Snoqualmie Valley School District #410

Employee Benefit Guide

2018-2019 School Year

Important Open Enrollment Information

Open Enrollment Period:

- Applications must be received by Lori Becker no later than **September 14th** to be effective by the beginning of the plan year on October 1st.
- Please note: if you elect to change dental plans during open enrollment, the change is effective November 1st. Changes to dental must still be received by **September 14th**.

Benefits Fair

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

Date: Thursday, September 6th 2018

Time: 2:30 PM-7:00 PM

Location: Mount Si High School

8651 Meadowbrook Way SE

Snoqualmie, WA 98065

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 The Partners Group at (877) 455-5640.*** This summary was printed on August 8th, 2018. 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.

Welcome to Your Benefits!

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

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

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A Guide On How To Use This Booklet

- The State provides $843.97 per month for each full time (1.00 FTE) employee to pay for benefits offered by the school district. 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 $71.08 monthly (not applicable to some employees).
- In our district, each employee who receives this monthly allocation for benefits or some pro-rated share of that amount is required to participate in Dental Insurance, Vision Insurance, Long Term Disability Insurance, Life Insurance and Retiree Medical (not applicable to some employees). You have a choice as to whether or not you want to sign up for Medical Insurance.
- Currently employees can choose between two different Dental Plans and several different Medical Plans.
- Our district does Benefit Allocation Pooling by Bargaining Groups so there is the opportunity to receive more than the $843.97 per month, depending upon the make-up and choices of your particular pool members. For now, consider the $843.97 as a minimum amount that a full-time employee receives. Each year in October (October & April for SVEA), 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 (October & April for SVEA) payroll calculation. The pool then remains static (except SVEA) between October and the following September.
- 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 = $843.97. First step is to subtract $71.08 (will be prorated for part time employees) for Retiree Medical (not applicable to some employees); subtract $27.50 for Vision Insurance; subtract $13.47 for Long Term Disability; subtract $8.68 for Life Insurance. This leaves $723.24. 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 $87.40 from your remaining balance and have $637.14 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.
- If you are changing your Dental Plan Coverage or Medical Plan Coverage from the previous year, or want to drop Medical Coverage altogether, you must log into Employee Access and complete your change via the Online Open Enrollment Tab.

Affordable Care Act

- Snoqualmie Valley School District offers affordable, minimum value medical coverage (as defined by the Affordable Care Act) to its eligible employees and their dependents, including spouses. If you or your spouse are seeking medical coverage through the Marketplace (State or Federal) Exchange Program and you qualify for a tax credit, you may be required to return these tax credits to the IRS if you are eligible for a medical plan with the district. Review the rules before accepting tax credits.

Enrolling or Making Changes to your Benefits

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

You have the following time periods to enroll:

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

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

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.

Types of Qualifying Events

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

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

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

Dependents

Your legal spouse or domestic partner is eligible for coverage as well 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.

Benefit Changes for the 2018-2019 School Year

Washington State Allocation

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

Aetna

- No benefit changes
- Rate pass.

Kaiser Permanente

- No benefit changes.
- 5.79% blended increase.

WEA – Delta Dental of Washington

- The annual maximum will increase to $2,300 when a Delta Dental PPO dentist is used and to $2,000 when a Delta Dental Premier dentist is used.
- The annual maximum will be effective 11/1/2018 through 12/31/2019.
- Member cost shares for pediatric dental needs for children aged 14 and under will be eliminated when a Delta Dental provider is used.
- -1.4% rate decrease.

WEA - Willamette Dental 1 with Ortho 6

- No benefit changes.
- 5.5% rate increase.

NBN Vision Plan

- No benefit changes.
- -9.7% rate decrease.

Cigna Long Term Disability

- No benefit changes.
- 2.0% rate increase.

Cigna Life/AD&D

- No benefit changes.
- No rate changes.

Cigna Voluntary Life/AD&D

- No benefit changes.
- No rate changes.

Medical Insurance

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

Preferred Provider Organization (PPO)

These type plans 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 Aetna.

