Open Enrollment
August 21st through September 8th, 2017

Benefits Fair
Tuesday, August 29, 2017
8:00 am - 12:30 pm
Aberdeen High School Commons
410 North G Street
Aberdeen, WA 98520

2017-2018 School Year
If you need assistance or have questions on any of your benefits, you can always contact Cindy Lee at 360-538-2011 or our Insurance Broker:

The Partners Group
Phone: 1-877-455-5640
IMPORTANT OPEN ENROLLMENT INFORMATION

Open Enrollment Period: August 21st to September 8th, 2017

• All applications must be submitted to Cindy Lee no later than September 8th for an effective date of October 1st for new hires and November 1st for returning employees.

• For Regence Medical, you will need to complete a paper enrollment form to enroll or make changes to your Regence medical plan.

• For WEA Select Delta Dental or Willamette Dental, if you are a new hire or wish to make changes, you will need to enroll or make changes using the online system at http://resources.hewitt.com/wea or by calling the WEA Select Benefits Center at 1-855-668-5039. If you do not wish to make any changes, (i.e. add or remove dependents), you will automatically stay in your current plan.

• For Ameritas Dental (Administrative, Principals, PSE and Unaffiliated Employees), you will need to complete a paper enrollment form to enroll or make changes to your Ameritas dental plan.

BENEFITS FAIR

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

Date: Tuesday, August 29, 2017

Time: 8:00 am - 12:30 pm

Location: Aberdeen High School Commons

410 North G Street

Aberdeen, WA 98520

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 Cindy Lee at 360-538-2011, Jim Sawin at 360-538-2222 or The Partners Group at 877-455-5640. This summary was printed on August 7, 2017. Any further information, revision by bargaining units or by insurers after this date could change or modify the information contained herein.
Welcome to Your Benefits!

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

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

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## Insurance Contact Information

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<tr>
<th>Carrier Name</th>
<th>Coverage</th>
<th>Group/Policy #</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regence Blue Shield</td>
<td>Medical</td>
<td>10029944</td>
<td>888-367-2112</td>
<td><a href="http://www.wa.regence.com">www.wa.regence.com</a></td>
</tr>
<tr>
<td>Delta Dental</td>
<td>Dental</td>
<td>186</td>
<td>800-554-1907</td>
<td><a href="http://www.deltadentalwa.com">www.deltadentalwa.com</a></td>
</tr>
<tr>
<td>Willamette Dental</td>
<td>Dental</td>
<td>W005</td>
<td>855-433-6825</td>
<td><a href="http://www.willamettedental.com">www.willamettedental.com</a></td>
</tr>
<tr>
<td>Ameritas Dental</td>
<td>Dental</td>
<td>G-10-301277-1</td>
<td>800-487-5553</td>
<td><a href="http://www.ameritasgroup.com">www.ameritasgroup.com</a></td>
</tr>
<tr>
<td>WA State Council of County and City Employees</td>
<td>Dental</td>
<td>F36</td>
<td>866-737-7572</td>
<td></td>
</tr>
<tr>
<td>Northwest Benefit Network</td>
<td>Vision</td>
<td>AN</td>
<td>800-732-1123</td>
<td><a href="http://www.nwadmin.com">www.nwadmin.com</a></td>
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<tr>
<td>Cigna</td>
<td>Life/Long Term Disability</td>
<td>N/A</td>
<td>800-362-4462</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td>American Fidelity</td>
<td>WEA Short Term Disability/Cancer Insurance</td>
<td>N/A</td>
<td>866-576-0201</td>
<td><a href="http://www.afadvantage.com">www.afadvantage.com</a></td>
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<tr>
<td>Discovery Benefits</td>
<td>Flexible Spending Account</td>
<td>N/A</td>
<td>866-451-3399</td>
<td><a href="http://www.discoverybenefits.com">www.discoverybenefits.com</a></td>
</tr>
<tr>
<td>Cigna</td>
<td>Employee Assistance Program</td>
<td>N/A</td>
<td>800-538-3543</td>
<td><a href="http://www.cignabehavioral.com">www.cignabehavioral.com</a></td>
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<tr>
<td>TSA Consulting Group</td>
<td>403(b)</td>
<td>N/A</td>
<td>800-695-1471</td>
<td></td>
</tr>
<tr>
<td>AFLAC</td>
<td>Supplemental Insurance</td>
<td>N/A</td>
<td>360-500-9411</td>
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## District Contact Information

<table>
<thead>
<tr>
<th>Business Office</th>
<th>Cindy Lee</th>
<th>360-538-2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources</td>
<td>Jim Sawin</td>
<td>360-538-2222</td>
</tr>
<tr>
<td>Business Office</td>
<td>Elyssa Louderback</td>
<td>360-538-2007</td>
</tr>
</tbody>
</table>

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

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

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 Cindy Lee at 360-538-2011, Jim Sawin at 360-538-2222 or The Partners Group at 877-455-5640. This summary was printed on August 7, 2017. Any further information, revision by bargaining units or by insurers after this date could change or modify the information contained herein.
Enrolling or Making Changes to your Benefits

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

You have the following time periods to enroll:

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

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

Types of Qualifying Events

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

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

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

Dependents

Your legal spouse or domestic partner is eligible for coverage as well as any of your children (biological or step) up to age 26. Coverage is also available beyond age 26 for incapacitated children. Please see Human Resources for more information if you have questions on dependent eligibility.
Benefit Changes for the 2017-2018 School Year

Washington State Allocation
State allocation for employee benefits is $820.00.

