FERNDALE
SCHOOL DISTRICT

...Making A Difference

Employee Benefit Guide

CERTIFICATED EMPLOYEES

2015-2016 School Year

Important Open Enrollment Information

Open Enrollment Period: August 24th to September 30th, 2015

- **All Benefit effective dates are November 1. All other benefit online enrollment/change forms for WEA plans (Premera, Delta Dental of WA, Willamette) must be completed no later than 4:00 pm on September 30th.**
- WEA Select Plans can be previewed beginning August 20th at http://resources.hewitt.com/wea.
- If you are currently enrolled in any WEA Select Plan and do not wish to make any changes, you will automatically stay in your current plan.
- **If you are a new hire or wish to make changes, you will need to enroll using the online system at http://resources.hewitt.com/wea or by calling the WEA Select Benefits Center at 1-855-668-5039.**
- **NEW HIRES ONLY** - Enrollment forms and online enrollment must be completed by September 11th, 4:00 pm. Benefits are effective October 1.

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: Tuesday September 1st, 2015

Time: 1:00 pm - 4:00 pm

Location: Ferndale High School Cafeteria

The information herein is not a contract. It is a summary of the benefits available. It is not intended to be an all-inclusive description of Plan benefits, limitations or exclusions, and should not be used in lieu of a Plan book. Be sure to consult your Plan booklet, or consult with the insurance company representative before making your selection. If there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets prevail. Questions may be directed to your insurance committee representative listed later in this publication or The Partners Group at 1-877-455-5640. This summary was printed on August 14, 2015. Any information not provided by that time or revisions by bargaining units or by insurers after this date could change or modify the information contained herein.

If you are unable to attend the Ferndale School District Benefits Fair…

…many of our vendors will be attending the following Whatcom County School District benefits fairs.

Bellingham School District, Wednesday, August 19th, 2:00 - 6:00 p.m.
2020 Cornwall Ave
Bellingham, WA 9822

Blaine School District, Tuesday, September 1st, 7:30 - 9:00 a.m.
Blaine Middle School / High School Cafeteria
975 “H” St.
Blaine, WA 98230

Lynden School District, Thursday, September 10th, 2:30-5:00 p.m.
Lynden High School Cafeteria
1203 Bradley Rd.
Lynden, WA 98264

Meridian School District, Monday, August 31st, 3:30-5:30 p.m.
Meridian High School Cafeteria
194 W. Laurel Rd.
Bellingham, WA 98226-9699

Mount Baker School District, Tuesday, September 1st, 3:00-5:00 p.m.
Mount Baker High Commons
4936 Deming Road
Deming, WA 98244-0095

Nooksack Valley School District, Thursday, September 3rd, 2:30 - 5:30 p.m.
Nooksack Valley High School
Performing Arts Center Commons
3326 E. Badger Road
Everson, WA 98247

PLEASE NOTE: A Premera Blue Cross representative will be attending the Bellingham, Ferndale and Mount Baker benefits fairs ONLY.

A Willamette Dental representative will be attending the Bellingham, Blaine, Ferndale, Meridian, Mount Baker and Nooksack benefits fairs ONLY.

Welcome to Your Benefits!

Our District is proud to offer a comprehensive 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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Enrolling or Making Changes to your Benefits

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

You have the following time periods to enroll:

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

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

Types of Qualifying Events

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

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

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

Dependents

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

Medical Insurance

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

Preferred Provider Organization (PPO)

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

Your PPO plan options are available through Premera.

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

Qualified High Deductible Health Plan (QHDHP)

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

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

Your QHDHP plan option is available through Premera.

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

Health Maintenance Organization (HMO)

These type plans provide you with managed benefits and usually a lower cost at the time of service. However, these plans require that you select a primary care provider (PCP) from their list of providers. Your primary care provider will either provider or coordinate all of your care except in the case of a medical emergency.

Your HMO plan option is available through Group Health.

To find a Group Health provider, visit www.ghc.org.

