Clover Park School District

Creating Promising Futures.

Benefit Handbook 2016-2017

Health and Wellness Fair

Wednesday, September, 14th

2:30pm – 6:00 pm

SSC Building

ENROLLMENT DEADLINE

August 22nd through September 30th for

November 1st, 2016 Coverage

This Benefit Handbook is only a brief description of your insurance coverage under the Clover Park School District benefits program. The provisions of the actual plan documents and contracts will govern in the case of any discrepancy. Please contact the Payroll Department with questions regarding this Benefit Handbook.

Dear Colleagues:

We are proud of the people behind the work, vision and passion for serving our students. The following pages describe the medical, dental, vision, disability, life and optional benefit coverage offered to you by the district. For the benefit year 2016/2017 we are faced with a number of changes. Along with premium changes, there are several changes to each Premera plan. Please review the following summary of changes on pages 5 and 6 for more details.

To help comply with the Affordable Care Act, this year Premera Plan 5 is no longer being offered by the district. If you are on Premera Plan 5 and do not make a plan selection during open enrollment, you will automatically be enrolled on Premera Plan 2.

There is a significant network change to the Easy Choice B and Basic plans that will limit the hospitals members have access to.

The Life and Disability programs are now all through The Standard at a significant cost savings. We made significant enhancements to the vision program this year as well.

We encourage your participation in this year's Health & Wellness Fair. We hope that employees take advantage of all of the vendor offerings this year!

The Health & Wellness Fair is on September 14th, 2016 in the Clover Park SSC Building from 2:30 to 6:00 p.m.

Thank you for the service you provide to our district, children, families, and fellow CPSD teammates. Here's to a GREAT 2016-2017 school year.

NOTICE OF PRIVACY PRACTICES

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.

This Notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (the "HIPAA Privacy Rules"). The HIPAA Privacy Rules are federal laws that seek to ensure the privacy and confidentiality of your health information. The HIPAA Privacy Rules require your employer (the "Plan") to take certain actions to protect the privacy of your health information. Protected Health Information means information related to a past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in written, electronic or any other form. This Notice has been prepared to advise you of the uses and disclosures of your Protected Health Information that may be made by the Plan and to advise you of your rights and the Plan's legal duties relating to the privacy of your Protected Health Information.

As an individual enrolled in the Plan, you should be aware that the Plan may have access to your Protected Health Information from time to time. The Plan may receive your Protected Health Information in a variety of ways. An example of how the Plan may receive this information is when your health care provider, such as your doctor or your hospital, submits bills for services rendered to you to be paid by the Plan. The law permits the Plan to use or disclose Protected Health Information to carry out "treatment," "payment" and other "health care operations". When the Plan makes uses or disclosures of your Protected Health Information for treatment, payment or health care operations purposes, the Plan is not required to notify you or obtain your Authorization.

For uses or disclosures of Protected Health Information that are not made for treatment, payment, or health care operations purposes and for which no exception regarding Authorization applies, the law requires the Plan to obtain your Authorization. You may revoke an Authorization at any time, but a revocation is not effective if the Plan has already reasonably relied on your Authorization to make a particular use or disclosure. Additionally, if you request that the Plan make use or disclosure of your Protected Health Information to a third party, the Plan may require that you sign an Authorization that permits the Plan to honor your request.

The Plan has the right to disclose your Protected Health Information to the Plan Sponsor, which is usually your employer, subject to certain limitations. The Plan may generally disclose to the Plan Sponsor information regarding whether you are enrolled in the Plan and "summary health information," which means information that summarizes the claims history and experiences of the individuals enrolled in the plan without specifically identifying you or other plan participants. The Plan may disclose this information without your Authorization, and the Plan Sponsor may only use the information for its activities relating its sponsorship of the Plan.

The Plan may communicate your Protected Health Information to you in a variety of ways, including by mail or telephone. If you believe that the Plan's communications to you by the usual means will endanger you or your health care and you would like the Plan to make its communications that involve Protected Health Information to you at an alternate location, you may contact the Plan's Privacy Officer to obtain the appropriate request form. The Plan will only accommodate reasonable requests and may require information as to how payment, if any, will be handled.