To find a preferred provider through Aetna, visit www.aetna.com.

Accredited Care Organization (ACO)

This plan is a cross between a traditional HMO and a narrower PPO. If you choose to receive care through the ACO, the insurance company will pay a higher percentage of the charges than if you receive care from a provider that is not part of the ACO. Unlike the traditional HMO, you do not have to select a primary care physician who will direct all your care. And unlike the PPO, you must compress all your care to the ACO network.

To find doctors associated with the ACO through Aetna, visit www.aetna.com.

High Deductible Health Plan (HDHP)

These type plans operate almost like the PPO plans. If you choose to receive care through a preferred provider, the insurance company will pay a higher percentage of the charges than if you receive care from a non-preferred provider. ***Unlike a PPO plan, the deductible must be satisfied before the HDHP 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 HDHP, 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 HDHP, 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 HDHP's and HSA's are located further in this guide.

Your HDHP plan option is available through Aetna.

To find a preferred provider through Aetna, visit www.aetna.com.

Health Maintenance Organization (HMO)

These 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).

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

ER 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	Aetna PPO Plan 1 (Group # 847081)		Aetna PPO Plan 2 (Group # 847081)	
Network	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Deductible	$200 person / $600 family PCY	$400 person / $1,200 family PCY	$200 person / $600 family PCY	$200 person / $600 family PCY
Rx Deductible	None		None	
4th Qtr. Carry Over	Does NOT apply		Does NOT apply	
Carrier Coinsurance	90%	70%	80%	60%
Medical Out of Pocket Max	$1,000 person / $2,000 family PCY	$2,000 person / $4,000 family PCY	$1,500 person / $4,500 family PCY	$1,500 person / $4,500 family PCY
Rx Out of Pocket Max	Included in Medical		Included in Medical	
Office Visit	$15 copay (dw)	Ded & coin	$25 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Ded & coin	Covered in full	Ded & coin
Diagnostic Lab & X-Ray	Ded & coin	Ded & coin	20% (dw)	Ded & coin
Advanced Diagnostic Imaging	Ded & coin	Ded & coin	20% (dw)	Ded & coin
Emergency Care**	$75 copay then 10% after deductible		$75 copay (dw)	
Ambulance	10% after deductible		20% after deductible	
Hospital (Inpatient)	$200 per admit after ded	Ded & coin	$150 per admit then 20% after ded	Ded & coin
Hospital (Outpatient)	Ded & coin	Ded & coin	Ded & coin	Ded &coin
Spinal Manipulations	Unlimited Manipulations		Unlimited Manipulations	
Vision Care	1 exam every 24 months		1 exam every 24 months	
Rehab - Outpatient (Speech, Massage, OT, PT)	60 visits PCY		60 visits PCY	
	$15 copay (dw)	Ded & coin	$25 copay (dw)	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	Unlimited days PCY		Unlimited days PCY	
	$200 per admit after ded	Ded & coin	$150 per admit then 20% after ded	Ded & coin
Prescriptions	**Generic / Brand / Non-Preferred - At Participating Pharmacies**			
Retail Cost Share	$10 / $25 / $50 (30 day supply)		$10 / $20 / $40 (34 day supply)	
Mail Order Cost Share	$20 / $50 / $100 (90 day supply)		$20 / $40 / $80 (90 day supply)	
Specialty Cost Share	Subject to applicable retail or mail order copay (30 day supply)		Subject to applicable retail or mail order copay (30 day supply)	
Life/AD&D Insurance	None			

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

Unless stated otherwise, benefits reflect member responsibility.

To locate an Aetna provider, visit www.aetna.com.

Per Calendar Year (PCY) means deductibles, out-of-pocket maximums, and visitation limits reset annually on January 1st of each year.

