Lopez Island School District #144

Employee Benefit Guide

2018-2019 School Year

Important Open Enrollment Information

Open Enrollment Period:

- The open enrollment period will be August 27th -September 28th, 2018 for an effective date of November 1, 2018 for all lines of coverage.
- WEA Select Plans can be previewed beginning Aug 27th at http://resources.hewitt.com/wea.
- If you are currently enrolled in a WEA Select Dental or Vision Plan and do not wish to make any changes, you will automatically stay in your current plan.
- To select a WEA Select Medical plan or to make changes to your dental or vision plan, you will need to enroll using the online system or by calling the WEA Select Benefits Center at 1-855-668-5039, Monday through Friday, 7:00 am to 6:00 pm Pacific Time.

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 **District Office** or **The Partners Group at (877) 455-5640.** This summary was printed on August 7, 2018 . Any further information, revision 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. In addition, you can contact the District Office 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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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
- 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.

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 District Office for more information if you have questions on dependent eligibility.

**The employee and domestic partner must complete and sign the district's Declaration of Domestic Partnership form to establish domestic partner status. The IRS only permits benefits for spouses and tax dependents – known as Section 152 dependents – to be provided by employers on a tax favorable basis. If a domestic partner and/or a domestic partner's children do not fulfill the applicable Internal Revenue Service criteria for Section 152 dependents, insurance premium funds provided by the employer for domestic partner coverage shall be calculated as extra compensation for the affected employee. This additional compensation is subject to applicable taxes and cannot be paid under a Section 125 premium only pre-tax deduction plan.*

Benefit Changes for the 2018-2019 School Year

Washington State Allocation

State allocation for employee benefits will increase to $843.97. The 2018- Retiree Carve-out amount is $71.08.

Kaiser Permanente

- No benefit changes.
- 16.44% rate increase.

WEA Medical Plans (Plan 2, Plan 3, EasyChoice, Basic and QHDHP)

All plans

- Deductibles and out-of-pocket maximums are effective 11/1/2018 through 12/31/2019.
- The family deductible multiplier will be reduced from 3 times the individual deductible to 2 times the individual deductible on Plans 2, 3, 5, and EasyChoice.
- The medical and prescription drug out-of-pocket maximums will be combined on plans 2, 3, 5 and EasyChoice.
- The Cost Shares for Tiers 2 and 3 for Prescription Drugs will be limited to $150 on Tier 2 and $300 on Tier 3 per retail prescription on EasyChoice A.
- The Cost Shares for Specialty Prescription Drugs will be limited to $200 per prescription for specialty prescriptions on EasyChoice A and EasyChoice B.
- Physical Therapy will be covered at the specialist office visit copay on Plans 2 and 3.

WEA Aetna plans

- The Emergency Room Copay will increase by $50 on all plans except the QHDHP.

WEA United Healthcare (UHC) plans

- The Emergency Room Copay will change to a flat $300 copay, which includes all emergency room services on all plans. The deductible and coinsurance will not apply.

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.
- 1.8% rate decrease

WEA - Willamette Dental

- No benefit changes.
- 5.8% rate increase.

WEA – Vision

- The in-network frame allowance will increase to $150 and the In-network contact allowance will DECREASE to $180.
- The contact lens frequency will change to once each calendar year (in lieu of frames/lenses).

CIGNA- Long Term Disability

- No benefit changes.
- 2% rate increase.

Medical Insurance

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

Preferred Provider Organization (PPO)

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

Your PPO plan options are available through Aetna and United Healthcare.

To find a preferred provider through Aetna or United Healthcare, visit www.weaselect.com.

Qualified High Deductible Health Plan (QHDHP)

These type of plans operate almost like the PPO plans. If you choose to receive care through a preferred provider, the insurance company will pay a higher percentage of the charges than if you receive care from a non-preferred provider. ***Unlike a PPO plan, the deductible must be satisfied before the QHDHP plan will pay for any care (except preventive care), including prescriptions. Also, unlike a PPO plan, if there is more than one person enrolled on your plan, the family deductible must be satisfied before the plan will pay benefits (except for preventive care) for any enrolled member.***

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

Your QHDHP plan option is available through Aetna and United Healthcare.

To find a preferred provider through Aetna or United Healthcare, visit www.weaselect.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 option is available through Kaiser Permanente.

