Chimacum
School District
Benefit Handbook
2010-2011

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Governmental Employers are not subject to federal ERISA law. This Benefit Handbook is not a Summary Plan Description (SPD) as defined by federal legislation (called ERISA) that governs employers offering benefit programs. Please thoroughly review the plan booklet (SPD) issued by each carrier for the coverage in which you are enrolled. If this Benefit Handbook and/or the SPD are in conflict regarding a particular matter addressed in the Master Group Contract, the Master Group Contract will control. If this Benefit Handbook and/or the SPD are silent regarding a particular matter addressed in the Master Group Contract, the Master Group Contract will control. You may request to review or receive a copy of the Master Group Contract at any time by making this request to your Human Resource Office. If you have questions or comments please call Berg Andonian, Inc. at 888-858-5115 for assistance.

IMPORTANT NOTES:
1.) While it is hoped that the plans summarized in this Benefit Handbook will continue indefinitely, your employer reserves the right to change or terminate any plan or plans in the future.
2.) Each carrier retains discretionary authority to administer their program according to the terms of the Master Group Contract.
3.) You must exhaust all claim appeal remedies outlined in the carrier's Master Group Contract before pursuing further/other legal action.

BENEFITS OFFERED

MEDICAL INSURANCE

The district offers a range of plan choices for each employee. Employees may choose from two KPS Health Plans and three Premera Blue Cross plans. Chimacum Education Association (CEA) members are able to select only from the three Premera Blue Cross plans.

MAINTENANCE AND CUSTODIAL STAFF

Maintenance and Custodial Staff have medical, dental and vision benefits through PEBB (Agency #600-E05). For more information, contact Public Employees Benefits Board (PEBB) at 1-800-200-1004 or 360-412-4200 in Olympia, or visit their website at http://www.pebb.hca.wa.gov/.

DENTAL INSURANCE

Dental coverage is provided through Washington Dental. Washington Dental pays a percentage of charges for preventive care, basic care, major care and portion of orthodontia (children only).

VISION INSURANCE

Classified and certificated employees have vision coverage through VSP (Vision Service Plan) that covers both routine vision exams and vision hardware.

SALARY INSURANCE

Each employee has the opportunity to purchase voluntary salary insurance through American Fidelity at their own expense through payroll deduction (voluntary coverage). See the Payroll Department for additional information.

ADDITIONAL INSURANCE

Each employee has the opportunity to purchase additional insurance benefits (i.e. cancer insurance, intensive care insurance, etc.) from AFLAC at their own expense through payroll deduction.

FLEXIBLE SPENDING ACCOUNTS

You may set aside pre-tax dollars to pay for unreimbursed medical, dental, and vision expenses as well as dependent childcare or disabled dependent care expenses.

CUSTOMER SERVICE

If you have questions regarding specific benefits or claims processing problems call the following numbers. If you have difficulty obtaining answers to questions or resolving issues through the numbers listed above, contact Berg Andonian, Inc. at 888-858-5115.

	GROUP NUMBER	CUSTOMER SERVICE PHONE NUMBER	WEBSITE
MEDICAL			
KPS HEALTH PLANS Claims: PO Box 339 Bremerton, WA 98337	Enhanced 20045 Basic 22045	800-552-7114	www.kpshealthplans.com
PREMERA BLUE CROSS Claims: PO Box 91080 Seattle, WA 98111-9180	8000031-0001	800-932-9221	www.premera.com/wea
MAINTENANCE AND CUSTODIAL STAFF PUBLIC EMPLOYEES BENEFITS BOARD Claims:	Agency #600-E05	1-800-200-1004 / 360-412-4200	www.pebb.hca.wa.gov/
DENTAL			
WASHINGTON DENTAL Claims: PO Box 75688 Seattle, WA 98125	00186-03910	800-554-1907	www.deltadentalwa.com/wea
VISION			
VSP Claims: PO Box 997105 Sacramento, CA 95899	Plan C 8000031-0001	800-877-7195	www.vsp.com
FLEXIBLE SPENDING ACCOUNTS			
AFLAC Fax number for unreimbursed medical / dependent daycare claims: (877) 353-9256	J5683	253-229-5301	www.aflac.com
STATE RETIREMENT			
DRS (Department of Retirement Systems)		800-547-6657	www.drs.wa.gov
BENEFIT ADVISOR			
Berg Andonian, Inc. Jessica Carr – Account Manager		888-858-5115	www.bergandonian.com

NOTABLE CHANGES TO BENEFITS, 2010/2011

The following is not an exhaustive listing of contract changes. It is recommended that you call your carrier's Customer Service Department for answers to specific benefit questions.