(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	Aetna PPO Plan 3 (Group # 847081)		Aetna Whole Health (Group # 847081)	
Network	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Deductible	$300 person / $900 family PCY	$300 person / $900 family PCY	$300 person/ $900 family PCY	$1,500 person/ $4,500 family PCY
Rx Deductible	None		None	
4th Qtr. Carry Over	Does NOT apply		Does NOT apply	
Carrier Coinsurance	80%	60%	90%	60%
Medical Out of Pocket Max	$2,500 person / $5,000 family PCY	$2,500 person / $5,000 family PCY	$2,500 person / $5,000 family PCY	$5,000 person / $10,000 family PCY
Rx Out of Pocket Max	Included in Medical		Included in Medical	
Office Visit	$30 copay (dw)	Ded & coin	$10 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Ded & coin	Covered in full	Ded & coin
Diagnostic Lab & X-Ray	20% (dw)	Ded & coin	Ded & coin	Ded & coin
Advanced Diagnostic Imaging	20% (dw)	Ded & coin	Ded & coin	Ded & coin
Emergency Care**	$100 copay then 20% (dw)		$100 copay then 10% (dw)	
Ambulance	20% after deductible		20% after deductible	
Hospital (Inpatient)	$300 per admit then 20% after ded	Ded & coin	$300 per admit then 10% after ded	Ded & coin
Hospital (Outpatient)	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Spinal Manipulations	Unlimited Manipulations		Unlimited Manipuations	
Vision Care	1 exam every 24 months		1 exam every 24 months	
Rehab - Outpatient (Speech, Massage, OT, PT)	60 visits PCY		60 visits PCY	
	$30 copay (dw)	Ded & coin	$10 copay (dw)	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	Unlimited days PCY		Unlimited days PCY	
	$300 per admit then 20% after ded	Ded & coin	$300 per admit then 10% after ded	Ded & coin
Prescriptions	**Generic / Brand / Non-Preferred - At Participating Pharmacies**			
Retail Cost Share	$15 / $25 / $40 (30 day supply)		$15 / $25 / $40 (30 day supply)	
Mail Order Cost Share	$30 / $50 / $80 (90 day supply)		$30 / $50 / $80 (90 day supply)	
Specialty Cost Share	Subject to applicable retail or mail order copay (30 day supply)		Subject to applicable retail or mail order copay (30 day supply)	
Life/AD&D Insurance	**None**			

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Rx = Prescription Medication

Medical Plan Options

Plan	Aetna PPO Plan EasyChoice (Group # 847081)		Aetna PPO Plan Basic (Group # 847081)		Aetna HDHP (Group # 847081)	
Network	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Deductible	$750 person / $2,250 family PCY	$1,500 person / $4,500 family PCY	$3,000 person / $9,000 family PCY	$3,000 person / $9,000 family PCY	$1,500 person / $3,000 family PCY	$1,500 person / $3,000 family PCY
Rx Deductible	None		None		None	
4th Qtr. Carry Over	Does NOT apply		Does NOT apply		Does NOT apply	
Carrier Coinsurance	80%	50%	70%	50%	80%	50%
Medical Out of Pocket Max	$4,000 person / $12,000 family PCY	$10,000 person/ $30,000 family PCY	$6,000 person / $12,000 family PCY	$10,000 person / $30,000 family PCY	$3,425 person / $6,850 family PCY	$3,425 person / $6,850 family PCY
Rx Out of Pocket Max	Included in Medical		Included in Medical		Included in Medical	
Office Visit	$30 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin	Ded & coin	Ded & coin
Preventive Care*	Covered in full	Ded & coin	Covered in full	Ded & coin	Covered in full	Ded & coin
Diagnostic Lab & X-Ray	20% (dw)	Ded & coin	30% (dw)	Ded & coin	Ded & coin	Ded & coin
Advanced Diagnostic Imaging	20% (dw)	Ded & coin	30% (dw)	Ded & coin	Ded & coin	Ded & coin
Emergency Care**	$150 copay (dw)		$200 copay (dw)		Deductible & coinsurance	
Ambulance	Deductible & coinsurance		Deductible & coinsurance		Deductible & coinsurance	
Hopsital (Inpatient)	Ded & coin	Ded & coin	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Hosptial (Outpatient)	Ded & coin	Ded & coin	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Spinal Manipulations	Unlimited Manipulations		Unlimited Manipulations		Unlimited Manipulations	
Vision Care	1 exam every 24 months		1 exam every 24 months		1 exam every 24 months	
Rehab - Outpatient (Speech, Massage, OT, PT)	60 visits PCY		60 visits PCY		60 visits PCY	
	$30 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin	Ded & coin	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	Unlimited days		Unlimited days PCY		Unlimited days PCY	
	Ded & coin	Ded & coin	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Prescriptions	**Generic / Brand / Non-Preferred - At Participating Pharmacies**					
Retail Cost Share	$5 / $20 / $40 (30 day supply)		$20 / $40 / $70 (30 day supply)		After deductible $10 / $25 / $50 (30 day supply)	
Mail Order Cost Share	$10 / $40 / $80 (90 day supply)		$40 / $80 / $140 (90 day supply)		After deductible $20 / $50 / $100 (90 day supply)	
Specialty Cost Share	Subject to applicable retail or mail order copay (30 day supply)		Subject to applicable retail or mail order copay (30 day supply)		Subject to applicable retail or mail order copay (30 day supply)	
Life/AD&D Insurance	None					