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

Special Note about Hospitals and Emergency Rooms

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

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

Medical Plan Options - All Staff

Plan (Network)	WEA Plan 2 - All Staff			
	Aetna/UHC PPO		Aetna High Performance	UHC High Performance
	In Network	Out of Network	In Network Coverage Only*	In Network Coverage Only*
Medical Deductible**	$300 (2x family)		$300 (2x family)	$300 (2x family)
Rx Deductible	None		None	None
Carrier Coinsurance	80%	60%	80%	80%
Medical OOP Max**	$3,000 individual (2.5x family)	$4,400 individual ($11,700 family)	$3,000 individual (2.5x family)	$3,000 individual (2.5x family)
Office Visit *Primary/ Specialist*	$25/$35 (dw)	$30/$40 (dw)	$25/$35 (dw)	$25/$50 (dw)
Rx OOP	Included in Medical		Included in Medical	Included in Medical
Prescriptions	Generic/Preferred/Non-Preferred At Participating Pharmacies			
Retail Cost Share Copay	$10/$20/$35		$10/$20/$35	$10/$20/$35

Plan (Network)	WEA Plan 3 - All Staff			
	Aetna/UHC PPO		Aetna High Performance	UHC High Performance
	In Network	Out of Network	In Network Coverage Only*	In Network Coverage Only*
Medical Deductible**	$500 (2x family)		$500 (2x family)	$500 (2x family)
Rx Deductible	None		None	None
Carrier Coinsurance	80%	60%	80%	80%
Medical OOP Max**	$3,750 individual (2.5x family)	$6,650 individual ($18,075 family)	$3,750 individual (2.5x family)	$3,750 individual (2.5x family)
Office Visit *Primary/ Specialist*	$30/$40 (dw)	$40/$50 (dw)	$30/$40 (dw)	$30/$60 (dw)
Rx OOP	Included in Medical		Included in Medical	Included in Medical
Prescriptions	Generic/Preferred/Non-Preferred At Participating Pharmacies			
Retail Cost Share Copay	$15/$25/$40		$15/$25/$40	$15/$25/$40

This is a consolidated view of your Aetna and United Healthcare health insurance benefits. To access your full benefits, for additional information, or to find a provider, please visit www.weaselect.com.

*** No out-of-network benefits for Aetna or UHC High Performance plans.**

****Deductibles and out-of-pocket maximums are effective 11/1/2018 through 12/31/2019.**

Medical Plan Options - All Staff

Plan (Network)	EasyChoice A - All Staff			
	Aetna/UHC PPO		Aetna High Performance	UHC High Performance
	In Network	Out of Network	In Network Coverage Only*	In-Network Coverage Only*
Medical Deductible**	$1,250 individual (2x family)	$2,000 individual (2x family)	$1,250 (2x family)	$1,250 (2x family)
Rx Deductible	$500 (waived for generics)	Not Covered	$500 (waived for generics)	$500 (waived for generics)
Carrier Coinsurance	80%	50%	80%	80%
Medical OOP Max**	$5,000 individual (2x family)	Unlimited	$5,000 individual (2x family)	$5,000 individual (2x family)
Office Visit *Primary/ Specialist*	$25/$35 (dw)	50%/50%	$25/$35 (dw)	$25/$50 (dw)
Rx OOP	Included in Medical		Included in Medical	Included in Medical
Prescriptions	Generic/Preferred/Non-Preferred At Participating Pharmacies			
Retail Cost Share Copay	$10/30% to $150/30% to $300		$10/30% to $150/30% to $300	$10/30% to $150/30% to $300

Plan (Network)	EasyChoice B - All Staff			
	Aetna/UHC PPO		Aetna High Performance	UHC High Performance
	In Network	Out of Network	In Network Coverage Only*	In-Network Coverage Only*
Medical Deductible**	$750 individual (2x family)	$1,500 individual (2x family)	$750 (2x family)	$750 (2x family)
Rx Deductible	$250 (waived for generics)	Not Covered	$250 (waived for generics)	$250 (waived for generics)
Carrier Coinsurance	75%	50%	75%	75%
Medical OOP Max**	$4,500 individual (2x family)	Unlimited	$4,500 individual (2x family)	$4,500 individual (2x family)
Office Visit *Primary/ Specialist*	$30/$40 (dw)	50%/50%	$30/$40 (dw)	$30/$60 (dw)
Rx OOP	Included in Medical		Included in Medical	Included in Medical
Prescriptions	Generic/Preferred/Non-Preferred At Participating Pharmacies			
Retail Cost Share Copay	$5/$30/$45		$5/$30/$45	$5/$30/$45

This is a consolidated view of your Aetna and United Healthcare health insurance benefits. To access your full benefits, for additional information, or to find a provider, please visit www.weaselect.com.