Regence Blue Shield of Washington
- Innova 500 will be replaced by Innova 750.
- There are no benefit changes to any other plan.
- 15% rate increase.

WEA – Delta Dental of Washington
- No Benefit Changes.
- 2% rate decrease.

WEA – Willamette Dental
- Composite (tooth colored) Fillings will be covered on Posterior (back) teeth.
- No rate change.

Ameritas Dental
- No benefit changes.
- Rate will decrease to $109.00.

NBN – Vision
- Contact lens allowance will increase from $250 to $300.
- Coverage for plastic photochromatic lenses, anti-reflective and scratch coat treatments will be covered.
- The frame allowance will increase 20%.
- No rate change.

CIGNA - Long Term Disability
- No benefit changes.
- No rate change.

WEA Select Voluntary Short Term Disability Plans - American Fidelity Assurance Company (AFA)
- No benefit changes.
- No rate change.
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 of 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 Regence Blue Shield.

To find a preferred provider through Regence, visit www.wa.regence.com.

Qualified High Deductible Health Plan (QHDHP)

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

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

Your QHDHP plan option is available through Regence.

To find a preferred provider through Regence, visit www.wa.regence.com.

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Regence High Option</th>
<th>Regence Innova 750</th>
<th>Regence Innova 2500</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>Preferred Provider</td>
<td>Participating Provider</td>
<td>Preferred Provider</td>
</tr>
<tr>
<td>Medical Deductible</td>
<td>$200 person / $600 family</td>
<td>$750 person / $2,250 family</td>
<td>$2,500 person / $7,500 family</td>
</tr>
<tr>
<td>Rx Deductible</td>
<td>None</td>
<td>None</td>
<td>$500 person</td>
</tr>
<tr>
<td>4th Qtr. Carry Over</td>
<td>Applies</td>
<td>Applies</td>
<td>Applies</td>
</tr>
<tr>
<td>Carrier Coinsurance</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Medical Out of Pocket Max</td>
<td>$2,200 person / $6,600 family</td>
<td>$3,250 person / $9,750 family</td>
<td>$5,000 person / $10,000 family</td>
</tr>
<tr>
<td>Rx Out of Pocket Max</td>
<td>Included in Medical</td>
<td>Included in Medical</td>
<td>Included in Medical</td>
</tr>
<tr>
<td><strong>Office Visit</strong></td>
<td>$20 copay (dw)</td>
<td>$20 copay (dw)</td>
<td>$30 copay (dw)</td>
</tr>
<tr>
<td>Preventive Care*</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Diagnostic Lab &amp; X-Ray</td>
<td>90% (dw)</td>
<td>Covered in full up to $500 per year then ded &amp; coins</td>
<td>Covered in full up to $500 per year then ded &amp; coins</td>
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<tr>
<td>Emergency Care**</td>
<td>$75 copay + ded &amp; coin</td>
<td>$75 copay + ded &amp; coins</td>
<td>$75 copay + ded &amp; coin</td>
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<tr>
<td>Ambulance</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Hospital (Inpatient)</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Hospital (Outpatient)</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>$20 copay (dw)</td>
<td>$20 copay (dw)</td>
<td>$30 copay (dw)</td>
</tr>
<tr>
<td>Vision Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rehab - Outpatient (Speech, Massage, OT, PT)</td>
<td>Unlimited Visits PCY</td>
<td>25 visits PCY</td>
<td>25 visits PCY</td>
</tr>
<tr>
<td></td>
<td>Deductible &amp; Coinsurance</td>
<td>$20 copay (dw)</td>
<td>$30 copay (dw)</td>
</tr>
<tr>
<td>Rehab - Inpatient (Speech, Massage, OT, PT)</td>
<td>32 days PCY</td>
<td>30 days PCY</td>
<td>30 days PCY</td>
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<tr>
<td></td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td>Generic / Brand / Non-Formulary - At Participating Pharmacies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Cost Share</td>
<td>$5 / $20 / $40</td>
<td>(30 day supply)</td>
<td>$0 (dw) / $30 / $45</td>
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<tr>
<td>Mail Order Cost Share</td>
<td>$10 / $40 / $80</td>
<td>(90 day supply)</td>
<td>(30 day supply)</td>
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<tr>
<td>Specialty Cost Share</td>
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<td>(30 day supply)</td>
<td>$75 Copay through BriovaRx Only</td>
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<tr>
<td>Life/AD&amp;D Insurance</td>
<td>None</td>
<td></td>
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</table>

*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  
To locate a Regence provider, visit [www.wa.regence.com](http://www.wa.regence.com)
## Medical Plan Options