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To locate an Aetna provider, visit www.aetna.com.

Per Calendar Year (PCY) means deductibles, out-of-pocket maximums, and visitation limits reset annually on January 1st of each year.

Aetna HDHP: 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.

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Medical Plan Options

Plan	Kaiser Permanente Traditional Plan (Group # 68700)	Kaiser Permanente Deductible Plan (Group # 1146900)
Network	**At a Kaiser Facility/Provider Only**	**At a Kaiser Facility/Provider Only**
Medical Deductible	None PCY	$500 person / $1,500 family PCY
Rx Deductible	None	None
4th Qtr. Carry Over	N/A	Applies
Carrier Coinsurance	100%	80%
Medical Out of Pocket Max	$2,000 person / $4,000 family PCY	$2,600 person / $7,800 family PCY
Rx Out of Pocket Max	Included in Medical	Included in Medical
Office Visit	$20 copay	$20 + ded & coin
Preventive Care*	Covered in full	100% (dw)
Diagnostic Lab & X-Ray	Covered in full	Ded & coin
Advanced Diagnostic Imagining	Covered in full	Ded & coin
Emergency Care**	$75 copay	$75 copay + ded & coin
Ambulance	20%	Ded & coin
Hospital (Inpatient)	Covered in full	Ded & coin
Hospital (Outpatient)	$20 copay	$20 copay + ded & coin
Spinal Manipulations	10 manipulations PCY w/o prior authorization	10 manipulations PCY w/o prior authorization
Vision Care	One exam every 12 months	One exam every 12 months
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits PCY	30 visits PCY
	$20 copay	$20 copay + ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	45 days PCY	45 days PCY
	100%	Ded & coin
Prescriptions	**Generic / Formulary - At Kaiser Pharmacies Only**	
Retail Cost Share	$15 / $15 (30 day supply)	$15 / $30 (30 day supply)
Mail Order Cost Share	$5 discount for a 90 day supply	$30 / $60 (90 day supply)
Specialty Cost Share	Subject to applicable retail copay through Kaiser Specialty Medication Pharmacy Only (30 day supply)	Subject to applicable retail copay through Kaiser Specialty Medication Pharmacy Only (30 day supply)
Life/AD&D Insurance	None	

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High Deductible Health Plan and HSA Questions and Answers

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

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

What is a Health Savings Account (HSA)?

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

Who is eligible to participate in an HSA?

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

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

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

How much can I contribute to my HSA?

- Your current premium dollars includes a monthly contribution of $125 towards your HSA. **This does not apply to SVEA staff.**
- 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.