*** No out-of-network benefits for Aetna or UHC High Performance plans.**

****Deductibles and out-of-pocket maximums are effective 11/1/2018 through 12/31/2019.**

Medical Plan Options - All Staff

Plan (Network)	WEA Plan Basic - All Staff			
	Aetna/UHC PPO		Aetna High Performance	UHC High Performance
	In Network	Out of Network	In Network Coverage Only*	In-Network Coverage Only*
Medical Deductible**	$2,100 individual (2x family)	$2,500 individual (2x family)	$2,100 (2x family)	$2,100 (2x family)
Rx Deductible	$750 individual (2x family)	Not Covered	$750 individual (2x family)	$750 individual (2x family)
Carrier Coinsurance	70%	50%	70%	70%
Medical OOP Max**	$6,600 individual (2x family)	Unlimited	$6,600 individual (2x family)	$6,600 individual (2x family)
Office Visit *Primary/Specialist*	$35/$50 (dw)	50%	$35/$50 (dw)	$35/$75 (dw)
Rx OOP	Included in Medical		Included in Medical	Included in Medical
Prescriptions	Generic/Preferred/Non-Preferred At Participating Pharmacies			
Retail Cost Share Copay	$15/$30/$50		$15/$30/$50	$15/$30/$50

Plan (Network)	QHDHP - All Staff			
	Aetna/UHC PPO		Aetna High Performance	UHC High Performance
	In Network	Out of Network	In-Network Coverage Only*	In-Network Coverage Only*
Medical Deductible**	$1,750 individual (2x family)	$3,000 individual (2x family)	$1,750 (2x family)	$1,750 (2x family)
Rx Deductible	Subject to Medical Deductible		Subject to Medical Deductible	Subject to Medical Deductible
Carrier Coinsurance	80%	50%	80%	80%
Medical OOP Max**	$5,000 individual (2x family)	Unlimited	$5,000 individual (2x family)	$5,000 individual (2x family)
Office Visit *Primary/Specialist*	80%	50%	80%	80%
Rx OOP	Included in Medical		Included in Medical	Included in Medical
Prescriptions	Generic/Preferred/Non-Preferred At Participating Pharmacies			
Retail Cost Share Copay	20%		20%	20%

This is a consolidated view of your Aetna and United Healthcare health insurance benefits. To access your full benefits, for additional information, or to find a provider, please visit www.weaselect.com.

*** No out-of-network benefits for Aetna or UHC High Performance plans.**

****Deductibles and out-of-pocket maximums are effective 11/1/2018 through 12/31/2019.**

Medical Plan Options - All Staff

Plan (Network)	Kaiser Permanente
Network	**At a Kaiser Facility/Provider Only**
Medical Deductible	$200 person / $600 family
Rx Deductible	None
4th Qtr. Carry Over	Applies
Coinsurance	100%
Medical Out of Pocket Max	$2,000 person / $6,000 family
Rx Out of Pocket Max	Included in Medical
Office Visit	$15 copay + deductible
Preventive Care*	100%
Diagnostic Lab & X-Ray	100% after deductible
Advanced Diagnostic Procedures	100% after deductible
Emergency Care**	$75 copay + deductible
Ambulance	80%
Inpatient	100% after deductible
Outpatient	$15 copay + deductible
Spinal Manipulations	10 manipulations PCY
Vision Care	One exam every 12 months
Rehab - Outpatient (Speech, Massage, OT, PT)	45 visits PCY
	$15 copay after deductible
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY
	100% after deductible
Prescriptions	**Generic / Formulary At Kaiser Pharmacies Only**
Retail Cost Share (30 Day Supply)	$10 / $20
Mail Order Cost Share (90 Day Supply)	$25 / $55
Specialty Cost Share (30 Day Supply)	Subject to applicable retail copay through GHC Specialty Medication Pharmacy Only
Life/AD&D Insurance	None

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

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

To locate a Kaiser Permanente provider, visit www.kp.org/wa

High Deductible Health Plan and HSA Questions and Answers

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

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

What is a Health Savings Account (HSA)?

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

Who is eligible to participate in an HSA?

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

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

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

How much can I contribute to my HSA?

- Your current premium dollars includes a monthly contribution of $125 towards your HSA.
- You (and/or your employer) can contribute up to the Federal Annual Limit. For 2018, including employer contributions, it is $3,450 (individual) or $6,900 (family). For 2019, the limits increase to $3,500 (individual) and $7,000 (family).
- If you are over age 55, contributions may include an additional $1,000 per calendar year.
- Married couples with two separate HSAs are limited to a total of $6,900 ($7,000 for 2019) between the two accounts if one has an HDHP with employee & dependents enrolled.
- Contributions to your HSA are deducted from your paycheck on a pre-tax basis and deposited by your employer.

How do I use my HSA?