If you believe that the Plan has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules, you may file a complaint by contacting the Plan's Privacy Officer. You may send a letter outlining your complaint to the Privacy Officer. The Plan requests that you attempt to resolve your complaint with the Plan via these complaint procedures since the Plan is in the best position to respond to your complaint. However, if you believe the Plan has violated your privacy rights, you may also file a complaint with the Office of Civil Rights ("OCR") at the United States Department of Health and Human Services ("HHS"). You may contact the HHS OCR at: Medical Privacy, Complaint Division, Office of Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHS Building, Washington, D.C. 20201, Voice Hotline Number (800) 368-1019, Internet Address www.hhs.gov/ocr. It is against the policies and procedures of the Plan to retaliate against any person who has filed a privacy complaint, either with us or with HHS OCR. Should you believe that you are being retaliated against in any way upon your filing a complaint with us or the HHS OCR, please immediately contact the Plan's Privacy Officer, so that the Plan may properly address the issue.

CONTENTS

IMPORTANT

If you have had a change in your personal situation be sure to update your beneficiary information for both your life insurance and retirement plans. A W-4 review is also recommended if you need to change your federal tax withholding. Any of the following may necessitate a change:

- Marriage or divorce
- Birth or adoption of a child
- Loss of a dependent status
- Purchase of a new home
- Spouse starting or leaving employment
- Commencement or cessation of alimony payments
- Unexpected medical expenses
- Increased higher education expenses

Please pay attention to the WEA Premera Blue Cross plan in which you are enrolled. Price changes for the 2016-2017 plan year are different depending on the plan you choose.

This Benefit Handbook is not a Summary Plan Description (SPD). Always refer to the SPD issued by the insurance carrier for answers to specific questions.

While it is hoped that the plans summarized in this Benefit Handbook will continue indefinitely, your employer reserves the right to change or terminate any plan or plans in the future.

The Employer reserves the right to interpret, revise, supplement or rescind all or any portion of the Employee Benefit Handbook at any time at the employer's discretion.

You must exhaust all claim appeal remedies outlined in the carrier's Master Group Contract before pursuing further/other legal action.

Each carrier retains discretionary authority to administer their program according to the terms of their Summary Plan Description.

All health care services must meet medical criteria as determined by the carrier.

CUSTOMER SERVICE DIRECTORY

If you have questions, a representative at the numbers below may be able to help.

Medical Coverage	Premera Blue Cross (# WEA8000034) (Rx # BCWAPDB) Group Health (#1219600)	(800) 932-9221 www.premera.com/wea (800)391-9701 (Rx customer service) Nurse Hotline (800) 841-8343 (888) 901-4636 www.ghc.org Nurse Hotline (800)297-6877
Dental Coverage	Delta Dental of Washington (# 0186) Willamette Dental (WA44 direct or WEA400/WA288 WEA) MetLife Dental (KM05985290)	(800) 554-1907 www.deltadentalwa.com/wea (855) 433-6825 www.willamettedental.com (800) 275-4638 www.metlife.com
Vision Coverage	Vision Service Plan (#07108133)	(800) 877-7195 www.vsp.com
Group Life & Accident Coverage Voluntary Term Life Coverage	Standard Insurance (#161961)	(800) 284-7858 www.standard.com
Income Replacement • Long Term Disability insurance • Short Term Disability insurance	Standard Insurance (#161961)	(800) 284-7858 www.standard.com
Flexible Spending Accounts	Navia (formerly Flex-Plan Services) (# CLO)	(425) 452-3500 or (800) 669-3539 www.naviabenefits.com
Employee Assistance Plan	The Standard (Company ID standard, password eap4u)	(888) 293-6948 www.eapbda.com
Department of Retirement • TRS • SERS • PERS • Deferred Compensation	WA State Department of Retirement Systems	(800) 547-6657 www.drs.wa.gov (800) 327-5596 www.drs.wa.gov/dcp
403(b) Administrator • ROTH	Omni	(877) 544-OMNI www.omni403b.com
Benefits Advisor	OneDigital Jessica Carr Toni Gore	(888) 858-5115 / www.onedigital.com jcarr@onedigital.com tgore@onedigital.com
Payroll Department	Julie Mondry Jeanne Strong Sandy Ellis Anita Casiano	Ext. 5121 Payroll Supervisor Ext. 5122 Payroll Lead Ext. 5124 Payroll Specialist Ext. 5120 Payroll Specialist

NOTABLE CHANGES TO BENEFITS

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

OPEN ENROLLMENT

Those who wish to change their enrollment must notify Payroll before September 30th. Changes are effective 11/1/16. Access Your Benefits Resources at http://resources.hewitt.com/wea (or call 1-855-668-5039) to complete enrollment for Premera, