your coverage, whichever is less.

Dependent child(ren) – live birth to under age 19 years (25 if full-time student) may be insured for \$5,000 or \$10,000 (the benefit for children from live birth 6 months is limited to \$100).

Monthly Cost:

\$1,000

<u>Age</u>	<u>Rate per \$1,000</u>	<u>Age</u>	<u>Rate per</u>
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 per month for \$5,000 or \$3.00 per month for \$10,000, regardless of the number of children covered.

VOLUNTARY BENEFITS (Continued)

SALARY INSURANCE

LINCOLN FINANCIAL GROUP:

Eligible Classes:	<u>Teachers, Administrators & Classified Employees</u>
Description:	Voluntary short-term disability
Benefit Amount:	Up to 66 2/3% of your monthly income to a maximum of \$6,000 per month
Waiting Period:	0 days for accident/3 days for sickness
Benefit Period:	13 weeks

The above information does not constitute a contract. It only highlights general information regarding the voluntary short-term disability plans. Please be sure to consult the appropriate Lincoln Financial Group Short-Term Disability brochure for a summary of the plan's rates, specific benefits, limitations, exclusion information and pre-existing condition waiting periods before making your selection. The brochure is available in the human resource department. You may contact Lincoln Financial Group at 1-800-423-2765 or at clientservices@lfg.com.

LONG-TERM CARE INSURANCE

John Hancock Long Term Care Insurance

Over 40% of working age people needing long term care services are working age adults. You current medical plans provide little to no coverage for home health care, assisted living or nursing home care. The district offers you the opportunity to purchase long term care insurance through the John Hancock Life Insurance Company at **discounted rates**. Long term care insurance provides you with benefits to pay for care when you cannot take care of yourself and need services either in your own home, an assisted living facility, an adult family home or a nursing facility.

Any new hire age 18-64 working at least 30 hours a week that can answer "No" to 6 medical questions may submit enrollment materials within 30 days of date of hire in order to receive guaranteed acceptance without any additional underwriting.* If you choose not to enroll during your initial eligibility period, you may enroll at any other time but will be subject to full medical underwriting. Extended family members may also apply, but are subject to full medical underwriting. This is a very flexible plan which allows you to purchase the amount of coverage that makes sense for you and your family. Monthly premiums depend on your age and the amount of coverage purchased.

* Certain benefit maximums apply.

Applications and coverage information are available from the Payroll Department. You may also call or email Lehmann Wood Johnson, Inc. at 425-861-8700
Terry@lehmannwood.com or David@lehmannwood.com.

CANCER INSURANCE COVERAGE

Cancer Insurance through American Family Life Assurance Co (AFLAC).

Premiums are paid through payroll deduction. The rates you pay for this benefit are considerably less than the rates you would pay for an identical individual plan that is not tied to the District. If you should leave the District, you can maintain your same plan at the same rates. All benefits received from these policies are paid in addition to your medical insurance benefits. New employees have 60 days from date of hire to apply for coverage. In addition there will be an open enrollment, each fall, for all employees to apply for coverage. For more detailed information and/or questions, call our American Family Life Assurance Co. representative, Paula Wax – (206) 696-4278.

HELPFUL INFORMATION

QUALIFICATIONS FOR SHARED SICK LEAVE

Who may share their sick leave?

- Employees who have 61+ days of sick leave accrued.

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

- Yes, as long as the employee who is sharing the sick leave has 61+ days accrued. Maximum of 6 days allowed to be shared within a 12 month period.

What qualifications are required to receive shared sick leave?

- Employees who are requesting shared sick leave must have (and/or a relative, defined per the collective bargaining agreement) a condition(s) that is “extreme and/or extraordinary”. An “extreme and/or extraordinary” condition(s) would include a medical condition(s), which, if not treated, may result in severe consequences (i.e. death, permanent disability, etc). Effective 10/1/08 shared leave can be used by employees who are victims of domestic violence, sexual assault or stalking as well as for military leaves of absences. To qualify the employee must be in a position that his or her leave would put them in an unpaid situation or otherwise terminate employment. All other types of leave allowed under their bargaining agreement must be exhausted first.

Examples of “extreme and/or extraordinary” conditions include some of the following:

- cancer (treatment of cancer)
- some mental disorders
- major life threatening surgery
- medically necessary leaves due to injury and/or illness

Examples of conditions, which, do not qualify for shared sick leave include some of the following:

- flu
- maternity leave
- broken bones
- some mental disorders
- surgery that is not 100% medically necessary

Each request for shared sick leave is determined on an individual basis. As stated above, you (and/or a relative, defined per the collective bargaining agreement) must have an “extreme and/or extraordinary” condition, which, if not treated, may result in severe consequences (i.e. death, permanent disability, etc.) Or the employee must be a victim of domestic violence, sexual assault, stalking or on military leave.