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

Important Information Regarding your 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.

High Deductible Health Plan and HSA Questions and Answers continued

- 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 less expensive 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

Employees working a minimum of 17.5 hours per week may choose to enroll in either of the dental plans below.

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

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

Delta Dental Incentive Dental Plan A	
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

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

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

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

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

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

Mandatory Vision Benefits

Our District provides vision coverage for all employees working a minimum of **17.5 hours per week** through the WEA Select Vision Plan C via VSP. The below is a summary of **in-network** benefits provided by VSP contracted providers.
For out of network benefits, consult the plan booklet at www.vsp.com.

	Frequency	In-Network VSP Provider
Copayments		$5.00 exams $15.00 materials
Exams	Once per calendar year	Paid at 100%
Lenses (pair)	Once per calendar year	Paid at 100%
Frames	Once per two calendar years	$110.00 max allowance
Contacts - elective (in lieu of lenses and frames)	Once per two calendar years	$200.00 max allowance

This is a summary of In-Network benefits only. For Out-Of-Network benefits, please refer to the WEA Select Vision Plan C.

Mandatory Long Term Disability Insurance

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

Benefits begin paying at:	After the 90th day of disability
Benefit Amount	60% of your gross monthly income up to $10,000/month
Minimum Benefit Amount	10% of your maximum benefit or $100, whichever is greater.
Benefits stop paying at:	To age 65
Restrictions	Mental Illness/Drug & Alcoholism is covered only for 24 months
Own Occupation Period	24 months
Return to Work Incentive	Included, 24 months
Partial Disability Benefit	Included
Pre-Exisiting Waiting Period	3/12

Pre-Existing Waiting Period: A Pre-Existing condition is an injury, sickness or pregnancy for which the employee in the past 3 months before the effective date: received medical treatment, consultation, care, services, took prescription medications or had medications prescribed; *or had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care or treatment. No benefit would be payable under the plan in connection with a disability that is due to a pre-existing condition for 12 consecutive months under the plan.

Own Occupation Period: Unable to perform your job duties for a specific amount of time.

Return to Work Benefit: If you are unable to return to work on a full-time basis, but can work part-time you will be eligible to receive benefits, but not to exceed 100% of your original income.

Partial Disability Benefit: If you are partially disabled and can only earn 80% (or less) of your original income you could be eligible to receive disability benefits.

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

Employee Assistance Program

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

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

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

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

This program's unique advantages include:

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

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

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

Section 125 Plan / Flexible Spending Account

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

Our plan year is from March 1 - February 28 (29).

American Fidelity Assurance Company:

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

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

The eligible insurance plans available under Section 125 include dental, health, and vision insurance. These benefits will automatically be pre-taxed under the plan. If an employee does not want to participate in this plan, they must sign and return a "Premium Payment Plan Refusal" form to **the District Office by September 7th, 2018**. Elections made under the Section 125 plan must remain in place for the length of the plan year unless the employee experiences an allowable election change event mid-plan year (consult your employer for more details). An employee cannot change or revoke their Health FSA election during the contract year. Cancellation or changes for this account are allowed only during the next annual open enrollment period.

To take advantage of either or both of the Flexible Spending Accounts, you must complete an election form and return it to the District Office prior to **February 15th, 2019.** Employees currently participating in either of the Flexible Spending Accounts also need to submit a new election form for the 2018-2019 plan year to the District Office.

Carryover: The Health FSA allows up to $500 of unused contributions to be carried over to the next plan year. This amount will be added to any contributions you elect for the next plan year. The plan allows for a 90 day runoff period after the end of the plan year during which the participant can submit eligible Health FSA or Dependent Day Care FSA claims incurred during the preceding plan year for reimbursement. Any amount over $500 remaining at the end of the runoff period will be forfeited.

Helpful Information

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

Family Medical Leave Act of 1993 (FMLA)

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

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

COBRA and Continuation of Coverage

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

Human Resources
Lopez Island School District
86 School Road
Lopez Island, WA 98261
(360) 468-2202 ext. 2300

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

The Lopez Island School District does not offer advice regarding retirement plan benefits.
The District provides directions on how to get the information that you may need to make an informed decision.

Healthy Kids Now through Apple Health

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

Apple Health Hotline

1-877-KIDS-NOW

www.insurekidsnow.gov

Washington State Deferred Compensation Program (DCP)

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

With DCP, you decide how much money you want deducted from each paycheck. That can be as little as $360 per year or as much as the annual legal maximum of $18,500 if you are under age 50 and $24,500 if you are over age 50 for 2018.

How does Deferred Compensation Work?