<table>
<thead>
<tr>
<th>Plan</th>
<th>Regence Innova A</th>
<th>Regence Innova B</th>
<th>Regence HSA 1500</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>Preferred Provider</td>
<td>Participating Provider</td>
<td>Preferred Provider</td>
</tr>
<tr>
<td>Medical Deductible</td>
<td>$1,000 person / $3,000 family</td>
<td>$750 person / $2,250 family</td>
<td>$1,500 person / $3,000 family</td>
</tr>
<tr>
<td>Rx Deductible</td>
<td>$500 person</td>
<td>$250 person</td>
<td>None</td>
</tr>
<tr>
<td>4th Qtr. Carry Over</td>
<td>Applies</td>
<td>Applies</td>
<td>Does NOT Apply</td>
</tr>
<tr>
<td>Carrier Coinsurance</td>
<td>80%</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>Medical Out of Pocket Max</td>
<td>$4,000 person / $8,000 family</td>
<td>$3,500 person / $7,000 family</td>
<td>$5,000 person / $10,000 family</td>
</tr>
<tr>
<td>Rx Out of Pocket Max</td>
<td>Included in Medical</td>
<td>Included in Medical</td>
<td>Included in Medical</td>
</tr>
</tbody>
</table>

### Medical Deductible
- **Regence Innova A**: $1,000 person / $3,000 family
- **Regence Innova B**: $750 person / $2,250 family
- **Regence HSA 1500**: $1,500 person / $3,000 family

### Rx Deductible
- **Regence Innova A**: $500 person
- **Regence Innova B**: $250 person
- **Regence HSA 1500**: None

### 4th Qtr. Carry Over
- **Regence Innova A & B**: Applies
- **Regence HSA 1500**: Does NOT Apply

### Carrier Coinsurance
- **Regence Innova A**: 80%
- **Regence Innova B**: 60%
- **Regence HSA 1500**: 75%

### Medical Out of Pocket Max
- **Regence Innova A**: $4,000 person / $8,000 family
- **Regence Innova B**: $3,500 person / $7,000 family
- **Regence HSA 1500**: $5,000 person / $10,000 family

### Rx Out of Pocket Max
- **Regence Innova A & B**: Included in Medical
- **Regence HSA 1500**: Included in Medical

### Office Visit
- **Primary/Specialist**
  - **Regence Innova A**: $15 copay (dw)
  - **Regence Innova B**: $30 copay (dw)
  - **Regence HSA 1500**: $45 copay (dw)

### Preventive Care*
- **Regence Innova A**: Covered in full
- **Regence Innova B**: Covered in full
- **Regence HSA 1500**: Covered in full

### Diagnostic Lab & X-Ray
- **Regence Innova A**: Covered in full up to $1,000 per year then ded & coins
- **Regence Innova B**: Covered in full up to $400 per year then ded & coins
- **Regence HSA 1500**: Deductible & Coinsurance

### Advanced Diagnostic Imaging
- **Regence Innova A**: Covered in full up to $1,000 per year then ded & coins
- **Regence Innova B**: Covered in full up to $400 per year then ded & coins
- **Regence HSA 1500**: Deductible & Coinsurance

### Emergency Care**
- **Regence Innova A**: $100 copay + ded & coin
- **Regence Innova B**: $150 copay + ded & coin
- **Regence HSA 1500**: Deductible & Coinsurance

### Ambulance
- **Regence Innova A & B**: Deductible & Coinsurance
- **Regence HSA 1500**: Deductible & Coinsurance

### Hospital (Inpatient)
- **Regence Innova A & B**: Deductible & Coinsurance
- **Regence HSA 1500**: Deductible & Coinsurance

### Hospital (Outpatient)
- **Regence Innova A & B**: Deductible & Coinsurance
- **Regence HSA 1500**: Deductible & Coinsurance

### Spinal Manipulations
- **Regence Innova A**: $15 copay (dw)
  - 12 manipulations PCY
- **Regence Innova B**: $30 copay (dw)
  - 12 manipulations PCY
- **Regence HSA 1500**: Unlimited manipulations

### Vision Care
- **Regence Innova A**: Not Covered
- **Regence Innova B**: Not Covered
- **Regence HSA 1500**: Not Covered

### Rehab - Outpatient (Speech, Massage, OT, PT)
- **Regence Innova A**: 30 visits PCY
- **Regence Innova B**: 45 visits PCY
- **Regence HSA 1500**: 25 visits PCY

### Rehab - Inpatient (Speech, Massage, OT, PT)
- **Regence Innova A**: $15 copay (dw)
  - 30 days PCY
- **Regence Innova B**: $30 copay (dw)
  - 30 days PCY
- **Regence HSA 1500**: 30 days PCY