High Deductible Health Plan and HSA Questions and Answers continued

Important Information Regarding your HDHP and HSA

- The HSA is a bank account, in your name, that belongs to you. If you leave your employer, the account goes with you and you can continue to use it for qualified medical expenses. Any monthly banking fees for the HSA are your responsibility and will be deducted directly from your HSA.
- Over-the-Counter medications are not a qualified medical expense under an HSA.
- Any use of HSA funds for a non-qualified medical expense is subject to a 20% tax penalty and applicable income taxes. You should keep all your receipts for purchases made with your HSA in case you are audited by the IRS.
- You cannot use HSA funds for any item or service provided prior to your effective date on your HDHP. For example, if your HDHP was effective 11/1/2018 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 HDHP. You cannot, however, use your HSA funds for qualified medical expenses for someone who is not a tax dependent (e.g. a child over the age of 26.)
- All deductibles on your HDHP reset January 1st of each calendar year. There is no carry forward of deductibles met in the prior year. If you enroll in an HDHP on November 1, your medical expenses will be subject to the entire annual deductible for the remainder of the calendar year and will reset on January 1.

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

Saving Money on Your Medical Costs

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

Use The Emergency Room for Emergencies Only

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

Select Generic Prescription Drugs When Available

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

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

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

Participate in the Flexible Spending Account

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

Mandatory Dental Benefits

Benefit eligible employees may choose to enroll in either of the dental plans below. Please note that both of these plans provide coverage for your entire family when you enroll.

Under the **Delta Dental of WA** 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 provider go to www.deltadentalwa.com/wea.

Delta Dental of WA Incentive Plan A (Group #186)	
Plan Year Maximum (Nov 1, 2018 - Dec 31, 2019)	$2,300 per person (Delta PPO providers) $2,000 per person (Delta Premier providers) $1,750 per person (Non-Delta 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
Orthodontics- Plan B (Children Only)	50% to $1,000 (lifetime maximum benefit)

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

The **Willamette Dental** plan is an Exclusive Provider Organization. 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 #W410)	
Plan Year Maximum (Nov 1, 2018 - Dec 31, 2019)	No annual max
Preventive (Exams, X-Rays, Cleaning etc.)	$15 copay then covered at 100%
Restorative Services (Fillings, Extractions, etc.)	$15 copay then covered at 100%
Major Care (Crowns, Dentures, Partials Bridges, etc.)	$50 copay plus a $15 copay per visit, then covered at 100%
Temporomandibular Joint Disorder	$1,000 Annual Max Benefit $5,000 Lifetime Max Benefit
Nightguards	$15 copay then covered at 100%
Orthodontics - Plan 6 (Adults & Children)	$15 copay per visit then covered at 100% $2,000 orthodontia copay

Mandatory Vision Benefits

Our District provides its eligible employees working a minimum of **17.5 hours per week** vision care coverage through Northwest Benefit Network (NBN). This plan allows you to use any licensed provider. However, if you use an NBN panel provider, your benefits are greater, your out of pocket costs are less and payment is made directly to the provider. Please refer to the table below to find out how often you are eligible for services and what benefits are provided.

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

NBN (Group #SQ)	Frequency	Panel Provider
Copayment for lenses/frames		No copay
Exams	Once each 365 days	Paid in full*
Lenses (pair)	Once each 365 days	Paid in full**
Frames	Once each 365 days	Paid in full***
Contacts -subnormal (in lieu of all other services, requires approval from NBN Claims)	Once each 365 days	Paid in full*
Contacts - elective (in lieu of all other hardware services)	Once each 365 days *(To receive this allowance, you must be eligible for an exam & lenses at time of services for contacts begin)*	$225 allowance towards the cost of fitting fee and lenses at an NBN provider

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

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

Obtaining services from a Panel Provider:

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

2. Present your NBN Vision ID card when you arrive for your appointment. Failure to tell your NBN eye care professional that you have NBN Vision eye care coverage could result in significant out of pocket expenses. Need additional ID cards? You can print extras online at www.nwadmin.com.

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

4. After your services are complete, pay your NBN Vision provider any co-payments (if your plan requires them) and/or charges for any uncovered items you elected to receive. NBN will pay the panel provider directly for professional services and eyewear covered under your NBN Vision Plan.

