Lynden School District #504
Employee Benefit Guide

This guide contains important Annual Notices including Health Care Notices and other Notices that you should review.

2018-2019 School Year

Important Open Enrollment Information

Open Enrollment Period: September 1st to September 28th, 2018

- **Enrollment forms are to be turned in to DeeEtta Pullar in the District Payroll Office. Forms are available on Lynden School District website or at the Benefit Fair.**
- **New Employee enrollment forms are due by August 31st with an effective date of October 1, 2018.**
- **All plans have an effective date of November 1, 2018.**
- **Dental:** If you are a new hire or wish to make changes, you will need to enroll, for your dental election, using the online system or by calling the WEA Select Benefits Center at 1-855-668-5039.

If you have enrollment questions, please contact DeeEtta Pullar at 360-354-4443 #2.

Benefits Fair

Please plan on attending one of these events, as you will have an opportunity to meet with our insurance representatives.

Date: Thursday, September 6th 2018
Time: 2:30 PM - 5:00 PM
Location: LHS Cafeteria

Date: Monday, September 17th 2018
Time: 3:30 PM - 6:30 PM
Location: Fisher Elementary Library

Premera and Kaiser Reps will also be at Benefits Fairs at the following locations:

- Bellingham: Wednesday, August 22nd, 2018 - 2:00 PM - 6:00 PM - Bellingham High School - 2020 Cornwall Ave Bellingham, WA 98225
- Blaine: Tuesday, August 28th, 7:30-8:30 am Blaine Middle School / High School Cafeteria, 975 “H” St Blaine, WA 98230
- Ferndale: Wednesday, August 22nd, 1:00-4:00 pm Vista Middle School Cafeteria, 6051 Vista Drive Ferndale, WA 98248-0428
- Meridian: Tuesday, August 28th, 3:30 PM - 5:30 PM Meridian High School, 194 W. Laurel Rd. Bellingham, WA 98226-9699
- Mt Baker: Monday, August 27th, 2:30-5:00 pm Mount Baker High School, 4936 Deming Road Deming, WA 98244-0095
- Nooksack: Thursday, August 30th, 2:30-5:00 pm Nooksack Valley High School Commons, 3326 E. Badger Road Everson, WA 98247
- Premera and Kaiser Plans Only: September 18th, 3:30-5:30 pm Mt. Baker High School Commons - 4936 Deming Road, Deming, WA 98244

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 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 29, 2018. 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.

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 Payroll 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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Major Insurance Plan Changes for 2018-2019

State Allocation for Benefits

Employee benefits allocation depends on your bargaining group.

Kaiser Permanente - Welcome 500 Plan

- No benefit changes
- Premium rates increased 10.43%.

Regence Blue Shield

- All Regence Blue Shield Plans have been discontinued.

Premera Blue Cross - Available to all Employees

- NEW PLAN: Heritage Plus EasyChoice A.
- NEW PLAN: Heritage Plus EasyChoice B.
- NEW PLAN: Heritage Plus Basic Plan.
- NEW PLAN: Heritage Plus QHDHP HSA Plan.
- EviCore prior authorization for outpatient rehabilitation, including massage, has been removed from all plan options.

Delta Dental of Washington

- The annual maximum increased to $2,300 when a Delta Dental PPO dentist is used and to $2,000 when a Delta Dental Premier dentist is used.
- The annual maximum will be effective **11/1/2018 through 12/31/2019.**
- Member cost shares and the annual maximum will be eliminated for children ages 14 and under.
- Premium rates decreased 1.8%.

Cigna

- No changes in plan benefits.
- Premium rates increased 2%.

Northwest Benefit Network Vision

- No changes in benefit plan.
- No changes in premium rates.

Enrolling or Making Changes to your Benefits

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

You have the following time periods to enroll:

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

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

NOTE: If you are removing a dependent due to a qualifying event, you must inform payroll **within 30 days** of the qualifying event date. The effective date for the removal of coverage will be the first of the month following the qualifying event date.