### Prescriptions

<table>
<thead>
<tr>
<th>Generics / Brand / Non-Formulary - At Participating Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Cost Share</strong></td>
</tr>
<tr>
<td>$0 (dw) / 30% / 30% (30 day supply)</td>
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<tr>
<td>$0 (dw) / 30% / 30% (30 day supply)</td>
</tr>
<tr>
<td>Deductible &amp; Coinsurance (30 day supply)</td>
</tr>
</tbody>
</table>

| **Mail Order Cost Share** |
| $0 (dw) / 30% / 30% (90 day supply) |
| $0 (dw) / 60% / 90% (90 day supply) |
| Deductible & Coinsurance (90 day supply) |

| **Specialty Cost Share** |
| 35% Coinsurance through BriovaRx Only (30 day supply) |
| $75 Copay through BriovaRx Only (30 day supply) |
| Deductible & Coinsurance through BriovaRx Only (30 day supply) |

### Life/AD&D Insurance
- **Regence HSA 1500**: None

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*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/Plans Innova A & B have a separate out of network deductible

Rx = Prescription Medication

ƗRegence HSA 1500: If more than one person is enrolled, the family deductible must be satisfied before benefits are payable for any enrolled person. An individual member on family coverage will have a $6,850 Out of Pocket Maximum.

To locate a Regence provider, visit [www.wa.regence.com](http://www.wa.regence.com)
High Deductible Health Plan and HSA Questions and Answers

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

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

**What is a Health Savings Account (HSA)?**

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

**Who is eligible to participate in an HSA?**

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

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

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

**How much can I contribute to my HSA?**

- You (and/or your employer) can contribute up to the Federal Annual Limit. For 2017, including employer contributions, it is $3,400 (individual) or $6,750 (family). For 2018, the limit increases to $3,450 (individual) and to $6,900 (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 $6,750 between the two accounts if one has an HDHP with employee & dependents enrolled.
- Contributions to your HSA are deducted from your paycheck on a pre-tax basis and deposited by your employer.

**How do I use my HSA?**

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

- The HSA is a bank account, in your name, that belongs to you. If you leave your employer, the account goes with you and you can continue to use it for qualified medical expenses. Any monthly banking fees for the HSA are your responsibility and will be deducted directly from your HSA.
- Over-the-Counter medications are not a qualified medical expense under an HSA.
- Any use of HSA funds for a non-qualified medical expense are subject to a 20% tax penalty and applicable income taxes. You should keep all your receipts for purchases made with your HSA in case you are audited by the IRS.
- You cannot use HSA funds for any item or service provided prior to your effective date on your HDHP. For example, if your HDHP was effective 11/1/2017 and your dentist performed a crown on 9/5/2017, 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](http://www.treasury.gov), and on IRS Publication 969 and 502 or by consulting your tax professional.
Saving Money on Your Medical Costs

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

Use The Emergency Room for Emergencies Only

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

Select Generic Prescription Drugs When Available

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

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

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

Participate in the Flexible Spending Account

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

You may choose to enroll in either of the dental plans below.

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

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

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

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

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

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

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

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

Mandatory Dental Benefits for Custodians & Maintenance Employees

<table>
<thead>
<tr>
<th>Washington State Council of County &amp; City Employees</th>
<th>Dental Plan 8 (Group #F36)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Year Maximum (Jan 1 - Dec 31)</strong></td>
<td>$2,000 per person</td>
</tr>
<tr>
<td>Preventive (Exams, X-Rays, Cleaning etc.)</td>
<td>100% of eligible charges*</td>
</tr>
<tr>
<td>Restorative Services (Fillings, Extractions, etc.)</td>
<td>100% of eligible charges*</td>
</tr>
<tr>
<td>Major Care (Crowns, Dentures, Partials Bridges, etc.)</td>
<td>100% of eligible charges*</td>
</tr>
<tr>
<td>Orthodontia (Adults &amp; Children)</td>
<td>50% up to a maximum lifetime benefit of $1,500</td>
</tr>
</tbody>
</table>

*Up to the maximum allowed by the plan. Please refer to your plan booklet for list of allowances. (Administered by Zenith Administrators).
Mandatory Dental Benefits for Administrative, Principals, PSE & Unaffiliated Employees

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

Under the Ameritas Dental 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.

To find a Ameritas provider go to www.ameritasgroup.com.

<table>
<thead>
<tr>
<th>Ameritas Incentive Dental (Group #G-10-301277-1)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Maximum</td>
<td>$1,900 per person*</td>
</tr>
<tr>
<td>(Oct 1, 2017 - October 31, 2018)</td>
<td></td>
</tr>
<tr>
<td>Diagnostics, Preventive Exams/Services, Cleaning, X-Rays</td>
<td>70% - 100% Incentive**</td>
</tr>
<tr>
<td>Restorative Services</td>
<td>70% - 100% Incentive**</td>
</tr>
<tr>
<td>Fillings, Extractions,Crowns, etc.</td>
<td></td>
</tr>
<tr>
<td>Major Care</td>
<td>50%</td>
</tr>
<tr>
<td>Dentures, Partial Bridges, etc.</td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontia (Adults &amp; Children)</td>
<td>50% up to a $1,000 lifetime maximum</td>
</tr>
</tbody>
</table>

*The Annual Plan Maximum will increase by $400 each plan year, to a maximum of $2,950, provided you have at least one visit be plan year and utilize $750 or less in benefits.