Special Note about Hospitals and Emergency Rooms

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

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

Medical Plan Options

Plan (Network)	Premera Blue Cross PPO 2 (Heritage)		Premera Blue Cross PPO 3 (Heritage)		Premera Blue Cross PPO 5 (Foundation)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$200 person / $600 family		$300 person / $900 family		$200 person/ $600 family	$350 per person
Rx Deductible	None		None		None	
4th Qtr. Carry Over	Nov & Dec Only		Nov & Dec Only		Nov & Dec Only	
Coinsurance	80%	60%	80%	60%	90%	70%
Medical Out of Pocket Max	$1,700 person / $5,100 family	$3,400 person / $10,200 family	$2,950 person / $8,850 family	$5,900 person / $17,700 family	$700 person/ $2,100 family	None
Rx Out of Pocket Max	$2,000 person/$4,000 family		$2,000 person/$4,000 family		$2,000 person/$4,000 family	
Office Visit	$25 copay (dw)	$30 copay (dw)	$30 copay (dw)	$40 copay dw)	$15 copay (dw)	70%
Preventive Care*	100% (dw)	80% (dw)	100% (dw)	80% (dw)	100% (dw)	Not covered
Diagnostic Services	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance	
Emergency Care**	$75 copay + ded & coin		$100 copay + ded & coins		$50 copay + ded & coin	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance		$50 copay + deductible	
Hospital (Inpatient)	$150 copay per day / $450 max PCY then ded & coin		$300 copay per day / $900 max PCY then ded & coin		$150 copay per day / $450 max PCY then ded & coin	
Hospital (Outpatient)	Surgery- $100 copay then ded & coin All other services- Ded & coin		Surgery- $150 copay then ded & coin All other services- Ded & coin		Deductible & Coinsurance	
Spinal Manipulations Visits	Unlimited Visits		Unlimited Visits		Unlimited Visits	
Vision Care	Not Covered		Not Covered		Not Covered	
Rehab- Outpatient (Speech, Massage, OT, PT)	45 visits PCY Unlimited visits for PT		45 visits PCY Unlimited visits for PT		45 visits PCY	
	$25 copay (dw) PT: ded & coin	$30 copay (dw) PT: ded & coin	$30 copay (dw) PT: ded & coin	$40 copay (dw) PT: ded & coin	$15 copay (dw)	Ded & coin
Rehab- Inpatient (Speech, Massage, OT, PT)	120 days PCY		30 days PCY		30 days PCY	
	See Hospital Inpatient		See Hospital Inpatient		See Hospital Inpatient	Ded & coin
Prescriptions	**Generic / Preferred / Non - Preferred At Participating Pharmacies**					
Retail Cost Share (30 Day Supply)	$10 / $20 / $35 (34 day supply)		$15 / $25 / $40 (34 day supply)		$10 / $15 / $30	
Mail Order Cost Share (90 Day Supply)	$15 / $30 / $45 (100 day supply)		$20 / $35 / $50 (100 day supply)		$15 / $30 / $60	
Specialty Cost Share (30 Day Supply)	$50 Copay through Accredo or Walgreens Specialty Pharmacy Only		$60 copay through Accredo or Walgreens Specialty Pharmacy Only		$50 copay through Accredo or Walgreens Specialty Pharmacy Only	
Life/AD&D Insurance	$12,500 Term Life and AD&D for Employee Only					

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

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

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

Medical Plan Options

Plan (Network)	Premera Blue Cross EasyChoice A (Heritage)		Premera Blue Cross EasyChoice B (Heritage)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$1,000 person/ $3,000 family	$2,000 person/ $6,000 family	$750 person/ $2,250 family	$1,500 person/ $4,500 family
Rx Deductible	$500		$250	
4th Qtr. Carry Over	Nov & Dec Only		Nov & Dec Only	
Coinsurance	80%	50%	75%	50%
Medical Out of Pocket Max	$4,000 person/ $8,000 family	None	$3,500 person/ $7,000 family	None
Rx Out of Pocket Max	$2,500 person/$5,000 family		$2,500 person/$5,000 family	
Office Visit	$15 copay (dw)	50%	$30 copay (dw)	50%
Preventive Care*	100% (dw)	Screenings-50% Exams Only	100% (dw)	Screenings-50% Exams Only
Diagnostic Services	Paid in full to $1,000 then ded & coin		Deductible & Coinsurance	
Emergency Care**	$100 copay + ded & coin		$150 copay + ded & coin	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Inpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Outpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Spinal Manipulations Visits	12 visits PCY		12 visits PCY	
Vision Care	Not Covered		Not Covered	
Rehab-Outpatient (Speech, Massage, OT, PT)	30 visits PCY		45 visits PCY	
	$15 copay (dw)	50%	$30 copay (dw)	50%
Rehab-Inpatient (Speech, Massage, OT, PT)	30 days PCY		45 days PCY	
	Ded & coin		Ded & coin	
Prescriptions	**Generic / Preferred / Non - Preferred At Participating Pharmacies**			
Retail Cost Share (30 Day Supply)	$5 (dw) / 30% / 30%		$5 (dw) / $30 / $45	
Mail Order Cost Share (90 Day Supply)	$10 (dw) / 25% / 25%		$10 (dw) / $75 / $112	
Specialty Cost Share (30 Day Supply)	30% through Accredo or Walgreens Specialty Pharmacy Only		30% through Accredo or Walgreens Specialty Pharmacy Only	
Life/AD&D Insurance	$12,500 Term Life and AD&D for Employee Only			

*Preventive Services as defined by the Affordable Care Act

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OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

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

Medical Plan Options

Plan (Network)	Premera Blue Cross Basic (Heritage Prime)		Premera Blue Cross QHDHP (Foundation)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$1,250 person/ $2,500 family	$2,500 person/ $5,000 family	$1,500 person/ $3,000 family†	$3,000 person/ $6,000 family†
Rx Deductible	$500 person/ $1,000 family	Not covered	Subject to Medical Deductible	
4th Qtr. Carry Over	Nov & Dec Only		Does NOT Apply	
Coinsurance	70%	50%	80%	50%
Medical Out of Pocket Max	$4,500 person/ $9,000 family	Unlimited	$4,000 person/ $8,000 family	None
Rx Out of Pocket Max	$2,100 person/ $4,200 family	Not covered	Included in Medical	
Office Visit	$30 copay (dw)	Ded & coin	80%	50%
Preventive Care*	100% (dw)	Screenings-50% Exams Only	100% (dw)	Screenings-50% Exams Only
Diagnostic Services	Ded & coin	Ded & coin	80%	50%
Emergency Care	$200 copay + Ded & coin		80%	
Ambulance	Deductible & coinsurance		80%	
Hospital (Inpatient)	Ded & coin	Ded & coin	80%	50%
Hospital (Outpatient)	Ded & coin	Ded & coin	80%	50%
Spinal Manipulations Visits	12 visits PCY		12 visits PCY	
Vision Care	Not Covered		Not Covered	
Rehab- Outpatient (Speech, Massage, OT, PT)	30 visits PCY		15 visits PCY	
	$30 copay (dw)	Ded & coin	80%	50%
Rehab- Inpatient (Speech, Massage, OT, PT)	30 days PCY		30 days PCY	
	Ded & coin	Ded & coin	80%	50%
Prescriptions	**Generic / Preferred / Non- Preferred At Participating Pharmacies**			
Retail Cost Share (30 Day Supply)	$15 / $30 / $45		80%	
Mail Order Cost Share (30 Day Supply)	$15 / $60 / $90		80%	
Specialty Cost Share (30 Day Supply)	30% through Accredo or Walgreens Specialty Pharmacy Only		80% through Accredo or Walgreens Specialty Pharmacy Only	
Life/AD&D Insurance	$12,500 Term Life and AD&D for Employee Only			

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

Premera QHDHP, the deductible must be satisfied before benefits are payable. If more than one person is enrolled, the family deductible must be satisfied before benefits are payable for ANY enrolled person.

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

(dw)= Deductible waived
PCY= Per Calendar Year
Ded & coin = Deductible & coinsurance apply
OT= Occupational Therapy
PT= Physical Therapy
Rx = Prescription Medication

Medical Plan Options

Plan (Network)	Group Health
Network	**At a GHC Facility/Provider Only**
Medical Deductible	$500 person / $1,500 family
Rx Deductible	None
4th Qtr. Carry Over	Applies
Coinsurance	80%
Medical Out of Pocket Max	$2,000 person / $6,000 family
Rx Out of Pocket Max Per Person PCY	Included in Medical
Office Visit	$20 Copay 100% (dw 1st 4 Visits) deductible applies on 5th
Preventive Care*	100% (dw)
Diagnostic Services	1st $500 100% (dw) then ded & coins
Emergency Care**	$100 copay + Ded & Coins
Ambulance	Deductible + Coinsurance
Hospital Care	Deductible + Coinsurance
Inpatient	Deductible + Coinsurance
Outpatient	$20 Capay + Ded & Coins
Spinal Manipulations	10 visits PCY
Vision Care	One exam every 12 months
Rehab-Outpatient (Speech, Massage, OT, PT)	60 visits PCY
	$20 copay after deductible
Rehab-Inpatient (Speech, Massage, OT, PT)	60 days PCY
	Deductible + Coinsurance
Prescriptions	**Generic / Formulary At GHC Pharmacies Only**
Retail Cost Share (30 Day Supply)	$10 / $30
Mail Order Cost Share (90 Day Supply)	$20 / $60
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 Medicine

To locate a Group Health provider, visit www.ghc.org.

Benefit Changes for the 2015-2016 School Year

State Allocation for Benefits:

State allocation for employee benefits will increase from $768.00 to $780.00. The Retiree Medical Carve out amount will increase from $64.40 to $65.25.

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

- **All plans**
  - All specialty medications must be filled through the Walgreen's specialty pharmacy or the Accredo Health specialty pharmacy.

- **NEW PLAN: Basic plan**
  - Plan will use the Heritage Prime Network.

- **Plan 2**
  - The in-network individual medical out-of-pocket maximum has increased from $1,500 to $1,700.
  - The in-network family medical out-of-pocket maximum has increased from $4,500 to $5,100.
  - There is a new, separate prescription drug out-of-pocket maximum. The individual prescription out-of-pocket maximum is $2,000 and the family prescription out-of-pocket maximum is $4,000.
  - There is a new, separate out-of-network medical out-of-pocket maximum, $3,400 for individuals and $10,200 for families.
  - Premera has added a specialty medication copayment of $50.
  - Mail order prescription copayments have increased from $10/$20/$35 to $15/$30/$45 for up to a 100-day supply.
  - 7.5% rate increase.

- **Plan 3**
  - The in-network individual medical out-of-pocket maximum has increased from $2,750 to $2,950.
  - The In-network family medical out-of-pocket maximum has increased from $8,250 to $8,850.
  - There is a new, separate prescription drug out-of-pocket maximum. The individual prescription out-of-pocket maximum is $2,000 and the family prescription out-of-pocket maximum is $4,000.
  - There is a new, separate out-of-network medical out-of-pocket maximum, $5,900 for individuals and $17,700 for families.
  - Premera has added a specialty medication copayment of $60.
  - Mail-order prescription copayments have increased from $15/$25/$40 to $20/$35/$50 for up to a 100-day supply.
  - 6% rate increase.

- **EasyChoice**
  - **EasyChoice Plan C will be eliminated November 1, 2015.** Members enrolled in Plan C will be automatically enrolled in Plan B if they do not make a proactive change to another plan at open enrollment.

- **EasyChoice Plan A**
  - The in-network family medical out-of-pocket maximum has decreased from $12,000 to $8,000.
  - The separate prescription drug out-of-pocket maximum has decreased from $5,000 per person to $2,500 per individual and $5,000 per family.
  - The copay for generic medications has increased from $0 to $5. The deductible is waived for generic medications.
  - 8.5% rate increase.