Types of Qualifying Events

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

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 chose 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.

Qualified High Deductible Health Plan (QHDHP)

These type of plans operate almost like the PPO plans. If you choose to receive care through a preferred provider, the insurance company will pay a higher percentage of the charges than if you receive care from a non-preferred provider. ***Unlike a PPO plan, the deductible must be satisfied before the QHDHP plan will pay for any care (except preventive care), including prescriptions. Also, unlike a PPO plan, if there is more than one person enrolled on your plan, the family deductible must be satisfied before the plan will pay benefits (except for preventive care) for any enrolled member.*** **However, a single member on family coverage will not pay more than $6,900 OOPM for annual cost sharing. When a single member on family coverage reaches the $6,900 OOPM, benefits will be paid at 100% of the allowed amount for that 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 Blue Cross.

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

Health Maintenance Organization (HMO)

These type of 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 Kaiser Permanente.

To find a Kaiser Permanente provider, visit https://wa.kaiserpermanente.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 EasyChoice A (Heritage)		Premera Blue Cross EasyChoice B (Heritage)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$1,250 person/ $3,750 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	
Carrier 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	Shared with Medical		Shared with Medical	
Office Visit *Primary/Specialist*	$25/$35 copay (dw)	Ded & coin	$30/$40 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Not covered except Screenings-ded & coin	Covered in full	Not covered except Screenings-ded & coin
Diagnostic Lab & X-Ray	Paid in Full to $1,000 then Ded & Coin		Deductible & Coinsurance	
Advanced Diagnostic Imaging			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	$25 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin
	12 manipulations PCY		12 manipulations PCY	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits		45 visits	
	$35 copay (dw)	Ded & coin	$40 copay (dw)	Ded & coin
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	$10 (dw) / 30% / 30% (30 day supply)		$5 (dw) / $30 / $45 (30 day supply)	
Mail Order Cost Share	$20 (dw) / 30% / 30% (90 day supply)		$10 (dw) / $75 / $112 (90 day supply)	
Specialty Cost Share	30% through Accredo or Walgreens Specialty Pharmacy only (30 day supply)		30% through Accredo or Walgreens Specialty Pharmacy only (30 day supply)	
Life/AD&D Insurance	$25,000 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 Medication

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

Medical Plan Options

Plan (Network)	Premera Blue Cross Basic (Heritage)		Premera Blue Cross QHDHP (Heritage)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$2,100 person/ $4,200 family	$2,500 person/ $5,000 family	$1,750 person/ $3,500 family†	$3,000 person/ $6,000 family†
Rx Deductible	$750 person/ $1,500 family	Not covered	Subject to Medical Deductible	
4th Qtr. Carry Over	Nov & Dec Only		Does NOT Apply	
Carrier Coinsurance	70%	50%	80%	50%
Medical Out of Pocket Max	$6,600 person/ $13,200 family	Not Applicable	$5,000 person/ $10,000 family	Unlimited
Rx Out of Pocket Max	Shared with Medical	Not covered	Shared with Medical	
Office Visit *Primary/Specialist*	$35/$50 copay (dw)	Ded & coin	Ded & coin	Ded & coin
Preventive Care*	Covered in full	Not covered except Screenings-ded & coin	Covered in full	Not covered except Screenings-ded & coin
Diagnostic Lab & X-Ray	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Advanced Diagnostic Imaging	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Emergency Care**	$200 copay + Ded & coin		Ded & coin	
Ambulance	Deductible & coinsurance		Ded & coin	
Hospital (Inpatient)	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Hospital (Outpatient)	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Spinal Manipulations	$35 copay (dw)	Ded & coin	Deductible & Coinsurance	
	12 manipulations PCY		12 manipulations PCY	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits		15 visits PCY	
	$50 copay (dw)	Ded & coin	Ded & coin	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY		30 days PCY	
	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Prescriptions	**Generic / Preferred / Non- Preferred - At Participating Pharmacies**			
Retail Cost Share	$15 / $30 / $50 (30 day supply)	Not covered	Ded & coin (30 day supply)	
Mail Order Cost Share	$30 / $60 / $100 (90 day supply)	Not covered	Ded & coin (90 day supply)	
Specialty Cost Share	30% through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)	Not covered	20% through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)	
Life/AD&D Insurance	$25,000 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