**During your 1st benefit year on this plan, 70% of covered benefits are paid. This advances by 10% annually (on October 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 level to drop back down to 70%. Each eligible employee creates their own percentage level. Percentage levels do not affect the 50% level on allowable prosthetics (dentures and bridges) and orthodontics.

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

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

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

<table>
<thead>
<tr>
<th>Willamette Dental (Group #W005)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Maximum</td>
<td></td>
</tr>
<tr>
<td>(Nov 1 - Oct 31)</td>
<td></td>
</tr>
<tr>
<td>Diagnostics, Preventive Exams/Services, Cleaning, X-Rays</td>
<td>$15 copay then covered at 100%</td>
</tr>
<tr>
<td>Restorative Services</td>
<td></td>
</tr>
<tr>
<td>Fillings, Extractions, etc.</td>
<td></td>
</tr>
<tr>
<td>Major Care</td>
<td></td>
</tr>
<tr>
<td>Crowns, Dentures, Partial Bridges, etc.</td>
<td>$50 copay plus a $15 copay per visit, then covered at 100%</td>
</tr>
<tr>
<td>Temporomandibular Joint Disorder</td>
<td></td>
</tr>
<tr>
<td>$1,000 Annual Max Benefit</td>
<td></td>
</tr>
<tr>
<td>$5,000 Lifetime Max Benefit</td>
<td></td>
</tr>
<tr>
<td>Nightguards</td>
<td></td>
</tr>
<tr>
<td>$15 copay then covered at 100%</td>
<td></td>
</tr>
<tr>
<td>Orthodontia (Willamette Plan #4, Children &amp; Adults)</td>
<td>Covered in full after a $15 copay (per visit) and a $1,500 orthodontia copay</td>
</tr>
</tbody>
</table>
Mandatory Vision Benefits

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

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

<table>
<thead>
<tr>
<th>Copayment for lenses/frames</th>
<th>Frequency</th>
<th>Panel Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>Once per calendar year</td>
<td>Paid in full*</td>
</tr>
<tr>
<td>Lenses (pair)</td>
<td>Once per calendar year</td>
<td>Paid in full**</td>
</tr>
<tr>
<td>Frames</td>
<td>Once per two calendar years</td>
<td>Paid in full***</td>
</tr>
<tr>
<td>Contacts - subnormal (in lieu of all other services, requires approval from NBN Claims)</td>
<td>Once per calendar year</td>
<td>Paid in full*</td>
</tr>
<tr>
<td>Contacts - elective (in lieu of all other hardware services)</td>
<td>Once per calendar year</td>
<td>$300 allowance towards the cost of fitting fee and lenses at an NBN provider</td>
</tr>
</tbody>
</table>

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

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

Obtaining services from a Panel Provider:

1. Log on to www.nwadmin.com or NWA’s mobile app and use the NBN Vision Provider Locator feature to find an NBN eye care professional. It’s also a good idea to verify your eligibility status online prior to receiving services.
2. Present your NBN Vision ID card when you arrive for your appointment. Failure to tell your NBN eye care professional that you have NBN Vision eye care coverage could result in significant out of pocket expenses. Need additional ID cards? You can print extras online at www.nwadmin.com.
3. Complete any paperwork your eye care provider may require.
4. After your services are complete, pay your NBN Vision provider any co-payments (if your plan requires them) and/or charges for any uncovered items you elected to receive. NBN will pay the panel provider directly for professional services and eyewear covered under your NBN Vision Plan.

Obtaining reimbursement for services at a Non-Panel Provider:

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

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

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

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

Lens Extras

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

<table>
<thead>
<tr>
<th>Generic Flat Top Multi Focal</th>
<th>Blended</th>
<th>Progressive**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oversize blanks</td>
<td>Prism Segs</td>
<td>Slab Off</td>
</tr>
<tr>
<td>Laminated</td>
<td>Double Segs</td>
<td>Pink 1 &amp; 2 Tints</td>
</tr>
<tr>
<td>Sun Tints</td>
<td>Glass Photo Chromatic Lite Shades</td>
<td>Glass Photo Chromatic Dark Shades</td>
</tr>
<tr>
<td>Other Tints</td>
<td>Anti-Reflective Multi Layer</td>
<td>Color Coat</td>
</tr>
<tr>
<td>Scratch Coat</td>
<td>Anti-Reflective + Scratch Coat**</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Plastic Photo Chromatic**</th>
<th>Edge Coat</th>
<th>Special Lens Edge Treatments</th>
</tr>
</thead>
</table>

Hi-Index** (extra thin, light weight lenses) are covered by your NBN Vision plan only when necessary.