ALL MEDICAL PLANS

- **Chemical Dependency –** The benefit limit of $14,500 every 24 consecutive months no longer applies. Eligible services no longer have a specific dollar limit.
- **Mental Health –** Inpatient day limit and Outpatient visit limits no longer apply. Eligible services have no specific limits
- **Organ Transplant** - Lifetime maximum benefit has increased from $250,000 to $350,000.
- **Dependent age –** Dependents are now covered to age 26 (including those who are married).
- **Domestic Partners –** State registered domestic partners will be eligible for coverage as any other spouse.
- **Lifetime Dollar Maximums –** Lifetime maximum dollar amounts no longer apply.
- **Preventive Care –** Copays and Coinsurance (cost shares) for the member are no longer applied to preventive care.

KPS MEDICAL

- **PENDING – Annual dollar limits –** Pending additional information from Health & Human Services, annual dollar limits may be revised.

PREMERA BLUE CROSS MEDICAL

- **Select Disease Management –** Select Disease Management Program is discontinued.

WDS DENTAL

- **Annual Maximum –** The benefit limit of $1,750 every year will be increased to $2,000 if a WDS PPO Provider is used.

FLEXIBLE SPENDING ACCOUNTS

- **Medical Reimbursement Over-the-Counter Medications –** As of January 1, 2011, over-the-counter (OTC) medicines and drugs will need a prescription to be considered an eligible benefit.

ENROLLMENT INFORMATION

YOUR ELIGIBILITY

The month of September is Open Enrollment. The deadline for changing plans is **September 30th**. In order for you to have coverage effective for October 1, you must submit your new enrollment or any enrollment changes to the Payroll Department by September 10th. If you submit paperwork and/or changes between September 10th and September 30th, the coverage changes will be effective on November 1st.

Payroll deductibles in September will reflect the new pricing effective October 1st.

YOUR INSTRUCTIONS

1. Once you are eligible, choose the medical and/or voluntary insurance plans in which you wish to participate.
2. Fill out the appropriate applications in full (applications available at the Payroll Department).
3. Return completed forms to the Payroll Department (see above deadlines).

MONTHLY RATES

MEDICAL	KPS ENHANCED PLAN	KPS BASIC PLAN	PREMERA BLUE CROSS PLAN I	PREMERA BLUE CROSS PLAN 2	PREMERA BLUE CROSS PLAN 3
DEDUCTIBLE	$0	$200	$50	$100	$200
OFFICE VISIT COPAY	$15	$20	$20	$25	$30
INPATIENT COVERAGE	Covered at 80% after a $150 copay per day (max 5 copays)	Covered at 80% after deductible and a $200 copay per day (max 5 copays)	Covered at 90% after deductible and a $100 copay per day (max 3 copays)	Covered at 80% after deductible and a $150 copay per day (max 3 copays)	Covered at 80% after deductible and a $300 copay per day (max 3 copays)
PRESCRIPTION COPAYS	$5 generic $15 brand name 50% non-preferred brand name (minimum $35 copay)	$10 generic $25 brand name 50% non-preferred brand name (minimum $35 copay)	$10 generic $15 brand name $30 non-preferred brand name	$10 generic $20 brand name $35 non-preferred brand name	$15 generic $25 brand name $40 non-preferred brand name
	CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT AND EXEMPT GROUPS				
Emp	$815.72	$610.13	$796.45	$696.45	$623.55
Emp/Spouse	$1,635.37	$1,220.25	$1,515.30	$1,352.35	$1,210.05
Emp/Children	$1,198.74	$899.90	$1,116.05	$974.15	$872.05
Emp/Sp/Children	$2,020.39	$1,508.23	$1,870.00	$1,630.05	$1,458.55
			CHIMACUM EDUCATION ASSOCATION (CEA) RATES		
Emp			$719.80	$629.80	$563.40
Emp/Spouse	n/a	n/a	$1,398.45	$1,219.85	$1,091.50
Emp/Children			$1,007.15	$879.80	$787.20
Emp/Sp/Children			$1,685.80	$1,469.85	$1,315.30

	MONTHLY PREMIUM
DENTAL Washington Dental	$126.75
VISION VSP	$27.65

MONTHLY COST WORKSHEET

District Contribution per 1.0 FTE	$768.00
Dental Premium – WDS – mandatory	-$126.75
Vision Premium – VSP – mandatory	- $27.65
Total dollars available towards optional medical premium	= $613.30
Enter your medical premium rate	-
Monthly payroll deduction	=

Note:
Any excess dollars will be applied to your pool as required by Washington State law. The total monthly payroll deduction will, in some cases, be different (lower) than your calculation above due to pooling, and Section 125 law allowing payroll deduction amounts to be taken from gross pay (pre-taxed) instead of take home pay. Payroll deductions in September will reflect the new pricing effective October 1st.

CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT and EXEMPT GROUPS MEDICAL BENEFITS

	KPS Enhanced Plan	KPS Basic Plan
Rates		
Employee Only	$815.72	$610.13
Employee & Spouse	$1,635.37	$1,220.25
Employee & Children	$1,198.74	$899.90
Employee, Spouse & Children	$2,020.39	$1,508.23
BENEFITS AT A GLANCE		
Provider Network	To receive the benefit shown below you must use a provider from the **KPS** or First Choice network	To receive the benefit shown below you must use a provider from the **KPS** or First Choice network
Annual Deductible	No deductible	$200 per individual, $600 per family
Office Calls and Urgent Care	$15 copay	$20 copay
Out-of-pocket Maximum	$1,200 per individual, $3,600 per family	$2,500 per individual, $7,500 per family
Prescription Drugs		
Generic	$5 copay	$10 copay
Preferred Brand Name	$15 copay	$25 copay
Non-Preferred Brand Name	50% copay; $35 minimum	50% copay; $35 minimum
Days Supply	30 Maintenance Rx 90-day supply for 2 copays (applies to retail or mail order)	30 Maintenance Rx 90-day supply for 2 copays (applies to retail or mail order)
Spinal Manipulations (Chiropractic)	$15 copay, 20 visit limit	$20 copay, 12 visit limit
Diagnostic X-Ray / Lab	80% in hospital, 100% in physician's office	80% after deductible in hospital, 100% in physician's office
PREVENTIVE CARE		
Well Child Care	Covered in full	Covered in full
Routine Physicals	Covered in full	Covered in full
Benefits Accrue	Based on Contract Year (contract year begins 10/1)	Based on Contract Year (contract year begins 10/1)

CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT AND EXEMPT GROUPS MEDICAL BENEFITS

WEA Premera Blue Cross Select Plan 1	WEA Premera Blue Cross Select Plan 2	WEA Premera Blue Cross Select Plan 3
$796.45 $1,515.30 $1,116.05 $1,870.00	$696.45 $1,352.35 $974.15 $1,630.05	$623.55 $1,210.05 $872.05 $1,458.55
To receive the benefit shown below you must use a provider from the Premera **Heritage** network	To receive the benefit shown below you must use a provider from the Premera **Heritage** network	To receive the benefit shown below you must use a provider from the Premera **Heritage** network
$50 per person, $150 per family per calendar year	$100 per person, $300 per family per calendar year	$200 per person, $600 per family per calendar year
$20 copay	$25 copay	$30 copay
Once the member has paid $444 in a calendar year, coinsurance is paid at 100% for the remainder of the calendar year.	Once the member has paid $1,375 in a calendar year, coinsurance is paid at 100% for the remainder of the calendar year.	Once the member has paid $2,500 in a calendar year, coinsurance is paid at 100% for the remainder of the calendar year.
Retail / Mail Order $10 copay / $10 copay $15 copay / $15 copay $30 copay / $30 copay 34 / 100	Retail / Mail Order $10 copay / $10 copay $20 copay / $20 copay $35 copay / $35 copay 34 / 100	Retail / Mail Order $15 copay / $15 copay $25 copay / $25 copay $40 copay / $40 copay 34 / 100
$20 copay	$25 copay	$30 copay
90% after deductible	80% after deductible	80% after deductible
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
Based on Calendar Year	Based on Calendar Year	Based on Calendar Year

CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT AND EXEMPT GROUPS MEDICAL BENEFITS

	KPS Enhanced Plan	KPS Basic Plan
HOSPITAL		
Inpatient Care	80% after $150 copay per day (5 copay limit)	80% after deductible and $200 copay per day (5 copay limit)
Emergency Care	$75 copay	$75 copay
OTHER BENEFITS		
Acupuncture	$15 copay, 12 visit limit	$20 copay, 12 visit limit
Ambulance Services	80%, $2,000 limit Ground Ambulance per year; $5,000 limit Air Ambulance per trip	80% after deductible, $2,000 limit Ground Ambulance per year; $5,000 limit Air Ambulance per trip
Chemical Dependency	80%	80% after deductible
Lifetime Maximum	No longer applies	No longer applies
Maternity	80%	80% after deductible
Mental Health	Inpatient – (must be pre-authorized) 80% Outpatient - $15 copay	Inpatient – (must be pre-authorized) 80% after deductible Outpatient - $20 copay
Naturopathic	$15 copay	$20 copay
Outpatient Surgery	80%	80% after deductible
Rehabilitation (includes Physical Therapy)	Outpatient 80%, $1,500 limit No inpatient benefit	Outpatient 80% after deductible, $1,000 limit No inpatient benefit
Dependents covered to	Age 26	Age 26

CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT AND EXEMPT GROUPS MEDICAL BENEFITS

WEA Premera Blue Cross Select Plan 1	WEA Premera Blue Cross Select Plan 2	WEA Premera Blue Cross Select Plan 3
90% after deductible and $100 copay per day ($300 maximum copays collected)	80% after deductible and $150 per day copay ($450 maximum copays collected)	80% after deductible and $300 per day copay ($900 maximum copays collected)
90% after deductible and $75 copay	80% after deductible and $75 copay	80% after deductible and $100 copay
$20 copay, 12 visits	$25 copay, 12 visits	$30 copay, 12 visits
90% after deductible	80% after deductible	80% after deductible
Inpatient: 90% after deductible and $100 copay per day ($300 maximum copays collected) Outpatient: 90% after deductible	Inpatient: 80% after deductible and $150 copay per day ($450 maximum copays collected) Outpatient: 80% after deductible	Inpatient: 80% after deductible and $300 copay per day ($900 maximum copays collected) Outpatient: 80% after deductible
No longer applies	No longer applies	No longer applies
90% after deductible; $100 inpatient copay per day ($300 maximum copays collected)	80% after deductible; $150 inpatient copay per day ($450 maximum copays collected)	80% after deductible; $300 inpatient copay per day ($900 maximum copays collected)
Inpatient: 90% after deductible and $100 copay per day ($300 maximum copays collected) Outpatient: $20 copay	Inpatient: 80% after deductible and $150 copay per day ($450 maximum copays collected) Outpatient: $25 copay	Inpatient: 80% after deductible and $200 copay per day ($900 maximum copays collected) Outpatient: $30 copay
$20 copay	$25 copay	$30 copay
$50 copay and 90% after deductible	$100 copay and 80% after deductible	$150 copay and 80% after deductible
Inpatient: 90% after deductible and $100 copay per day ($300 maximum copays collected), 120 day maximum Outpatient: $20 copay, 45 visit limit Physical Therapy: 90% after deductible, no visit limit	Inpatient: 80% after deductible and $150 copay per day ($450 maximum copays collected), 120 day maximum Outpatient: $25 copay, 45 visit limit Physical Therapy: 80% after deductible, no visit limit	Inpatient: 80% after deductible and $300 copay per day ($900 maximum copays collected), 30 day limit Outpatient: $30 copay, 45 visit limit Physical Therapy: 80% after deductible, no visit limit
Age 26	Age 26	Age 26

CHIMACUM EDUCATION ASSOCATION (CEA) MEDICAL BENEFITS

	WEA Premera Blue Cross Select Plan 1	WEA Premera Blue Cross Select Plan 2	WEA Premera Blue Cross Select Plan 3
Rates			
Employee Only	$719.80	$629.80	$563.40
Employee & Spouse	$1,398.45	$1,219.85	$1,091.50
Employee & Children	$1,007.15	$879.80	$787.20
Employee, Spouse & Children	$1,685.80	$1,469.85	$1,315.30
BENEFITS AT A GLANCE			
Provider Network	To receive the benefit shown below you must use a provider from the Premera **Heritage** network	To receive the benefit shown below you must use a provider from the Premera **Heritage** network	To receive the benefit shown below you must use a provider from the Premera **Heritage** network
Annual Deductible	$50 per person, $150 per family	$100 per person, $300 per family	$200 per person, $600 per family
Office Calls and Urgent Care	$20 copay	$25 copay	$30 copay
Out-of-pocket Maximum	Once the member has paid $444 in a calendar year, coinsurance is paid at 100% for the remainder of the calendar year.	Once the member has paid $1,375 in a calendar year, coinsurance is paid at 100% for the remainder of the calendar year.	Once the member has paid $2,500 in a calendar year, coinsurance is paid at 100% for the remainder of the calendar year.
Prescription Drugs	Retail / Mail Order	Retail / Mail Order	Retail / Mail Order
Generic	$10 copay / $10 copay	$10 copay / $10 copay	$15 copay / $15 copay
Preferred Brand Name	$15 copay / $15 copay	$20 copay / $20 copay	$25 copay / $25 copay
Non-Preferred Brand Name	$30 copay / $30 copay	$35 copay / $35 copay	$40 copay / $40 copay
Days Supply	34 / 100	34 / 100	34 / 100
Spinal Manipulations (Chiropractic)	$20 copay	$25 copay	$30 copay
Diagnostic X-Ray / Lab	90% after deductible	80% after deductible	80% after deductible
PREVENTIVE CARE			
Well Child Care	Covered in full	Covered in full	Covered in full
Routine Physicals	Covered in full	Covered in full	Covered in full
Benefit Accrue	Based on Calendar Year	Based on Calendar Year	Based on Calendar Year