(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	Kaiser Permanente Welcome 500
Network	**At a Kaiser facility/Provider only**
Medical Deductible	$500 person / $1,500 family
Rx Deductible	None
4th Qtr. Carry Over	Does not apply
Carrier Coinsurance	80%
Medical Out of Pocket Max	$2,000 person / $6,000 family
Rx Out of Pocket Max	Included in Medical
Office Visit *Primary/Specialist*	Visits 1-4 - $20 copay (dw) Visits 5+ - $20 copay then ded & coin
Preventive Care*	Covered in full
Diagnostic Lab & X-Ray	Covered in full up to $500 per year then ded & coins
Advanced Diagnostic Imaging	
Emergency Care**	$100 copay + ded & coin
Ambulance	80%
Hospital (Inpatient)	80% deductible
Hospital (Outpatient)	$20 copay then ded & coin
Spinal Manipulations	10 manipulations PCY without prior authorization; Counts as an office visit
Vision Care	One exam every 12 months; 100% (dw)
Rehab - Outpatient (Speech, Massage, OT, PT)	45 visits (PT, Speech, Massage, OT)
	See Office Visit limits
Rehab - Inpatient (Speech, Massage, OT, PT)	30 visits (PT, Speech, Massage, OT)
	80%+ deductible
Prescriptions	**Generic / Brand / Non-Formulary - At Participating Pharmacies**
Retail Cost Share	$15 / $30 (30 day supply)
Mail Order Cost Share	$30 / $60 (90 day supply)
Specialty Cost Share	Subject to applicable retail copay through Kaiser Specialty Medication Pharmacy Only (30 day supply)
Life/AD&D Insurance	None

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

Non participating providers are subject to ded & coin and may balance bill for services

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

Things to be Aware of Regarding Your Medical Plans:

Plan Year vs. Contract Year

School districts renew their contracts with the insurance companies on November 1 each year. This is considered the contract year and it is when changes in rates occur. Deductibles and out-of-pocket maximum amounts renew January 1 (plan year). This means that if you have met your deductible for the year on your current plan, then you do not need to meet it again until January 1 if you are not changing plans. If you are changing plans see below for the rules relating to deductibles and out-of-pocket maximums.

Delta Dental of Washington's plan year and contract year begin November 1 each year.

Changing from One Provider to Another (Kaiser Permanente to Premera or Premera to Kaiser Permanente)

When changing to a Kaiser Permanente plan from another carrier, Kaiser Permanente WILL CREDIT deductibles and out-of-pocket maximums met in 2018 (Explanation of Benefits -EOBs and Deductible Credit forms are required by Dec. 31, 2018).

When changing from a Kaiser Permanente plan to Premera, Premera will credit your previous plan's deductible and out-of-pocket maximum. The 4th quarter carry over will also apply for the new plan.

4th Quarter Carry-Over (A benefit for you if you meet your deductible in the months of October-December)

If you are on a Premera plan and any or all of your deductible is met in November - December, that amount counts toward the deductible you will have to meet when the plan year resets on January 1st. For example, in November you meet $200 of the $750 deductible. In the new plan year starting January 1st you only have to meet $550 instead of $750. 4th quarter carry-over does not apply to out-of-pocket maximums on any plan. 4th quarter carry over does not apply to the HSA plan, or to the Kaiser plan.