- **EasyChoice Plan B**
  - The in-network family medical out-of-pocket maximum has decreased from $10,500 to $7,000.
  - The separate prescription drug out-of-pocket maximum has decreased from $5,000 per person to $2,500 per individual and $5,000 per family.
  - The copay for generic medications has increased from $0 to $5. The deductible is waived for generic medications.
  - 8.5% rate increase.

Benefit Changes for the 2015-2016 School Year (Continued)

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

- **Plan 5**
  - The in-network individual medical out-of-pocket maximum has increased from $500 to $700.
  - The in-network family medical out-of-pocket maximum has increased from $1,500 to $2,100.
  - There is a new, separate prescription drug out-of-pocket maximum. The individual prescription out-of-pocket maximum is $2,000 and the family prescription out-of-pocket maximum is $4,000.
  - Premera has added a specialty medication copayment of $50.
  - Mail order generic prescription copayment has increased from $10 to $15 for up to a 90-day supply.
  - The hospital admission copayment has changed from $200 copay per admission with $600 annual maximum per person and $1,000 annual maximum per family to $150 copay per day, with 3-copay maximum per person.
  - 7.5% rate increase.

- **QHDHP**
  - No benefit changes.
  - 8.5% rate increase.

WEA – Delta Dental of Washington

- Removing the age limit for Sealants & preventive Resin Restorations.
- 3% rate decrease.

WEA - Willamette Dental

- No benefit changes.
- 5% rate increase.

Northwest Benefit Network – Vision Plan

- No benefit changes.
- No rate change.

CIGNA – Long Term Disability

- No benefit changes.
- No rate change.

High Deductible Health Plan and HSA Questions and Answers

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

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

What is a Health Savings Account (HSA)?

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

Who is eligible to participate in an HSA?

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

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

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

How much can I contribute to my HSA?

- You (and/or your employer) can contribute up to the Federal Annual Limit. For 2015, including employer contributions, it is $3,350 (individual) or $6,650 (family). The limit for 2016 remains at $3,350 (individual) and increases to $6,750 (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 the Federal Annual Limit 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 Things to Be Aware of About your HDHP and HSA

- The HSA is a bank account, in your name, that belongs to you. If you leave your employer, the account goes with you and you can continue to use it for qualified medical expenses. Any monthly banking fees for the HSA are your responsibility and will be deducted directly from your HSA.
- Over-the-Counter medications are not a qualified medical expense under an HSA.
- Any use of HSA funds for a non-qualified medical expense are subject to a 20% tax penalty and applicable income taxes. You should keep all your receipts for purchases made with your HSA in case you are audited by the IRS.
- You cannot use HSA funds for any item or service provided prior to your effective date on your HDHP. For example, if your HDHP was effective 11/1/2015 and your dentist performed a crown on 9/5/2015, 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

All eligible employees must choose to enroll in either of the dental plans below.

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

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

Delta Dental of WA Incentive Plan A (Group #186)	
Plan Year Maximum (Nov 1 - Oct 31)	$1,750 per person (Non-PPO providers) $2,000 per person (PPO providers)
Preventive Services (Exams, X-Rays, Cleanings, Fluoride, Sealants)	70% - 100% Incentive
Restorative Services (Fillings, Oral Surgery, Endo, Perio)	70% - 100% Incentive
Onlays, Crowns	70% - 100% Incentive
Major (Dentures, Bridges, Partials & Implants)	50%
Temporomandibular Joint Disorder	50% up to $1,000 Annual Maximum $5,000 Lifetime Maximum

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

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

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

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

Willamette Dental (Group #W005)	
Plan Year Maximum(Nov 1 - Oct 31)	No annual max
Preventive (Exams, X-Rays, Cleaning etc.)	$15 copay then covered at 100%
Restorative Services (Fillings, Extractions, etc.)	$15 copay then covered at 100%
Major Care (Crowns, Dentures, Partials Bridges, etc.)	$50 copay plus a $15 copay per visit, then covered at 100%
Temporomandibular Joint Disorder	$1,000 Annual Max Benefit $5,000 Lifetime Max Benefit
Nightguards	$15 copay then covered at 100%