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

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

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

Email: dcpinfo@drs.wa.gov

Mail: PO BOX 40931 Olympia, WA 98504-0931

Insurance Contact Information

Carrier Name	Coverage	Group/ Policy #	Phone Number	Website
Aetna	Medical		855-878-4101	www.weaselect.com
United Healthcare	Medical		844-219-3630	www.weaselect.com
Kaiser Permanente	Medical	0519700	888-901-4636	www.kp.org/wa
Washington Dental Service	Dental	186	800-554-1907	www.deltadentalwa.com
Willamette Dental	Dental	W144	855-433-6825	www.willamettedental.com
VSP	Vision	N/A	800-877-7195	www.vsp.com
Cigna	Long Term Disability	SGD600157	800-362-4462	www.cigna.com
Cigna	Employee Assistance Program	N/A	800-538-3543	www.cignabehavioral.com

District Contact Information

Human Resources	Renee Koplan	360-468-2202 ext 2303

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

The Partners Group
Phone: 1-877-455-5640

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

Notes

Notes

Monthly Insurance Rates for 2018-2019

MEDICAL WEA Plan 2	Aetna		United HealthCare	
	PPO	High Performance	PPO	High Performance
Employee Only	$972.38	$933.82	$1,014.95	$909.72
Employee & Spouse	$1,788.84	$1,717.63	$1,867.46	$1,673.10
Employee & Child(ren)	$1,306.87	$1,254.93	$1,364.20	$1,222.46
Family	$2,143.57	$2,058.17	$2,237.85	$2,004.77

MEDICAL WEA Plan 3	Aetna		United HealthCare	
	PPO	High Performance	PPO	High Performance
Employee Only	$890.22	$854.95	$925.56	$835.82
Employee & Spouse	$1,638.86	$1,573.64	$1,704.20	$1,538.27
Employee & Child(ren)	$1,196.20	$1,148.69	$1,243.80	$1,122.93
Family	$1,961.59	$1,883.46	$2,039.87	$1,841.10

MEDICAL WEA EasyChoice A	Aetna		United HealthCare	
	PPO	High Performance	PPO	High Performance
Employee Only	$670.86	$644.37	$680.35	$610.24
Employee & Spouse	$1,227.30	$1,178.55	$1,244.75	$1,115.75
Employee & Child(ren)	$898.74	$863.13	$911.49	$817.26
Family	$1,467.10	$1,408.75	$1,487.99	$1,333.60

MEDICAL WEA EacyChoice B	Aetna		United HealthCare	
	PPO	High Performance	PPO	High Performance
Employee Only	$699.59	$671.94	$712.39	$638.85
Employee & Spouse	$1,283.60	$1,232.60	$1,307.23	$1,171.55
Employee & Child(ren)	$937.34	$900.18	$954.55	$855.71
Family	$1,533.80	$1,472.78	$1,562.06	$1,399.76

MEDICAL WEA Basic Plan	Aetna		United HealthCare	
	PPO	High Performance	PPO	High Performance
Employee Only	$554.72	$532.87	$575.01	$518.25
Employee & Spouse	$1,025.07	$984.40	$1,062.82	$957.20
Employee & Child(ren)	$742.09	$712.75	$769.34	$693.12
Family	$1,218.45	$1,170.05	$1,263.38	$1,137.68

Monthly Insurance Rates for 2018-2019

MEDICAL *WEA QHDHP	Aetna		United HealthCare	
	PPO	High Performance	PPO	High Performance
Employee Only	$636.69	$616.56	$653.54	$602.35
Employee & Spouse	$1066.98	$1029.64	$1098.23	$1003.26
Employee & Child(ren)	$809.81	$782.76	$832.46	$763.65
Family	$1224.63	$1200.18	$1281.82	$1168.79

**WEA QHDHP: Your premiums include a $125 contribution towards your HSA.

MEDICAL	Kaiser Permanente
Employee Only	$875.13
Employee & Spouse	$1,750.26
Employee & Child(ren)	$1,531.48
Family	$2,406.61

DENTAL	Delta Dental	Willamette Dental
Composite/Family Rate	$99.79	$82.95

Dental plan rates are composite rated, meaning the rates are the same for single employees or employees choosing to cover their families.

VISION	VSP Plan C
Composite/Family Rate	$30.80

Vision plan rates are composite rated like our dental plans. This means the rates are the same for single employees and employees choosing to cover their families.

LONG TERM DISABILITY	Cigna
Employee Only Rate	$10.82

2018-2019 State Allocation = **$843.97** for full time employees. From the above state allocation come the following premiums: Dental, Vision, and Long-Term Disability. The amount remaining, depending on the pooling outcome, goes toward medical premiums.