Changing Plans Within the Same Plan Provider (Premera to Premera or Kaiser Permanente to Kaiser Permanente)

You change from a $200 deductible plan to a $500 deductible plan on November 1, 2018, and you have already met the $200 deductible, you will have to meet an additional $300 starting November 1. Likewise, if you change from a $500 deductible plan to a $250 deductible plan, and have already met the $500 deductible, you are not responsible for any additional deductible amount until January 1, 2019.

When Moving Employment from one Whatcom County School District to Another Whatcom County School District

Premera will credit the amount of deductible and out-of-pocket maximum you have already met this calendar year. Kaiser Permanente will credit the amount of deductible you have met but will not credit the out-of-pocket maximum.

Pre-existing Condition Waiting Periods

There are no waiting periods for preexisting conditions under Kaiser Permanente, or Premera.

Coverage for Self-Employed

Premera covers on-the-job injuries for self-employed individuals and their spouses IF the enrolled employee or spouse is exempt from state or federal workers' compensation law. Effective November 1, 2016 there are no benefit maximums for work-related conditions for those who qualify (the only benefit limitation is the usual limitation of the medical plan the member is covered under). Kaiser Permanente does not cover on-the-job injuries.

Premera will cover dependent maternity services.

Generic Drug Usage Saves Money!

Generic drug usage not only saves money for individual members but improves overall group utilization and helps keep premiums down.

Prescriptions by Mail

If you take the same medication(s) routinely (or for several months at a time), filling prescriptions through the mail can save you money! Typically, you will receive a 3-month supply but only pay two copays. If you take just one non-formulary medication with a $30 copay, this can mean $120 in savings in one year. Before you run out of your current medication, ask your physician for a written prescription authorizing the maximum quantity your plan allows and for one year of refills (not allowed for some drugs). If it's a new medication, ask for two prescriptions; one to fill locally for immediate use and one to mail in.

Call the mail-order service for your plan to find out what details to include with the prescription. Premera subscribers can call Express Scripts, the number will be on the back of your card, Express Scripts handles specialty prescriptions as well. Kaiser Permanente members should call Kaiser Permanente Mail Order Pharmacy at 1-800-245-7979.

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

How do I use my HSA?

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

Important Information Regarding your HDHP and HSA

- The HSA is a bank account, in your name, that belongs to you. If you leave your employer, the account goes with you and you can continue to use it for qualified medical expenses. Any monthly banking fees for the HSA are your responsibility and will be deducted directly from your HSA.
- Over-the-Counter medications are not a qualified medical expense under an HSA.
- Any use of HSA funds for a non-qualified medical expense 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.

High Deductible Health Plan and HSA Questions and Answers continued

- You cannot use HSA funds for any item or service provided prior to your effective date on your HDHP. For example, if your HDHP was effective 11/1/2018 and your dentist performed a crown on 9/5/2018, you cannot use HSA funds on this service.
- Unlike an FSA, you can only use the funds that have already been deposited in your HSA. If you receive a bill for $400 for services but only have $200 in your HSA available, you can only use $200.
- You can use your HSA funds for qualified medical expenses for any tax dependent even if they are not covered by your HDHP. You cannot, however, use your HSA funds for qualified medical expenses for someone who is not a tax dependent (e.g. a child over the age of 26.)
- All deductibles on your HDHP reset January 1st of each calendar year. There is no carry forward of deductibles met in the prior year. If you enroll in an HDHP on November 1, your medical expenses will be subject to the entire annual deductible for the remainder of the calendar year and will reset on January 1.