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

Mandatory Long Term Disability Insurance

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

<table>
<thead>
<tr>
<th>Benefits begin paying at:</th>
<th>After the 90th day of disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount</td>
<td>60% of your gross monthly income up to $5,000/month</td>
</tr>
<tr>
<td>Minimum Benefit Amount</td>
<td>10% of your maximum benefit or $100, whichever is greater.</td>
</tr>
<tr>
<td>Benefits stop paying at:</td>
<td>Your Social Security Normal Retirement Age (if disabled before age 65)</td>
</tr>
<tr>
<td></td>
<td>If disabled after age 65, benefits end based on age when disabled. See plan documents for schedule.</td>
</tr>
<tr>
<td>Restrictions</td>
<td>Mental Illness/Drug &amp; Alcoholism is covered only for 24 months</td>
</tr>
</tbody>
</table>

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

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

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

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

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

This program’s unique advantages include:

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

To access online resources visit: [www.cignabehavioral.com/cgi](http://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.

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**Voluntary Short Term Disability/Salary Insurance**

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

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>All Benefit Eligible Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AmFi Brochure #</strong></td>
<td>SB-30485</td>
</tr>
<tr>
<td><strong>Benefit Amount</strong></td>
<td>Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month</td>
</tr>
<tr>
<td><strong>Waiting Period</strong></td>
<td>0 days for injury / 7 days for sickness (benefits begin on 8th day for sickness)</td>
</tr>
<tr>
<td><strong>Benefit Period</strong></td>
<td>60 days</td>
</tr>
</tbody>
</table>

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.

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.

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**Voluntary Life Insurance**

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

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

<table>
<thead>
<tr>
<th>Monthly Cost</th>
<th>Age</th>
<th>Rate per $1,000</th>
<th>Age</th>
<th>Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 30</td>
<td>$.06</td>
<td>50-54</td>
<td>$.42</td>
</tr>
<tr>
<td></td>
<td>30-34</td>
<td>$.07</td>
<td>55-59</td>
<td>$.65</td>
</tr>
<tr>
<td></td>
<td>35-39</td>
<td>$.10</td>
<td>60-64</td>
<td>$.88</td>
</tr>
<tr>
<td></td>
<td>40-44</td>
<td>$.17</td>
<td>$65-69</td>
<td>$1.46</td>
</tr>
<tr>
<td></td>
<td>45-49</td>
<td>$.28</td>
<td>Children</td>
<td>$1.50/$5,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$3.00/$10,000</td>
</tr>
</tbody>
</table>
Flexible Spending Accounts

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

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

How the Flexible Spending Account Works?

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

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

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

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

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

<table>
<thead>
<tr>
<th>Employee A</th>
<th>Employee B</th>
</tr>
</thead>
<tbody>
<tr>
<td>$35,000 Gross Pay</td>
<td>$35,000 Gross Pay</td>
</tr>
<tr>
<td>-$7,092.50 Taxes</td>
<td>-$2,400 Medical Costs</td>
</tr>
<tr>
<td>$27,908.50 Take Home Pay</td>
<td>$32,600 Take Home Pay</td>
</tr>
<tr>
<td>-$2,400 Medical Costs</td>
<td>-$6,548.90 Taxes</td>
</tr>
<tr>
<td>$25,507.50 Net Pay</td>
<td>$26,051.10 Net Pay</td>
</tr>
</tbody>
</table>

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

Examples of Qualified Health Care Expenses

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

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

Premium Conversion Program

The premium conversion program provides employees to pay certain out-of-pocket insurance premiums on a pre-tax basis thereby reducing your costs. This program is a financial benefit to most employees that have out-of-pocket premiums. This program is limited to dental, health and vision premiums. This program will be automatically given to each employee. If an employee does not want to participate in this program, they must sign and return a “Premium Payment Refusal” form by December 1, 2017. Premiums will then be deducted on an after-tax basis.
Credit Union Options

| Twin County Credit Union | Inspirus Credit Union  
(formerly WA School Employees Credit Union) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>800-235-8946 / 800-235-8947</td>
<td>888-628-4010</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.inspiruscu.org">www.inspiruscu.org</a></td>
</tr>
</tbody>
</table>

Active school employees, working in Washington State or retired school employees who live in Washington State, are eligible to become members of the above named Credit Unions. The advantages of joining a Credit Union include paying lower interest rates on loans, Classic Money Market Accounts, Savings Plans, Check Overdraft Protection along with specific accounts just for children. If you’d like more information please contact the Business Office or the Credit Unions above.

Tax-Sheltered Annuity (TSA)
If you’d like more information on a TSA (also known as a Tax-Deferred Account or 403(b) plan) contact Elyssa Louderback at 360-538-2007.

Your maximum contribution levels are $18,000 if you’re under age 50 or $24,000 if you are over age 50 for 2015.

We are also offering a Roth IRA through VALIC. A Roth IRA is a individual retirement account where you pay taxes on your contributions and then all future distributions are tax free after certain conditions are met.

Further information on how a Roth IRA functions can be obtained from VALIC at 206-254-1000 or www.valic.com.

AFLAC Supplemental Insurance
AFLAC is supplemental insurance that pays in addition to other insurance. The benefits paid are paid directly to you, therefore you may spend them as you see fit. The types of insurance available are; Accident/Disability, Short Term Disability, Cancer, Personal Recovery Plus and Dental.