Obtaining reimbursement for services at a Non-Panel Provider:

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

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

This is a summary only of the benefits of the plan. Actual benefits are based upon the plan agreement which may contain plan details not specified in this plan summary.

Register at www.nwadmin.com to review your past claims history, eligibility status, plan documents, print a claim form and more.

Mandatory Vision Benefits continued

Lens Extras

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

Generic Flat Top Multi Focal	Blended	Progressive**
Oversize blanks	Prism Segs	Slab Off
Laminated	Double Segs	Pink 1 & 2 Tints
Sun Tints	Glass Photo Chromatic Lite Shades	Glass Photo Chromatic Dark Shades
Other Tints	Anti-Reflective Multi Layer	Color Coat
Scratch Coat	Special lens edge treatments	Plastic Photochromatic**
Anti-Reflective + Scratch Coat basic and premium	Mid-index lenses & High-index lenses, standard and premium covered without medical necessity	

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

- Computer lenses
- Mirror coating on plastic lenses
- Polycarbonate lenses
- Wrap Frames

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

Mandatory Long Term Disability Insurance

All benefit eligible employees 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 60th day of disability
Benefit Amount	60% of your gross monthly income up to $5,000/month
Minimum Benefit Amount	10% of your maximum benefit or $100, whichever is greater.
Benefits stop paying at:	Your Social Security Normal Retirement Age (if disabled before age 65) If disabled after age 65, benefits end based on age when disabled. See plan documents for schedule.
Restrictions	Mental Illness/Drug & Alcoholism is covered only for 24 months

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

Mandatory Life/AD&D Insurance

All benefit eligible employees will be covered by our District’s Life/AD&D Policy provided by Cigna. Plan benefits are below.

Benefit Amount	$50,000 flat including AD&D coverage
Benefit Reductions	At age 65 benefit drops to 67% of $50,000 At age 70 benefit drops to 45% of $50,000

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

Employee Assistance Program

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

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

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

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

This program's unique advantages include:

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

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

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

Employee Assistance Program

Voluntary Benefits

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

Voluntary Short Term Disability/Salary Insurance

Our district offers its eligible employees Short Term Disability/Salary insurance through Cigna. This policy is designed to provide you with a cash benefit in the event you suffer a qualified short term disability.
Enrollment in this plan is only available during our district's annual open enrollment period.

Eligible Class	**Teachers, Administrators & Classified Employees**
Benefit Amount	Any $50 increment, subject to a $100 min. or $1,400 max.; not to exceed 66 2/3% of your weekly earnings
Waiting Period	0 days for injury / 3 days for sickness (benefits begin on 4th day 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 Cigna 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 online under Staff Resources, Payroll/Benefits/Retirement or at the district office.

Voluntary Life Insurance

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

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

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

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, go to www.aflac.com. You may sign up for this coverage anytime throughout the year.

Flexible Spending Accounts

A Flexible Spending Account (FSA)/ Dependent Care Account (DCA) enables you to set aside money on a pre-tax basis to pay for health and day care costs. An FSA/DCA is the only benefit that actually saves you money on the cost of health and day care expenses. Our FSA is administered by Polestar Benefits.

You must complete a new election form each plan year (Jan 1 - Dec 31) to take advantage of the tax savings offered by this plan.

How the Flexible Spending Account Works?

You can elect to set aside up to $2,600 of your pre-tax earnings into your Flexible Spending Account. This pre-tax money can be used to pay for qualified health care expenses not covered by your medical, dental, or vision plans.

You can also choose to set aside up to $5,000 of your pre-tax earnings into a Dependent Care Account (if you are married and filing separately, your limit is $2,500.) This pre-tax money can be used to pay for qualified day care expenses for your children or disabled taxable dependent. There are some rules to consider before enrolling in a Dependent Care Account.