To apply for shared sick leave please contact the superintendent’s secretary at extension 8007 to get the forms. Only the superintendent’s office has the authority to send out requests to other employees to ask for donations of shared sick leave. Employees may not send out requests for donations of shared sick leave on your behalf.

HIPAA laws prevent any private medical information to be shared without an employee’s written consent.

EMPLOYEE ASSISTANCE PROGRAM

CIGNA’s Life AssistanceSM Program helps all covered employees 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:

Life Events Information, Research, and Referral Topics

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

<p>Prenatal Care</p> <p>Parenting <i>(includes online resources)</i></p> <p>Child Care <i>(includes online resources)</i></p>	<p>Adoption <i>(includes online resources)</i></p> <p>Summer Care</p> <p>Special Needs</p> <p>Senior Care <i>(includes online resources)</i></p>	<p>Education <i>(includes online resources)</i></p> <p>Pet Care <i>(includes online resources)</i></p> <p>Legal Services</p> <p>Financial Information</p>
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This program’s unique advantages include:

Proactive Outreach - Important outreach features in the claims process promote usage of CIGNA’s Life AssistanceSM program when employees need it most. Outreach includes reminders at the time of claim.

Emphasis on Personal Interaction - CIGNA’s Life AssistanceSM offers 24- hour, live, telephonic access to CIGNA’s licensed behavioral clinicians, and up to three, free face-to-face behavioral counseling sessions with independent specialists when needed.

Most Extensive Network of Behavioral Health Resources Available – Proximity and quick response are key during critical times. CIGNA Behavioral Health’s network of more than 54,000 contracted licensed behavioral health provides prompt, local access to support.

Comprehensive Life Events Services – The program offers information and referrals on a wide variety of topics, such as finding qualified child care, summer care, and 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 Healthy Rewards® Program - CIGNA’s Life AssistanceSM includes Healthy Rewards®, which offers discounts (up to 60%) on a range of health and wellness-related services and products, including discounts on Weight Watchers and smoking cessation programs, chiropractic care, fitness club memberships, hearing and vision care, massage therapy, acupuncture, pharmacy, vitamins, and more. A User ID and Password are required to use this benefit; User ID: snoqualmievalley

Assessment and Counseling - Up to three (3) in-person counseling sessions for employees and family members for assessment, problem solving, and referral to resources.

For further information: www.cignabehavioral.com/cgi

Or

1-800-538-3543

125 CAFETERIA PLAN

The Snoqualmie Valley School District 125 Cafeteria 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. Consider the following reasons to participate:

- **Tax advantages** – This program helps you lower your taxes and thereby, increase your take-home pay.
- **Control** – You decide how much to put into the program.
- **Flexibility** – You decide which portions of the program you participate in based on your individual needs.
- **Debit Card Convenience** – The plan offers the availability of the Flex Convenience Card that is used in conjunction with the Flexible Spending Accounts outlined below. The Flex Convenience Card operates like a debit card and is used to pay for out-of-pocket expenses at the time of the service.

Flexible Spending Accounts:

JEM Resource Partners is the third party administrator that handles the servicing of the Flexible Spending Accounts. This includes the Un-reimbursed Medical Account and the Dependent Care Account.

- **Un-reimbursed Medical** - is for out-of-pocket medical, dental or vision expenses – i.e. orthodontia, co-payments, deductibles, etc. Annual limit of \$3,600. **Beginning January 1, 2011, over-the-counter drugs (with the exception of insulin) are not eligible expenses unless you have a written prescription from a physician.**
- **Dependent Care** – enables the participant to pay certain dependent care costs (e.g., daycare) with pre-tax dollars and thus reduce your taxable income. Annual limit of \$5,000.

New IRS law allowing for a 2 ½ month grace period:

The law permits a grace period immediately following the end of each plan year during which unused benefits or contributions remaining may be paid or reimbursed to plan participants for qualified benefit expenses incurred during the grace period. The grace period must *not* extend beyond the fifteenth day of the third calendar month after the end of the immediately preceding plan year to which it relates (i.e., “the 2 and ½ month rule”). As under current practice, employers may continue to provide a “run-out” period after the end of the *grace period*, during which expenses for qualified benefits incurred *during* the plan year and the grace period may be paid or reimbursed.

WORKERS' COMPENSATION SELF-INSURANCE PROGRAM

The Snoqualmie Valley School District belongs to a group self-insured trust, called Puget Sound Workers' Compensation Trust. Our self-insured program applies to any work-related injury or illness. The industrial insurance laws of the State of Washington allow employers to insure their workers' compensation obligations through the State Fund or through self-insurance. The benefits and rights for injured workers are exactly the same under either system. By being self-insured, the Snoqualmie Valley School District assumes the cost of the actual medical charges and compensation expenses and pays, from district funds, all benefits prescribed by workers' compensation laws associated with an on-the-job injury or illness. Under our self-insurance program, you will no longer pay the medical-aid premium; however, the Supplemental Pension and Asbestos premium deduction will appear on your payroll check at each pay period. The deduction amount is determined by the Department of Labor and Industries and is subject to change annually.

If you sustain a work-related injury, the following steps are to be followed:

- Report the injury immediately to your supervisor (whether or not medical attention is required).
- Your supervisor will log the injury on the district's accident report form. If you seek medical treatment, you will be provided with a “*Self-Insurer Accident Report*” (form SIF-2) and a “*Physician's Initial Report*” (form PIR). Your supervisor will help you complete the SIF-2 form BEFORE you go for medical treatment. When you have completed and signed the claim form, you will receive the pink copy to take with you.

In the case of an emergency, your supervisor or other Snoqualmie Valley School District official will ensure that the treating physician or emergency facility is informed that Snoqualmie School District is self-insured through the ESD 121 Workers' Compensation Trust cooperative so that your claim can be processed properly. The Workers' Compensation Trust makes time loss determinations using information provided from, but not limited to the following:

- doctor's certificate of disability
- medical reports
- release-for-work slips
- medical progress report (SIF2)
- phone calls

If you have any questions, please contact Lori Becker, at the payroll department, (425) 831-8014.

FAMILY MEDICAL LEAVE ACT OF 1993 (FMLA)

The Federal Family and Medical Leave Act (FMLA) was signed into law in February 1993. The law took effect on August 5, 1993 and guarantees up to 12 weeks of unpaid leave each year to workers who need time off for 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.

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

For specific questions, contact the personnel department or contact the Department of Labor for a copy of the FMLA law.

GRAMM-LEACH BLILEY ACT OF 1999 (Privacy Act)

The Gramm-Leach Bliley Act of 1999 was implemented on July 1, 2001 by all financial institutions to safeguard the privacy of individuals. By now you have probably received some information from your bank or credit card company outlining their policy on this issue. This act is also applicable to insurance companies and how they conduct business with regards to applications, claims, customer service inquiries, etc....

What does this mean to the Snoqualmie Valley School District? In order for our agent, Baldwin Resource Group and/or school district personnel, to act on behalf of a Snoqualmie Valley School District employee, a signed authorization is required. The authorization must be specific to the particular issue and must be submitted to the insurance company before the company can provide Baldwin Resource Group or any school district personnel with any information. This authorization has a 3 – 12 month limitation depending upon the carrier. **Keep in mind that this will be applicable to any individual (e.g. payroll or personnel) trying to conduct business on an employee's behalf.**

As you can see, the act is well intentioned; however, it will require additional stipulations on everyone in order to be able to conduct everyday claim inquiries, customer complaint issues, etc. Baldwin Resource Group will work closely with the insurance carriers that the Snoqualmie Valley School District contracts with in order to try and facilitate this change as painlessly as possible.

Please do not hesitate to contact our agent, Baldwin Resource Group @ (877) 455-5640 if you have any questions or need assistance regarding this matter.

C.O.B.R.A.

AND CONTINUATION OF COVERAGE

COBRA coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to your spouse or dependent children who are covered under the Plan when they would otherwise lose their group health coverage. This means that you, your spouse and your covered dependents have the right to continue on the districts medical, dental and vision plans if you meet the requirements of a qualifying event. This coverage would be on a self pay basis where you would pay all the premiums plus a 2% COBRA fee. COBRA coverage usually extends for a period of 18 months but not in all instances.

COBRA Notices and Further Information. If you or a qualifying family member have any questions about notices provided to you by your employer, or questions about COBRA, please contact your employer representative below.

*Lori Becker @ (425) 831-8014
Snoqualmie Valley School District #410
8001 Silva Avenue SE
P.O. Box 400
Snoqualmie, WA 98065-0400
beckerL1@svsd410.org*

INDIVIDUAL HEALTH COVERAGE

If you find a family member needs to come off your health plan whether due to age or cost, Meacham Financial can help. You can get affordable, quality health coverage from a variety of plans offering different coverage levels and prices. Meacham Financial represents all of the leading health carriers and short-term medical.