CHIMACUM EDUCATION ASSOCATION (CEA) MEDICAL BENEFITS

	WEA Premera Blue Cross Select Plan 1	WEA Premera Blue Cross Select Plan 2	WEA Premera Blue Cross Select Plan 3
HOSPITAL			
Inpatient Care	90% after deductible and $100 copay per day ($300 maximum copays collected)	80% after deductible and $150 per day copay ($450 maximum copays collected)	80% after deductible and $300 per day copay ($900 maximum copays collected)
Emergency Care	90% after deductible and $75 copay	80% after deductible and $75 copay	80% after deductible and $100 copay
OTHER BENEFITS			
Acupuncture	$20 copay, 12 visits	$25 copay, 12 visits	$30 copay, 12 visits
Ambulance Services	90% after deductible	80% after deductible	80% after deductible
Chemical Dependency	Inpatient: 90% after deductible and $100 copay per day ($300 maximum copays collected) Outpatient: 90% after deductible	Inpatient: 80% after deductible and $150 copay per day ($450 maximum copays collected) Outpatient: 80% after deductible	Inpatient: 80% after deductible and $300 copay per day ($900 maximum copays collected) Outpatient: 80% after deductible
Lifetime Maximum	No longer applies	No longer applies	No longer applies
Maternity	90% after deductible; $100 inpatient copay per day ($300 maximum copays collected)	80% after deductible; $150 inpatient copay per day ($450 maximum copays collected)	80% after deductible; $300 inpatient copay per day ($900 maximum copays collected)
Mental Health	Inpatient: 90% after deductible and $100 copay per day ($300 maximum copays collected) Outpatient: $20 copay	Inpatient: 80% after deductible and $150 copay per day ($450 maximum copays collected) Outpatient: $25 copay	Inpatient: 80% after deductible and $200 copay per day ($900 maximum copays collected) Outpatient: $30 copay
Naturopathic	$20 copay	$25 copay	$30 copay
Outpatient Surgery	$50 copay and 90% after deductible	$100 copay and 80% after deductible	$150 copay and 80% after deductible
Rehabilitation (includes Physical Therapy)	Inpatient: 90% after deductible and $100 copay per day ($300 maximum copays collected), 120 day maximum Outpatient: $20 copay, 45 visit limit Physical Therapy: 90% after deductible, no visit limit	Inpatient: 80% after deductible and $150 copay per day ($450 maximum copays collected), 120 day maximum Outpatient: $25 copay, 45 visit limit Physical Therapy: 80% after deductible, no visit limit	Inpatient: 80% after deductible and $300 copay per day ($900 maximum copays collected), 30 day limit Outpatient: $30 copay, 45 visit limit Physical Therapy: 80% after deductible, no visit limit
Dependent Age	Age 26	Age 26	Age 26

OTHER MEDICAL INSURANCE OPTIONS

If you are not eligible or feel you cannot afford district medical insurance, the following options are available. These plans are not endorsed by the district, the information is provided strictly as a courtesy. No allocation dollars may be used towards these insurance options and the district cannot deduct premiums from your paycheck.

INDIVIDUAL MEDICAL COVERAGE OPTIONS

You may consider insuring your dependent spouse and/or dependent children for medical coverage by applying for an individual medical policy. If you would like to review available options use the quoting services at www.affordable-insurance.com or call **(877) 466-1999**. If calling, mention that you are a Chimacum School District employee.

APPLE HEALTH FOR KIDS PROGRAM

In Washington State, a program is offered to provide health insurance coverage to children under age 19, and qualification is based on the family income level. The program is funded by federal tax dollars, and almost all states have taken advantage of these dollars and developed similar programs.

Qualification for the Apple Heath for Kids program is as shown below:

The Family's Income is:	Up to 200% of "federal poverty level"*	250% of "federal poverty level"*	300% of "federal poverty level"*
Examples of Qualifying Income Levels	For a family of 2 people, 200% of federal poverty level is $2,429 monthly. For a family of 4, 200% is $3,675 monthly.	For a family of 2 people, 250% of federal poverty level is $3,036 monthly. For a family of 4, 250% is $4,594 monthly.	For a family of 2 people, 300% of federal poverty level is $3,643 monthly. For a family of 4, 250% is $5,513 monthly.
Monthly Cost to the Family	Free	$20 per child per month ($40 per month maximum).	$30 per child per month ($60 per month maximum).

Notes:

- Income levels are determined by the state and are adjusted each year on April. 1st.
- A pregnant woman counts as a family size of two. Other programs with different eligibility requirements are available for families and pregnant women. Call toll-free 1-877-543-7669 to find out more.

If you have questions regarding Apple Health for Kids and other programs you might qualify for, please call Apple Health for Kids toll-free at **(877) 543-7669**.

STATE SPONSORED COVERAGE

If you declined coverage when you were eligible to enroll in the group plan, you may subsequently apply for coverage in the event that the Department of Social and Health Services (DSHS) has determined that it is cost-effective to enroll you or your eligible dependents in this health plan. Applications must be submitted within 60 days following the determination by DSHS.

CHIPRA NOTIFICATION

If you are eligible for health coverage from your employer, but are unable to afford the premiums, Washington State has premium assistance programs that can help pay for coverage. The state uses funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can use the contact information below to find out how to apply. If you qualify, you can ask if there is a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

WASHINGTON – Medicaid

Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-877-543-7669

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration www.dol.gov/ebsa 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Ext. 61565

DENTAL BENEFITS

WASHINGTON DENTAL SERVICE (WDS)
WEA SELECT DENTAL PLAN

Provider Network	Use any licensed dentist. Use of WDS member dentists provides the highest level of benefits
Deductible	$0
Annual Maximum September 1 – August 31	$1,750 ($2,000 if WDS PPO dentist is used)
Class I- Diagnostic & Preventive * Exams, Prophys, Fluoride, X-rays, Sealants	70% Year 1 80% Year 2 90% Year 3 100% Year 4
Class II- Restorative** Restorations, Crowns, Inlays, Onlays, Oral Surgery, Root Canals, Endodontics, Periodontics	70% Year 1 80% Year 2 90% Year 3 100% Year 4
Class III- Major** Dentures, Bridges, Partials, Implants	50%
Orthodontia** Dependent children only (to age 26)	50% to $1,250 lifetime maximum
Dependent Covered To	Age 26

*Washington Dental requires each member to see the dentist at least once per year in order to move up to the next percentage. If you do not visit the dentist at least once in the year, your benefit percentages will drop by 10% below the last level of payment, but never below the original 70%.

You can find a participating dentist in your area by visiting the Washington Dental Service website at www.DeltaDentalWA.com/findadentist. Be sure to select the appropriate plan – Delta Dental PPO or Delta Dental Premier – and follow the prompts.

**If your dental work will be extensive (i.e. crowns, inlays, onlays, surgical periodontics and orthodontics), ask your dentist to call Washington Dental Service at 800-554-1907 or complete and submit a standard ADA claim form to Washington Dental, for a predetermination. This will allow you to know in advance exactly what procedures are covered, the amount Washington Dental will pay toward the treatment, and your financial responsibility.

For questions on your dental benefits, call Washington Dental Customer Service, 800-554-1907.

VISION BENEFITS

VISION SERVICE PLAN (VSP)

BENEFIT FREQUENCIES

Examinations	Once each calendar year
Lenses	Once each calendar year
Contact Lenses	Once every 2 calendar years
Frames	Once every 2 calendar years

	VSP PROVIDER	Non-VSP PROVIDERS
Examination Copay	**$5 COPAY**	
Examination	Paid in full	$60 allowance
Materials Copay	**$15 COPAY APPLIES TO ALL MATERIALS**	
Lenses		
Single Vision Lenses	Paid in full	$76 allowance
Bifocal Lenses	Paid in full	$112 allowance
Trifocal Lenses	Paid in full	$142 allowance
Lenticular	Paid in full	$148 allowance
Continuous Blend	Paid in full	$140 allowance
Lens Tinting, Coating or Oversized Lenses	Paid in full	No additional allowance
Frames	Large selection of frames from which to choose, paid in full up to $110 allowance	$60 allowance
Contact Lenses (in lieu of lenses and a frame)	$200	$200

To obtain a list of VSP member doctors call VSP at **800-877-7195**, or visit their website at www.vsp.com. VSP does not distribute ID cards. You will receive a letter from VSP with your unique VSP identification number.

When services are received from a VSP member doctor, reimbursement is made directly to the doctor. The patient will have no out-of-pocket expense other than the copayment, unless optional items are selected that VSP does not cover. Optional items include, but are not limited to, oversize lenses, coated lenses, no-line multifocal lenses or a frame that exceeds the wholesale allowance. If you obtain vision services from a non-participating vision provider, pay the bill and request an itemized copy of the bill showing the eye exam and materials, including lense type. Submit the following information for reimbursement:

- Itemized copy of the bill (breaking out the cost of the eye exam, materials and lense type)
- The name, address and phone number of the non-VSP provider
- The employee's VSP identification number and date of birth
- The employee's name, address, and phone number
- The name of your employer
- The patient's name, date of birth, address and phone number
- The patient's relationship to the covered member (such as self, spouse, child, student, etc.)