Mandatory Vision Benefits

Our District provides its eligible employees vision care coverage through Northwest Benefit Network (NBN). This plan allows you to use any licensed provider. However, if you use an NBN panel provider, your benefits are greater, your out of pocket costs are less and payment is made directly to the provider. Please refer to the table below to find out how often you are eligible for services and what benefits are provided. There is no co-payment required on materials or eye exams for either Panel (Participating) or Non-Panel Providers. Many benefits obtained from Panel Providers are covered at 100%, with a few of the exceptions listed below. For Non-Panel Providers, members pay all charges and are reimbursed up to the allowances listed below under "Non-Panel Providers". Either contacts or glasses may be obtained in a benefit period—not both. Children are eligible from birth to age 26

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

	Frequency †	NBN Panel Providers	Non-Panel Providers
Eye Exam	Every year	100%	$35
Single Vision Lenses	Every year	100% *	$30
Bifocal Lenses	Every year	100% *	$40
Trifocal Lenses	Every year	100% *	$45
Progressive Lenses	Every year	100% **	$40
Lenticular Lenses	Every year	100% *	$90
Continuous Blend	Every year	100% **	$40
Lens Coating, Tints, Oversize	Every year	Some covered	Not covered
Frames	Every 2 years	100% ***	$30
Elective Contacts	Every year	$175 ****	$90
Necessary Contacts	Every year	100%	$200

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

* Lenses necessary to correct the visual acuity of the patient are fully covered. Specialized lenses, special features and "extras" may not be covered.
** Standard grades of 'continuous blend' lenses are covered.
*** Plan pays 100% of a selection of frames; subscriber pays additional amount for more expensive frames.
**** $175 contacts allowance is for the exam, fitting and lenses combined, in lieu of all other services for 365 days.
† Every Year = 365 consecutive days. Every 2 Years = 730 consecutive days.

Group Health offers coverage for eye exams. Group Health subscribers can maximize their NBN contact allowance by billing their eye exam to Group Health.

Obtaining services from a Panel Provider:

Register on www.nwadmin.com to locate a panel provider and access your account.

Fill out and complete an online claim form and bring the form with you to your provider. You **MUST** bring this form with you at time of service. If you cannot obtain a form online contact your building secretary or payroll office.

The panel provider will go over what services are covered by your plan. They will submit the claim form to NBN for reimbursement. Any costs not covered by the plan will be your responsibility at time of service.

Obtaining reimbursement for services at a Non-Panel Provider:

Send in your itemized statement and NBN claim form to the NBN claims office. NBN will process your claim and reimburse you directly in accordance with the non-panel schedule of benefits.

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

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

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

Mandatory Long Term Disability Insurance

All Certificated employees working a minimum of **18.75 hours per week** will be covered by our District's Long Term Disability Policy provided by Cigna. This plan provides financial assistance if you are not able to return to work due to a qualified disabling condition. Plan benefits are below.

Benefits begin paying at:	After the 90th day of disability
Benefit Amount	60% of your gross monthly income up to $5,000/month
Benefits stop paying at:	Your Social Security Normal Retirement Age (if disabled before age 65) If disabled after age 65, benefits end based on age when disabled. See plan documents for schedule.
Restrictions	Mental Illness/Drug & Alcoholism is covered only for 24 months

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

Employee Assistance Program

Mandatory coverage for all employees paid for by the District.

The Health Promotion Network (HPN) of St. Joseph Hospital is our EAP provider. HPN is a totally confidential resource. Their staff of EAP professionals can offer up to **4** sessions to provide counseling and social work assistance to any employee (and the members of that employee's entire family household). Services include help with (but are not limited to):

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

You can set an appointment to meet with the EAP in person or it is possible to receive services via the phone or e-mail. The EAP is also intended as a resource for managers and supervisors to staff individual employee problems and team/work group intervention options. The EAP is pre-paid and is totally confidential. The HPN phone number is 1-800-244-6142.