AFLAC benefits are voluntary, payroll deducted benefits. If you are interested in any of the above coverages, contact :

Debbie Carter-Bowhay
(360) 500-9411.
Helpful Information

The information on the following pages is presented for your information. If you have any questions on this information, please contact Cindy Lee at 360-538-2011.

Family Medical Leave Act of 1993 (FMLA)

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

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

COBRA and Continuation of Coverage

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

Cindy Lee
Aberdeen School District
216 North G St
Aberdeen, WA 98520
360-538-2011

It is very important that you notify your employer regarding any change in your status such as; change in address, becoming eligible for Medicare, divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child. For changes in address or becoming eligible for Medicare, you must notify your employer immediately. For divorce, separation, and over-age dependent children, you must notify your employer within 60 days of the change in status. Please contact Cindy Lee at 360-538-2011 for the form(s) that may need to be filled out.

School Employees Retirement Systems

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

Department of Retirement Systems
800-547-6657
www.drs.wa.gov

Healthy Kids Now through Apple Health

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

Apple Health Hotline
1-877-KIDS-NOW
www.insurekidsnow.gov
Women’s Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women’s Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women’s Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

• All stages of reconstruction of the breast on which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
• Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

For more information regarding your rights after a mastectomy: [http://www.dol.gov/ebsa/publications/whcra.html](http://www.dol.gov/ebsa/publications/whcra.html)

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 Aberdeen School District (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 Aberdeen School District #5 in summary fashion so it can decide what coverages the Health Plan should provide.

• To Aberdeen School District #5 as Plan Sponsor. The Health Plan may disclose your health information to designated employees of Aberdeen School District #5 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.

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: Business Office, Aberdeen School District #5. 216 North G St Aberdeen, WA 98520. 360-538-2011
Washington State Deferred Compensation Program (DCP)

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

With DCP, you decide how much money you want deducted from each paycheck. That can be as little as $360 per year or as much as the annual legal maximum of $18,000 if you are under age 50 and $24,000 if you are over age 50 for 2017.

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 8:00-5:00 pm)
Email: dcpinfo@drs.wa.gov
Mail: PO BOX 40931 Olympia, WA 98504-0931

Shared Sick Leave Qualifications

Who may share their sick leave?

- Employees who have 22+ days of sick leave accrued after donation

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

- Yes, as long as the employee who is sharing their sick leave has 22+ days after their donation

What qualifications are required to receive shared sick leave?

- Employees who are requesting shared sick leave must have (and/or a member of their immediate family) a condition(s) that is “extreme and/or extraordinary”. An “extreme and/or extraordinary” condition(s) would include a medical condition(s), which if not treated, may result in severe consequences (i.e. death, permanent disability, etc.)

Examples of “extreme and/or extraordinary” conditions include some of the following:

- Cancer/Treatment of Cancer
- Major life threatening surgery
- Some mental disorders
- Medically necessary leaves due to injury and/or illness

Examples of conditions which DO NOT qualify for shared sick leave include some of the following:

- Broken bones
- Some mental disorders
- Flu
- Surgery that is not 100% medically necessary
- Maternity Leave

Each request for shared sick leave is determined on an individual basis. As stated above, your condition (and/or a member of your immediate family) must have an “extreme and/or extraordinary” condition, which if not treated, may result in severe consequences (i.e. death, permanent disability etc.).
Workers’ Compensation Self-Insurance Program

Aberdeen School District is a member of a self-insured cooperative under Washington State Workers’ Compensation Law. Washington State industrial insurance laws allow employers to cover for workers’ compensation under the State Fund or to self-insure. Aberdeen School District is one of 45 member school districts that have combined to form the ESB 113 Workers’ Compensation Trust cooperative. These 45 school districts are located in Washington state counties; Mason, Thurston, Lewis, Grays Harbor and parts of Pacific. The ESD 113 Trust is a self-administered self-insured entity. Both self-insured and State Fund systems pay exactly the same benefits and provide the same rights for insured workers. As a member of the self-insured cooperative, the Aberdeen School District assumes the cost of the actual medical charges and compensation expenses associated with an on-the-job injury or illness in the form of premium paid to the cooperative from district funds. Under the self-insured program, workers do not pay the medical aid premium.

If you sustain a work-related injury, the following steps are to be followed:

• Report the injury immediately to your supervisor (whether or not medical attention is required).
• Fill out the “Employee Incident Report” form. If you plan to seek medical treatment, call the ESD 113 at 360-464-6880. They will provide you with a claim number and will send you the “Self-Insurer Accident Report” (SIF-2). Your doctor will complete a “Physician’s Initial Report”.

In the case of an emergency, your supervisor or other Aberdeen School District official will ensure that the treating physician or emergency facility is informed that Aberdeen School District is self-insured through the ESD 113 Workers’ Compensation Trust Cooperative so that your claim can be processed properly. The Workers’ Compensation Trust makes time loss determinations using information provided, but not limited to the following:

• Doctor’s Certificate of Disability
• Release-for-Work slips
• Phone Calls
• Medical Reports
• Medical Progress Reports (SIF-2)

For questions about Workers’ Compensation, contact the ESD 113 at 360-464-6880.