- The expense must be allowing you and your spouse to work, actively look for work or be a full-time student
- Your taxable dependent must live with you (or live with you part time if in a shared custody situation) and must be 12 years old or younger. A dependent age 13 or older can be eligible if you can provide proof that the dependent cannot physically or mentally care for themselves
- The day care provider cannot be a dependent on your tax return or your child under the age of 19
- A Dependent Care Account works like a bank account. The reimbursement cannot exceed the account balance
- Some types of expenses are not eligible. Some of these include tuition for school at the kindergarten level or above, overnight camps, nursing home expenses, meals, activity or supply fees, and transportation costs

Once you elected the amounts you want to set aside into your FSA or Dependent Care Account, you cannot change that amount until the next enrollment period unless a Qualifying Event was to occur.

Understanding the tax savings behind an FSA can be confusing. With an FSA, you can set aside money from your paycheck BEFORE taxes are deducted. The below examples illustrate how an FSA can save you money.

Employee A	
$35,000	Gross Pay
- $7,092.50	Taxes
$27,908.50	Take Home Pay
-$2,400	Medical Costs
$25,507.50	Net Pay

Employee B saves $543 a year by contributing to their FSA

Employee B	
$35,000	Gross Pay
-$2,400	Medical Costs
$32,600	Take Home Pay
-$6,548.90	Taxes
$26,051.10	Net Pay

Examples of Qualified Health Care Expenses

- Copays for doctors visits
- Deductibles and coinsurance for your medical/dental plans
- Copays for your prescription drugs
- Dental expenses like crowns, dentures, orthodontia
- Vision expenses like frames, lenses, contacts

Most over-the-counter drugs are NOT eligible expenses unless you have a written prescription from a physician.

Carryover Provision:
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 runout 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.

COBRA 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.

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
Snoqualmie Valley School District #410
425-831-8014
beckerl1@svsd410.org
8001 Silva Ave SE
PO BOX 400
Snoqualmie, WA 98065-0400

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

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).

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

Qualifications for Shared Sick Leave

Who may share their sick leave?
Employees who have 22+ days of sick leave accrued.

Can employees from one bargaining group share their sick leave with an employee of another bargaining group?
Yes, as long as the employee who is sharing has 22+ days accrued.

Can employees from SVSD share with employees of outside entities (i.e. other school districts, colleges, etc.)
No, our district has chosen not to participate in this portion of the state plan.

What qualifications are required to receive shared sick leave?

Employees who are requesting shared sick leave must suffer from, or have a relative (WAC 392-126-055) or household member (WAC 392-126-060) suffering from, an illness, injury, impairment, or physical or mental condition which is of extraordinary or severe nature. An extreme and/or extraordinary condition which if not treated may result in severe consequences (i.e. death, permanent disability, etc.) Shared leave may also 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 complete an application, and 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 the bargaining agreement must be exhausted first. Application to request shared leave may be obtained from the superintendent's office.

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.

Only the superintendent's office has the authority to send out requests to other employees to ask for donations of sick leave. Employees may not send out requests for donations of share sick leave on your behalf. HIPAA laws prevent any private medical information to be shared without an employee's written consent.

To request paperwork for participation in Shared Sick Leave contact the Superintendent's office at extension #8007 or email at roeberk@svsd410.org.

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 complete an incident/accident report.

If you seek medical treatment you need to ask for an claim filing card from your supervisor (or their assistant). This card will instruct you on how to file a claim under the Puget Sound Worker's Compensation website. If you do not have access to a computer please ask for an actual claim packet instead.

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.

Insurance Committee

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

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

Heather Anderson – SVEA	Ruth Huschle – SVEA
Lori Becker – DO	Carol Nelson – SVASA
Megan Botulinski – Principals	Vernie Newell – Principals
Jacquelyn Gardner – PSE	Ryan Stokes – DO
Ingrid Garhart – PSE	Jim Ullman – SVEA
Betty Hamilton – PSE	Christina Williams – DO
Greg Hart – Principals	