Send the above information for claims reimbursement according to the above schedule to:

VSP Claims
PO Box 997100
Sacramento, CA 95899

FLEXIBLE SPENDING ACCOUNTS

AVAILABLE THROUGH AFLAC

PREMIUM ONLY PROGRAM

The district's Section 125 Premium Conversion Plan allows employees to avoid social security and federal income taxes on monthly amounts that are deducted for eligible group insurance (medical, dental, vision, life and salary insurance) premiums. The Payroll Department will automatically deduct qualifying insurance premiums from gross pay (pre-tax), unless you request in writing not to participate in the premium only program.

HEALTHCARE REIMBURSEMENT ACCOUNT PROGRAM

The medical and dental reimbursement account program gives you a tax break on many medical and dental care expenses that are either not covered by medical insurance or have deductibles and copayments. If you enroll in the program, you may set aside money each month into an account to pay these eligible medical expenses from pre-tax dollars.

The medical and dental reimbursement account program lets you use these pre-tax dollars to pay medical and dental care expenses up to an annual maximum of $1,500. Your contribution will be deducted from your gross pay (pre-tax) salary in equal amounts for the plan year. The following example illustrates the benefit of using a flexible reimbursement account.

Eligible Expenses

The expenses covered by, but not paid by, insurance such as the deductible, coinsurance (the percentage of charges not covered) and expenses over the maximum:

- Non-reimbursed medical expenses for preventive, diagnostic, and therapeutic care
- Medicine or other drugs prescribed by a medical doctor
- Non-reimbursed dental expenses for preventive, diagnostic endodontic, orthodontic and therapeutic care
- Medicine or other drugs prescribed by a dentist
- Non-reimbursed vision expenses

Non-Eligible Expenses

- As of January 1, 2011, over-the-counter (OTC) medicines and drugs will need a prescription to be considered an eligible benefit.
- Expenses reimbursed through any insurance policy or plan
- Expenses incurred before you enroll in the plan
- Expenses you claim as a deduction or credit for income tax purposes

DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account is a tax-effective way to pay childcare or other dependent care services that enable you or you and your spouse to work outside the home.

You may use this account to pay for eligible day care expense incurred for:
A child up to age 13 for whom you claim a deduction on your income tax form, or
A spouse or disabled dependent age 13 or older (your parent, for instance) who is physically or mentally incapable of self-care, who normally spends at least eight hours in your home each day, and for whom you pay more than half the cost of support.

Eligible day care expenses include costs for nursery schools, day care providers, babysitters and other types of day care. A provider cannot be another dependent of yours, such as an older child. Nursery schools and day care centers must comply with state and local regulations if their expenses are to be eligible for reimbursement.

You may set aside up to $5,000 each plan year in your Dependent Care Spending Account through automatic payroll deductions or $2,500 if you are married filing a separate return.

FLEXIBLE SPENDING ACCOUNTS

Dependent Care Spending Account vs. the Dependent Care Tax Credit
For most employees, the Dependent Care Spending Account is a better method than taking the dependent care tax credit on the income tax return. Generally, the tax credit is more beneficial if your adjusted gross income is less than $24,000.

Government Rules on Unused Funds
Federal tax law says that any money left in your account at the end of the plan year must be forfeited.

EXAMPLES OF TAX SAVINGS WITH FLEXIBLE REIMBURSEMENT ACCOUNTS

Without **Flexible Reimbursement Account**		***With*** **Flexible Reimbursement Account**	
Gross Monthly Salary	$2,500	Gross Monthly Salary	$2,500
Income Tax @ 15% plus		Qualifying Insurance Premiums	- 100
FICA @ 7.65%	-566	Qualifying Health Care Expenses	- 100
		Qualifying Dependent Care Expenses	- 350
Net Income (after taxes)	$1,934	Gross Taxable Income	$1,950
Qualifying Insurance Premiums	-100	Income Tax @ 15% plus	
Qualifying Health Care Expenses	-100	FICA @ 7.65%	-441
Qualifying Dependent Care Expenses	-350		
Net Spendable Income	**$1,384**	**Net Spendable Income**	**$1,509**

As you can see, with only $550 in monthly qualified expenses, by enrolling in the plan, you would have an extra $125 each month ($1,500 per year) of net spendable income, saving dollars you would otherwise be paying in taxes.