Call Sheri Ferguson at (425) 285-2317 / (800) 822-0822 or email sheri@meachamfi.com for a free quote and assistance in continuing to protect your family's health needs.

WASHINGTON STATE School Employees' Retirement System (DRS)

Questions regarding PERS / SERS / TRS benefit information please contact the
Department of Retirement Systems @ 800-547-6657.
Department of Retirement Systems Internet Site Address: www.drs.wa.gov

Other investment payroll deduction options are available through Deferred Compensation (457 plan) handled by the Washington State Department of Retirement and our (403(b) plan) handled by our TPA (third party administrator)

***The following programs are not offered through the Snoqualmie Valley School District.
They are included in this summary for informational purposes only.***

Healthy Kids Now!

Free or Low-Cost Health Insurance for Kids & Teens in Washington State

Infants through teenagers can receive free or low-cost health insurance. Many families in Washington State qualify and don't know it. These programs are flexible and cover kids in many types of households. This health insurance program covers a full range of services that all children need to stay healthy. For more information, please call 1-877-543-7669 or visit www.insurekidsnow.gov.

BASIC HEALTH OF WASHINGTON

Basic Health is a low cost health insurance program offered through the State of Washington, for residents who qualify. If you qualify for a subsidized rate (depending upon total family monthly income and family size) you could receive health insurance coverage for your children at a low cost through this program. Parents do not have to enroll in Basic Health in order to enroll their children. For more information on Basic Health, please call 1-800-660-9840 or visit www.basichealth.hca.wa.gov.

INSURANCE COMMITTEE MEMBERS

Ruth Moen – Principals
Freida Ellison – Accounting Supervisor
Ginger Harpel – PSE
Jim Ullman – SEA
Sarah Davis – SEA
Ryan Stokes – Director of Business Services

Lori Becker – Payroll Officer
Carol Gauntlett – Secretaries Assoc.
Barbara Beattie – PSE
Jana Treisman – SEA
Kathy Ryan – PSE

Please call Lori Becker if you are interested in serving on the Benefits Committee.

INSURANCE SUPPORT

Payroll Department _____ Lori Becker _____ (425) 831-8014
Business Office _____ Freida Ellison _____ (425) 831-8010
Director of Personnel _____ Beverly Root _____ (425) 831-8003
Insurance Consultants _____ Baldwin Resource Group _____ (877) 455-5640

INSURANCE COMPANY REPRESENTATIVES

Medical

Regence Blue Shield
Premier, High, Innova \$500, HSA 2.0
Customer Service - (888) 367-2112
(www.wa.regence.com)

Group Health Cooperative
Customer Service – (888) 901-4636
(www.ghc.org)

Dental

Washington Dental Service
Customer Service - (800) 554-1907
(www.deltadentalwa.com)

Willamette Dental
Patient Relations – (800) 360-1909
Appointments – (800) 359-6019
(www.willamettedental.com)

Vision

Northwest Administrators
Northwest Benefit Network - Vision
Customer Service - (800) 732-1123
(www.nwadmin.com)

Life, Disability

CIGNA
Life & Long Term Disability Insurance
Customer Service – (800) 362-4462
(<https://dmswebintake.group.cigna.com>)

Voluntary Products

Lincoln Financial Group
Voluntary Short Term Disability
Customer Service - (800) 423-2765
(clientservices@lfg.com)

CIGNA
Voluntary Life Insurance
Customer Service – (800) 732-1603

Jem Industries
Flexible Spending Account
Earl Johnson
Customer Service - (800) 943-9179
(www.jemtpa.com)

John Hancock
Long Term Care
Lehmann Wood Johnson, Inc.
(425) 861-8700
(terry@lehmannwood.com)

AFLAC, Voluntary Benefits
Contact – Paula Wax
(206) 696-4278
(www.aflac.com)

Employee Assistance Program

CIGNA Behavioral Health
Customer Service – (800) 538-3543
(www.cignabehavioral.com/cgi)

*If you have any questions, please contact any of the above insurance carriers or our agent,
Baldwin Resource Group (877) 455-5640
E-mail us at gkiss@baldwinrgi.com*

***** NOTES *****

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*Summary Prepared by: Baldwin Resource Group, Inc. for
Snoqualmie Valley School District #410
P.O. Box 400
Snoqualmie, WA 98065-0400*