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

Insurance Contact Information

Carrier Name	Coverage	Group/ Policy #	Phone Number	Website
Premera	Medical	4015854	855-756-0798	www.premera.com
Kaiser Permanente	Medical	Welcome - 147500	888-901-4636	www.kp.org/wa
Delta Dental of Washington	Dental	186	800-554-1907	www.deltadentalwa.com
Northwest Administrators	Vision	WS	800-732-1123	www.nwadmin.com
Cigna	Long Term Disability	N/A	800-362-4462	www.cigna.com
American Fidelity	Salary Insurance / Flexible Spending	N/A	866-576-0201	www.americanfidelity.com
Fort Dearborn	Life Insurance	N/A	800-633-3696	www.fortdearborn.com
Dept. of Retirement Systems	Retirement	N/A	800-547-6657	www.drs.wa.gov
VEBA Service Group	Health Reimbursement Plan	N/A	800-422-4023	www.veba.org
Health Promotion Northwest	Employee Assistance Program (EAP)	N/A	800-244-6142	www.peacehealth.org/health-promotion-northwest

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 29, 2018. Any further information, revision by bargaining units or by insurers after this date could change or modify the information contained herein.

Mandatory Dental Benefit

(Mandatory for certain bargaining groups and only available to those specific groups)

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 Dental (Group #186)	
Plan Year Maximum (11/01/2018 - 12/31/2019)	$1,750 per person (Non-Delta providers) $2,300 per person (Delta PPO providers) $2,000 per person (Delta Premier 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).

Mandatory Long Term Disability Insurance

All Administrative, Certificated and regular District Office employees working **17.5 or more 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 $9,000/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.

Mandatory Life Benefits

All Administrative and regular District office employees working 17.5 hours or more per week will be covered by our District's Life Insurance provided by Dearborn Life. This plan provides $50,000 of Life and AD&D insurance coverage. The benefit reduces to 65% at age 65 and to 50% at age 70. If you leave the District, convertibility to an individual policy is available.

Please review the Plan Summary for details.

Mandatory Vision Benefits

(Mandatory for certain bargaining groups and only available to those specific groups)

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.

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

Obtaining services from a Panel Provider:

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

Present your NBN Vision ID card when you arrive for your appointment. Failure to tell your NBN eye care professional that you have NBN Vision eye care coverage could result in significant out-of-pocket expenses. Additional ID cards can be printed online at www.nwadmin.com. Complete any paperwork your eye care provider may require. The panel provider will go over what services are covered by your plan. After your services are complete, pay your NBN Vision provider any required co-payments and/or charges for any uncovered items you elected to receive. NBN will pay the panel provider directly for professional services and eyewear covered under your NBN Vision Plan.

Obtaining reimbursement for services at a Non-Panel Provider:

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 eyeware 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.**

Employee Assistance Programs

Health Promotion Northwest EAP of St. Joseph Hospital

The Health Promotion Northwest EAP of St. Joseph Hospital is provided by the District. 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	Coworker 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

Cigna's Life Assistance EAP Program (Only available to groups with Group Long Term Disability (LTD)

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

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

Adoption*, **Parental Care**, **Summer Care**, **Pet Care***, **Parenting**, **Legal Services**, **Child Care***, **Special Needs**, **Financial Information**, **Senior Care***, and **Education***

**Includes online resources*

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

This program's unique advantages include:

- **Proactive Outreach** – Outreach includes reminders throughout the length of the issue.
- **Emphasis on Personal Interaction** – 24 hour live, telephone access to Cigna's licensed behavioral clinicians and up to three, free face to face behavioral counseling sessions with independent specialists when needed.
- **Extensive Network of Behavioral Health Resources** – Cigna Behavioral Health's network of more than 54,000 contracted licensed behavioral health clinicians provide prompt, local access to support.
- **Unique Health Rewards® Program** – Offers discounts (up to 60%) on a range of health and wellness related services and products including discounts on Jenny Craig, smoking cessation programs, chiropractic care, fitness club memberships, hearing and vision care, massage therapy, acupuncture, pharmacy, vitamins and more.
- **Assessment and Counseling** – Up to three (3) in-person counseling sessions for you and your family members for assessment, problem solving and referral to resources.

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

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

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 and Long Term Disability/Salary Insurance

Our district offers its eligible employees Short and Long 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 sick pay or vacation pay. 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.

Voluntary Short Term Disability

Eligible Class	**All Benefit Eligible Employees**
AmFi Brochure #	SB-30485
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	90 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 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.