Insurance Contact Information

Carrier Name	Coverage	Group/Policy #	Phone Number	Website
Aetna	Medical	847081	855-281-8858	www.aetna.com
Kaiser Permanente	Medical	Traditional - 687 Deductible - 1146900	888-901-4636	www.kp.org/wa
Delta Dental of WA	Dental	186	800-554-1907	www.deltadentalwa.com
Willamette Dental	Dental	W410	855-433-6825	www.willamettedental.com
Northwest Administrators	Vision	SQ	800-732-1123	www.nwadmin.com
Cigna	Life/AD&D Long Term Disability	Life - 961436 AD&D - OK961530 LTD - LK961141	800-362-4462	www.cigna.com
Cigna	Employee Assistance Program	VDT961445	800-538-3543	www.cignabehavioral.com
Cigna	Voluntary Short Term Disability	961445	800-362-4462	www.cigna.com
Cigna	Voluntary Life Insurance	961436	800-732-1603	www.afadvantage.com
Polestar Benefits	Flexible Spending Account	N/A	855-222-3358	www.polestarbenefits.com
AFLAC	Cancer Insurance	N/A	N/A	www.aflac.com

Insurance Support Information

Payroll Department	**Lori Becker**	**425-831-8014**
Business Office	**Christina Williams**	**425-831-8010**
Human Resources Director	**Lynn Heikkila**	**425-831-8002**

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

Jeanette Busby, Senior Account Manager
The Partners Group
Phone: 1-877-455-5640
jbusby@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 **Lori Becker** or **The Partners Group at (877) 455-5640.** This summary was printed on November 29, 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. For medical plans that is January 1 through December 31st.

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%.

Co-payment **-** 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. For medical plans that is January 1 through December 31st.

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. For medical plans that runs January 1 through December 31st.

Maximum Benefit – The largest dollar amount or number of visits a plan will pay towards the cost of a specific benefit or overall care. For medical plans that is January 1 through December 31st.

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, co-payments 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). Runs January 1 to December 31st for medical plans.

Out-of-Pocket Maximum – The amount that the enrollee must pay for deductibles, coinsurance and co-payments in a defined period (for Medical plans that is January 1 to December 31st) 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

Notes

Monthly Insurance Rates for 2018-2019

MEDICAL	Aetna PPO Plan 1	Aetna PPO Plan 2	Aetna PPO Plan 3	Aetna Whole Health
Employee Only	$1,148.19	$976.36	$854.34	$735.84
Employee & Spouse/WSRDP	$2,238.99	$1,903.89	$1,665.98	$1,434.90
Employee & Child(ren)	$1,607.48	$1,366.91	$1,196.09	$1,030.20
Family	$2,686.77	$2,284.68	$1,999.16	$1,721.88

MEDICAL	Aetna PPO Easychoice	Aetna PPO Basic	Aetna HDHP w/ HSA	Aetna HDHP w/o HSA (SVEA)	Kaiser Permanente Traditional	Kaiser Permanente Deductible
Employee Only	$727.74	564.53	$836.34	$711.34	$731.20	$573.79
Employee & Spouse/WSRDP	$1,411.82	$1,095.20	$1,512.14	$1,387.14	$1,419.84	$1,114.20
Employee & Child(ren)	$1,018.84	$790.35	$1,120.91	$995.91	$1021.71	$801.75
Family	$1,702.90	$1,320.97	$1,789.57	$1,664.57	$1710.29	$1,342.07

*Your Aetna HDHP plan premiums include a $125 monthly contribution to your HSA. **This does not apply to SVEA employees.**

WSRDP = Washington State Registered Domestic Partner.

DENTAL	Delta Dental Incentive Plan A with Ortho B	Willamette Dental Plan 1 with Ortho Plan 6
Composite/Family Rate	$109.69	$87.40

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

VISION	NBN Vision
Composite/Family Rate	$27.50

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.

Life & Disability	Life/AD&D	Long Term Disability
Employee Only	$8.68	$13.47

2018-2019 State Allocation (for all covered benefits) = $843.97 for full time employees. From the State Allocation come the following premiums: Retiree Medical ($71.08) (not applicable to some employees), 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, along with changes due to Washington State SSB 5940, you may now have payroll deduction costs or your current costs may increase with your present medical plan.