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 FEA employees Short Term Disability/Salary insurance through American Fidelity. This policy is designed to provide you with a cash benefit in the event you suffer a qualified short term disability. This plan includes offsets that will subtract any other sources of income, such as Social Security. This plan does not offset income received from sick pay for the first 30 days. Injury or sickness arising out of or in the course of any occupation for wage or profit for which you are entitled to Worker's Compensation will not be covered under the benefits listed below.

Eligible Class	**Certificated Employees**
AmFi Brochure #	SB-25660
Benefit Amount	Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month
Waiting Period	0 days for injury / 7 days for sickness (benefits begin on 8th day for sickness)
Benefit Period	60 days

These plans include a limitation to offset with other sources of income. Participants will be eligible to receive up to 70% of their monthly earnings, which includes other income received, such as sick pay (after 30 days) or unemployment compensation. Injury or Sickness arising out of or in the course of any occupation for wage or profit for which you are entitled to Worker's Compensation will not be covered under this plan.

The above information does not constitute a contract. It only highlights some general information. These products contain limitations, exclusions, and waiting periods. Please be sure to consult the appropriate WEA Select American Short-Term brochure for a summary of the plan's rates, specific benefits, limitations, exclusions, and elimination period information before making your selection. The brochure is available in the human resource department and/or through an American Fidelity Assurance Company representative at 1-866-576-0201 between 8:00 AM and 5:00 PM or via the Internet at www.americanfidelity.com.

Voluntary Life Insurance

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

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

Please see Human Resources if you are interested in this coverage.

Section 125 Plan / Flexible Spending Account

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

American Fidelity Assurance Company:

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

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

The eligible insurance plans available under Section 125 include dental, health, and vision insurance. These benefits will automatically be pre-taxed under the plan. If an employee does not want to participate in this plan, they must sign and return a "Premium Payment Plan Refusal" form to the Payroll Department by September 30, 2015. 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 meet with the American Fidelity representative and complete an election form prior to 11/30/2015. Employees currently participating in either of the Flexible Spending Accounts and want to continue for the 2015/2016 school year, need to submit a new election form each year. American Fidelity will be scheduling appointments in November 2015. All employees will need to see the American Fidelity Representative as no manual forms will be accepted.

Grace Period: The Health FSA allows for a 70 day grace period immediately following the end of each plan year. During the grace period, unused account balances remaining from the previous plan year may be used to reimburse eligible medical expenses incurred during the grace period. The plan also 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 (and, for the Health FSA, the grace period) for reimbursement.

To take advantage of the Flexible Spending Accounts, you must complete the appropriate election form with the American Fidelity Representative. All employees participating in the plan need to submit an application for 2016. All employees will need to see the American Fidelity Representative as no manual forms will be accepted.

Helpful Information

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

Family Medical Leave Act of 1993 (FMLA)

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

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

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

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

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

COBRA and Continuation of Coverage

If you leave the District, certain insurance coverages which have been provided may be continued. Should you decide to continue coverage, continuation will become effective when your current plan normally would have terminated. For additional information please refer to your plan booklet.

- Group Medical Insurance- Medical insurance may be continued under COBRA. It is also convertible to a guaranteed individual policy. The benefits of the policy will vary and are usually less than provided by your group policy. Other medical plans are available on an individual basis.
- Group Dental and Vision Insurance- Dental and vision insurance may be continued under COBRA. This coverage is not convertible to individual policies.

Federal law requires most group health plans maintained on behalf of 20 or more employees to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain cases. A “group health plan” includes any employer-provided medical, dental, vision care, or prescription drug coverage. If you or a qualifying family member wish to provide notice of any required events affecting your COBRA coverage, or have any questions about COBRA, please contact your employer representative: *Traci Irvine, Ferndale School District, (360) 383-9227.*

School Employees Retirement Systems

If you have questions regarding your retirement information under PERS / SERS / TRS, please contact:

Department of Retirement Systems

800-547-6657

www.drs.wa.gov

Healthy Kids Now through Apple Health

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

Apple Health Hotline
1-877-KIDS-NOW
www.insurekidsnow.gov

Washington State Deferred Compensation Program (DCP)

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

With DCP, you decide how much money you want deducted from each paycheck. That can be as little as $360 per year or as much as the annual legal maximum of $18,000 if you are under age 50 and $24,000 if you are over age 50 for 2015.