Voluntary Long Term Disability

Eligible Class	**All Benefit Eligible Employees**
AmFi Brochure #	SB-30486
Benefit Amount	Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month
Benefit Period	To your normal Social Security Retirement Age

This plan has limitations and exclusions. 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 plans.

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

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 DeeEtta Pullar by September, 30 2017 Elections made under the Section 125 plan must remain in place for the length of the plan year unless the employee experiences an allowable election change event mid-plan year (consult your employer for more details). An employee cannot change or revoke their Health FSA election during the contract year. Cancellation or changes for this account are allowed only during the next annual open enrollment period.

To take advantage of either or both of the Flexible Spending Accounts, you must complete an election form and return it to the payroll office prior to 6/15/2018. Employees currently participating in either of the Flexible Spending Accounts also need to submit a new election form for July 2019 - June 2020 to the payroll office.

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 2019. All employees will need to see the American Fidelity Representative as no manual forms will be accepted.

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a health plan to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This notice describes the ways the Lynden School District #504 (the "Health Plan") may use and disclose health information about you and your rights to review and control disclosure of this information.

The Health Plan needs to create, receive, maintain and disclose health information about you and your enrolled family members to administer the Health Plan and provide you with health care benefits. This notice describes the Health Plan's health information privacy practices with respect to your Medical, Prescription Drug, Dental, Vision and Employee Assistance Program benefits, and your Health Flexible Spending Account component of your Section 125 Plan. It does not address the health information policies or practices of your health care providers, such as your physician.

The privacy policy and practices of the Health Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. Your health information will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

HOW THE HEALTH PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following are the different ways the Health Plan may use and disclose your health information. Not every use or disclosure in a category is listed, but the ways in which the Health Plan is permitted to use and disclose information falls within one of the categories.

- For Treatment. The Health Plan may disclose your health information to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Health Plan may advise an emergency room physician about the types of prescription drugs you currently take.
- For Payment. The Health Plan may use and disclose your health information so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the plan. The Health Plan may need to obtain your authorization for this. For example, the Health Plan may receive and maintain information about surgery that you received to enable the Health Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- For Health Care Operations. The Health Plan may use and disclose your health information to enable it to operate or operate more efficiently or make certain all participants receive their health benefits. For example, the Health Plan may use your health information for case management or to perform population-based studies designed to reduce health care costs. In addition, the Health Plan may use or disclose your health information to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Health Plan may also combine health information about many Health Plan participants and disclose it to Lynden School District #504 in summary fashion so it can decide what coverages the Health Plan should provide.
- To Lynden School District #504 as Plan Sponsor. The Health Plan may disclose your health information to designated employees of Lynden School District #504 so they can carry out their Health Plan-related administrative functions, including the uses and disclosures described in this notice. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law.
- To a Business Associate. Certain services are provided to the Health Plan by third party administrators and other third parties known as "business associates." For example, the Health Plan may input information about your health care treatment into an electronic claims processing system maintained by the Health Plan's business associate so your claim may be paid. In so doing, the Health Plan will disclose your health information to its business associate so it can perform its claims payment function. However, the Health Plan will require its business associates, through contract, to appropriately safeguard your health information.
- Treatment Alternatives and Health-Related Benefits and Services. The Health Plan may use and disclose your health information to tell you about possible treatment options or alternatives and health-related benefits that may be of interest to you.
- Individual Involved in Your Care or Payment of Your Care. The Health Plan may disclose health information to a close friend or family member involved in or who helps pay for your health care. The Health Plan may also advise a family member or close friend about your condition or your location (for example, that you are in the hospital).
- As Required by Law. The Health Plan may disclose your health information when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

HIPAA Privacy Notice (Continued)

You have rights with regard to your health information. If you wish to exercise any of the following rights, please contact the Health Plan Privacy Official.