IMPORTANT PLAN RULES
CAUTION: The IRS requires that you use all the money you contribute to your account or forfeit the remainder at the end of the plan year. This is commonly referred to as the "use it or lose it" provision.

Services provided to you or any covered dependent are eligible for reimbursement. Expenses must be incurred during the plan year.

Medical and dental care expenses from a given year can only be paid with money deposited in your account that same year. You have 60 days from the end of the plan year to submit claims.

Making Changes
Your selection will be effective for the entire plan year. The plan year is October 1 through September 30.
You may change your benefit selection during the plan year within 31 days of a change in family status. These changes include: marriage, legal separation or divorce; birth, adoption or change in custody of a minor child; change in your spouse's employment status; death of your spouse or child; change between full-time and part-time status by an employee or spouse; unpaid leave of absence by employee or spouse; or significant change in coverage of employee or spouse due to spouse's employment.

Unless you have a change in family status, you cannot change your elections until the next open enrollment.

Making Claims
When you incur an eligible expense during the year, file a request for reimbursement form (forms are available at www.AFLAC.com). Enclose proof of payment, such as an invoice, receipt or canceled check.

FAMILY AND MEDICAL LEAVE ACT

NOTIFICATION

The Family and Medical Leave Act of 1993 (FMLA) is a federal law that became effective on August 5, 1993 for most companies and non profit organizations with 50 or more employees.

FMLA applies to all employees who have:

- 12 months of employment with the company *and*
- 1,250 hours or more of service in the preceding 12 months.

FMLA provides 12 weeks of unpaid leave in any 12 month period for the following reasons:

- To care for oneself, a child, spouse, or parent with a "serious health condition", or "covered service member" who is injured in the line of duty;
- To the immediate family members (spouses, children, or parents) of military personnel or reservists who have "any qualifying exigency" arising out of the service member's active duty or call to active duty in support of a contingency operation.

FMLA provides 12 weeks of unpaid leave in any 12 month period for public employees for the following reasons:

- Birth, adoption or placement of a child for foster care.

A SERIOUS HEALTH CONDITION IS DEFINED AS

- One that requires continuing treatment from a health care provider.
- Conditions that require an absence from work or regular daily activities for more than 3 days.
- Treatment for pregnancy and certain chronic conditions such as diabetes and asthma even though treatment may last less than three days.
- Conditions and medical treatments that are not ordinarily incapacitating on a day to day basis such as chemotherapy and radiation treatment, kidney dialysis, and physical therapy for severe arthritis.
- Mental illness may qualify.
- Specifically excluded are common colds, flu, upset stomach, routine dental problems and stress.

EMPLOYEE RESPONSIBILITIES

- Provide a 30-day notice for foreseeable leaves for birth, adoption, foster placement, or planned medical treatment.
- Continue to pay any required health plan contributions.

IT IS IMPORTANT TO REMEMBER

- With employer's approval, leave may be taken intermittently or by working a reduced week. However, an exception exists for an employee or family member's serious health condition whereby leave is taken whenever medically necessary.
- An employer is allowed to substitute an employee's accrued paid leave for any portion of the 12-week period.
- The employer is allowed to recover the cost of health benefits paid during the leave if the employee does not return to work.
- During the leave, the employee is ineligible for unemployment compensation.

COBRA

If you enroll yourself and any dependents in medical and/or dental coverage, you will be mailed an Initial Notice of COBRA Rights by your employer. **Both employee and spouse (if married) should carefully read through this information.** Should any of the following qualifying events occur while you are an active employee, you will be offered continued coverage rights through Federal COBRA law:

1. Termination of employment (for reasons other than gross misconduct), 18 months of continued coverage.
2. A reduction in your hours of employment; or
3. You are a retiree and your employer has filed for reorganization under Chapter 11 of the Bankruptcy Code, 18 months of continued coverage.

If you are the spouse or dependent child of an employee enrolled in a group medical, dental, and vision plans, you have the right to choose continuation of coverage for yourself if you lose group coverage for any of the following reasons:

1. Termination of your spouse's employment (for reasons other than gross misconduct), 18 months of continued coverage.
2. Death of your spouse, 36 months of continued coverage.
3. Divorce or legal separation from your spouse, 36 months of continued coverage.
4. Your spouse becomes eligible for Medicare (resulting in the loss of dependent coverage under this plan), 36 months of continued coverage.
5. Your retired spouse's employer files for Chapter 11 reorganization, 18 months of continued coverage.
6. Your child ceases to be a dependent or attains the maximum age allowed by the carrier, 36 months of continued coverage.
7. Your spouse's hours of employment are reduced, 18 months of continued coverage.

Berg Andonian
EMPLOYEE BENEFITS