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

Shared Sick Leave Qualifications

What qualifications are required to receive shared leave?

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

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

Who may share their leave?

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

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

- Yes.

Leave Share questions? Human Resources @ (360) 383-9206 or Gerri Gilmore @ (360) 383-9202 in Human Resources.

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 Human Resources.
Your committee members are:

Mary Copps - Teamsters	Gerri Gilmore - Prof-Tech / Admin	Tami Frost - FAAA
Mark Deebach - FSD / Admin	TBD - SEIU	Paul Douglas - FSD / Admin
TBD - PSE	TBD - FEA	

Insurance Contact Information

Carrier Name	Coverage	Group/ Policy #	Phone Number	Website
Premera	Medical	8000072	800-932-9221	www.premera.com/wea
Group Health	Medical	1305600	800-901-4636	www.ghc.org
Delta Dental of WA	Dental	186	800-554-1907	www.deltadentalwa.com
Willamette Dental	Dental	W005	855-433-6825	www.willamettedental.com
Northwest Administrators	Vision	WS	800-732-1123	www.nwadmin.com
Cigna	Life/Long Term Disability	N/A	800-362-4462	www.cigna.com
American Fidelity	Salary Insurance / Flexible Spending Account	N/A	866-576-0201	www.afadvantage.com
Health Promotion Network	Employee Assistance Program	N/A	800-244-6142	www.peacehealth.org/whatcom/eap
Dept. of Retirement Systems	Retirement	N/A	800-547-6657	www.drs.wa.gov
VEBA Service Group		N/A	800-422-4023	www.veba.org

District Contact Information

Human Resources	**Gerri Gilmore**	**360-383-9202**
Human Resources	**N/A**	**360-383-9206**

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

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

The information herein is not a contract. It is a brief summary of the benefits available. It is not intended to be an all-inclusive description of Plan benefits, limitations or exclusions, and should not be used in lieu of a Plan book. Be sure to consult your Plan booklet, or consult with the insurance company representative before making your selection. If there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets prevail. Please direct any questions to **Human Resources** or **The Partners Group at (877) 455-5640.** This summary was printed on August 14, 2015. Any further information, revision by bargaining units or by insurers after this date could change or modify the information contained herein.

Glossary of Terms

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%.

Monthly Insurance Rates for 2015-2016

MEDICAL	Premera Plan 2	Premera Plan 3	Premera Plan 5	Premera EasyChoice A & B	Premera Basic Plan	Premera QHDHP
Employee Only	$900.05	$794.35	$1,052.80	$580.40	$529.05	$581.30
Employee & Spouse	$1,647.15	$1,453.75	$2,023.00	$1,054.05	$960.40	$952.65
Employee & Child(ren)	$1,201.60	$1,060.55	$1,436.45	$769.85	$701.60	$729.85
Family	$1,974.70	$1,742.90	$2,437.05	$1,262.85	$1,150.55	$1,102.85

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

MEDICAL	Group Health Welcome 500
Employee Only	$1,148.36
Employee & Spouse	$2,198.14
Employee & Child(ren)	$1,748.11
Family	$2,796.12

DENTAL	Delta Dental Incentive Plan A	Willamette Dental
Composite/Family Rate	$105.35	$78.40

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	$23.50

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.

Long Term Disability	Cigna
Employee Only	$12.12

2015-2016 State Allocation = **$780.00** for full time employees (varies depending on pooling outcome). From the above state allocation, Dental, Vision, and Long Term Disability are deducted. Also, a Washington State health care reform bill enables retirees and disabled school employees to purchase health care insurance from the state Health Care Authority (HCA). In order to support the K-12 retiree health care plan, school districts are required to forward the HCA **$65.25** per month per full time employee from the State's monthly health benefit allocation.

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