- Right to Inspect and Copy. You have the right to inspect and copy your health information. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the Health Plan, submit your request in writing to the Health Plan. The Health Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Health Plan may deny your request to inspect and copy your health information.
- Right to Amend. If you feel that health information the Health Plan has about you is incorrect or incomplete, you may ask the Health Plan to amend it. In certain situations, the Health Plan may deny your request to amend your health information.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your health information. However, no accounting is available of disclosures prior to April 14, 2003.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the health information the Health Plan uses or discloses about you for treatment, payment, or health care operations, or to someone who is involved in your care or the payment for your care. For example, you could ask that the Health Plan not use or disclose information about a surgery you had. The Health Plan is not required to agree to your request.
- Right to Request Confidential Communications. You have the right to request that the Health Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Health Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address. The Health Plan will attempt to accommodate all reasonable requests.
- Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice upon request.

PRIVACY OBLIGATIONS OF THE HEALTH PLAN

The Health Plan is required by law to maintain the privacy of your health information, give you this notice of its legal duties and privacy practices with respect to health information, and to follow the terms of the notice that is currently in effect.

CHANGES TO THIS NOTICE

The Health Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Health Plan already has about you, as well as any information the Health Plan receives in the future.

COMPLAINTS

If you believe your privacy rights under this policy have been violated, you may file a complaint with the Health Plan Privacy Official at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred. Please contact the Privacy Official for additional information. You will not be penalized or retaliated against for filing a complaint.

CONTACT INFORMATION

If you have any questions about this notice, please contact the Health Plan Privacy Official. You may contact the Privacy Official as follows:

Human Resources Employee Benefits Department

Lynden School District

1203 Bradley Road

Lynden, WA 98264

(360)-354-4443

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 and Medical Leave Act (FMLA) was signed into law in February 1993. The law took effect on August 5, 1993 and guarantees up to 12 weeks of unpaid leave each year to workers who need time off for birth or adoption of a child, to care for a spouse or immediate family member with a serious illness, or who are unable to work because of a serious health condition.

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

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. The District will notify you of your options upon separation of employment.

Voluntary Life and Disability Insurance- The life coverage is convertible to an individual party without evidence of insurability. To be eligible for this conversion written application and payment of the initial premium must be received at the insurance company within 31 days after termination of employment.

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 DeeEtta Pullar, Lynden School District (360)-354-4443.

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Individual Health Coverage

If you find a family member needs to come off your health plan whether due to age or cost, The Partners Group can help. You can get affordable, quality health coverage from a variety of plans offering different coverage levels and prices.

- Personalized consultations with health insurance professionals in all 50 states
- Free tax subsidy eligibility review
- Streamlined, paperless, application process
- A variety of other plans available including dental, vision, and life

Call the Partners Individual Marketplace at (888) 465-9404 or visit www.partnersimarketplace.com for a free quote and assistance in continuing to protect your family's health needs.

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

Washington State Deferred Compensation Program (DCP)

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

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

How does Deferred Compensation Work?

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

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

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

Email: dcpinfo@drs.wa.gov

Mail: PO BOX 40931 Olympia, WA 98504-0931

403(b) Universal Availability Notice - Omni

If you work 20 hours or more per week, you have the opportunity to save additional (beyond your school retirement plan) for retirement by participating in your Employer's 403(b) retirement plan. If there are any questions, you may contact the Plan's Administrator, The OMNI Group at 877-544-6664, www.omni403b.com.

You can participate in the Plan with pre-tax contributions by submitting a Salary Reduction Agreement ("SRA") online via OMNI's website or by submitting a completed SRA form, found on the same website, to OMNI either by facsimile to (585) 672-6194 or by mail to 1099 Jay St., Bldg F, Rochester, NY, 14611. Additionally, prior to contributing you must open an account with an investment provider participating in the Plan. A list of the Plan's participating investment providers may be viewed on OMNI's website after submitting your Employer's name and state.

A copy of your SRA and your provider's paperwork must be provided to payroll.