Insurance Committee

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

If you are interested in participating on this committee, please contact Cindy Lee.

Your committee members are:

<table>
<thead>
<tr>
<th>Cindy Lee - Risk &amp; Benefits Manager</th>
<th>Alicia Henderson - Superintendent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jim Sawin - Director of Human Resources</td>
<td>Elyssa Louderback - Director of Finance</td>
</tr>
<tr>
<td>Debbie Copland - PSE</td>
<td>Lori Snyder - AEA</td>
</tr>
<tr>
<td>Carrie Erwin - AEA</td>
<td>Derek Cook - Principals</td>
</tr>
<tr>
<td>Lynn Green - Administrator</td>
<td>Patty Barber - Food/Transportation</td>
</tr>
<tr>
<td>Mike Toy County - City Rep</td>
<td>John Maki - Food/Transportation</td>
</tr>
<tr>
<td>Gayle Capsel - PSE</td>
<td></td>
</tr>
</tbody>
</table>
Grays Harbor County School Districts Group #AN 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 (Grays Harbor County School Districts Group #AN) (the “Plan”) is required by law to take reasonable steps to protect the privacy and confidentiality of your health information. This Notice describes the Plan’s privacy practices. The term “Protected Health Information” (PHI), as used in this Notice, includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, or electronic).

Section 1. Uses and Disclosures of PHI

Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Plan may tell a your vision care provider whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written authorization

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend’s involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

- When required by law, or for law enforcement purposes.
- When permitted for purposes of public health activities.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers or to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings.
- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.
- For research, subject to conditions.
- When authorized by and to the extent necessary to comply with workers’ compensation or other similar programs established by law.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures
You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

Right to Inspect and Copy PHI
You have a right to inspect and obtain a copy of your PHI contained in a designated record set, for as long as the Plan maintains the PHI.

Designated Record Set includes the enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.
Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You will be required to make request for amendment in writing and to provide a reason to support a request for amendment.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the effective date of this Notice.

The Right to Receive a Copy of This Notice Upon Request

To obtain a copy of this Notice, contact the person or office identified in section 5 below.

Section 3. The Plan’s Duties

The Plan is required by law to maintain the privacy of PHI, to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices, and to comply with the terms of this Notice.

This Notice is effective beginning April 14, 2003, however, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Plan’s compliance with legal regulations.

In addition, the Plan may use or disclose “summary health information” to the plan sponsor for obtaining premium bids or modifying, amending or terminating the plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits; and from which identifying information has been deleted.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the person or office identified in Section 5.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer:

Cindy Lee, Business Office
Aberdeen School District
216 North G Street
Aberdeen, WA 98520
(360) 538-2011
Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

**Specialty Medication** – Medications that treat serious health condition such as cancer and rheumatoid arthritis. They are complex and expensive, and may require intensive monitoring.
### Monthly Insurance Rates for 2017-2018

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>Regence High Option</th>
<th>Regence Innova 750</th>
<th>Regence Innova A or B</th>
<th>Regence Innova 2500</th>
<th>Regence HSA 1500*</th>
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<td>$1,106.51</td>
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<td>Employee &amp; Child(ren)</td>
<td>$1,381.85</td>
<td>$1,106.83</td>
<td>$939.12</td>
<td>$804.97</td>
<td>$841.01</td>
</tr>
<tr>
<td>Family</td>
<td>$2,270.93</td>
<td>$1,818.94</td>
<td>$1,543.36</td>
<td>$1,322.87</td>
<td>$1,301.69</td>
</tr>
</tbody>
</table>

*Your Regence HSA 1500 plan premiums include a $125 monthly contribution to your HSA.

### DENTAL

<table>
<thead>
<tr>
<th></th>
<th>WDS Incentive Plan A (AEA Certificated)</th>
<th>Willamette Dental (AEA Certificated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite/Family</td>
<td>$101.70</td>
<td>$78.40</td>
</tr>
</tbody>
</table>

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

### DENTAL

<table>
<thead>
<tr>
<th></th>
<th>Ameritas Dental (Admin. Principals, PSE &amp; Unaffiliated)</th>
<th>Willamette Dental Plan 1 w/ Ortho 4 (Admin, Principals, PSE &amp; Unaffiliated)</th>
<th>WA State Council of County &amp; City Employees (Custodians &amp; Maintenance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite/Family</td>
<td>$109.00</td>
<td>$89.45</td>
<td>$110.63</td>
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</tbody>
</table>

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

### VISION

<table>
<thead>
<tr>
<th></th>
<th>NBN Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite/Family</td>
<td>$22.00</td>
</tr>
</tbody>
</table>

Vision plan rates are composite rated just like our dental plans. The rate is the same if it’s just a single employee enrolled or an employee and his/her family.

2017-2018 State Allocation = **$820.00** for full time employees (varies depending on pooling outcome). From the above state allocation, Dental & Vision are deducted. The amount remaining, depending on pooling outcome, may be applies towards your medical premiums. **Please Note:** For Exclusions, Limitations and Clarifications, see the individual plan booklets. This comparison is not a contract.