Workers' Compensation, Occupational Safety & Accident Prevention Program

The Lynden School District is an insured employer through the Washington State Department of Labor & Industries. Our occupational safety and accident prevention program applies to any work-related injury or illness. If you sustain a work-related injury, the following steps are to be followed:

- Immediately report any injury (treated or untreated) to your supervision and complete the Accident Report Form.
- When the injury requires medical care take the Medical Provider Instructions & Forms packet with you to the doctor.
- The Return to Work Release Form is to be completed by the doctor and returned to the district Claims Manager prior to returning to work.
- If time loss is required or transitional work possible a Physical Capacities Evaluation is to be completed by the doctor and returned to the district Claims Manager prior to returning to work.
- Obtain the Washington State Fund Report of Industrial Injury or Occupational Disease form from the doctor and mail to the State. The employer portion is mailed to the district for completion of "Employer Information".

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%.

Help Getting Healthcare

- Know your health care options
- Establish a Medical Home
- Connect to community resources

WAHA is a local non-profit organization that connects people in our community to health care resources and services. We can help you identify options or apply for:

- Apple Health for Kids (Children's Medicaid to Age 19)
- Children's Health Insurance Program
- Medical Bill Assistance
- Dental Care Resources
- Mental Health Care Resources
- Commercial Insurance Information
- Other Health Care Programs

Family Size	**AHK**	**AHK $20 Premium**	**AHK $30 Premium**
	Gross Monthly Income		
1	$2,125	$2,631	$3,157
2	$2,881	$3,567	$4,281
3	$3,637	$4,503	$5,404
4	$4,393	$5,439	$6,527
5	$5,149	$6,375	$7,650
6	$5,905	$7,311	$8,773
7	$6,661	$8,247	$9,897
8	$7,417	$9,183	$11,020
9	$8,173	$10,119	$12,143
10	$8,929	$11,055	$13,266
11+	+$725	$936	$1,123

Health Access Services

WAHA's professional staff and trained volunteers offer free and confidential services to **help you understand health care options and resources for you and your family.**

- ✓ Go to **www.WhatcomAlliance.org** to find easy-to-understand and impartial health care information.
- ✓ Call **(360) 788-6594** to make an appointment with a WAHA's Connector Services staff for help identifying health care options or applying for eligible programs.
- ✓ Email the WAHA staff with your questions or to make an appointment at info@whatcomalliance.org

Monthly Insurance Rates for 2018-2019

MEDICAL	Premera EasyChoice A	Premera EasyChoice B	Premera Basic	Premera QHDHP
Employee Only	$711.09	$711.09	$573.93	$707.92
Employee & Spouse	$1,292.70	$1,292.70	$1,042.48	$1,183.83
Employee & Child(ren)	$943.78	$943.78	$761.35	$898.32
Family	$1,549.14	$1,549.14	$1,249.02	$1,376.32

*Your QHDHP plan premiums may include a $125 monthly contribution to your HSA or be $125 less than amount listed, depending on bargaining group.

MEDICAL	Kaiser Permanente Welcome 500
Employee Only	$753.96
Employee & Spouse	$1,441.80
Employee & Child(ren)	$1,146.93
Family	$1,833.60

DENTAL**	Delta	VISION**	Northwest Benefit Network	LONG TERM DISABILITY**	Cigna
Composite Rate	$99.79	Composite Rate	$24.00	Employee Only Rate	$11.77

Dental and Vision 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. Long Term Disability rate is for employee only coverage.

LIFE/AD&D**	Fort Dearborn†
Employee Only	$10.50

$50,000 benefit provided for eligible employees only.

**Each group votes on these benefits. Your Group may or may not have these benefits available depending on voting.

† Fort Dearborn rate subject to change effective **11/1/2018.**

Individual allocation amounts vary depending on bargaining group and FTE. Each employee will be provided with an individual Monthly Benefit Rate sheet which will include allocation amount, if known at the time the sheets are printed.

Net paycheck must be enough to cover any out-of-pocket expense.

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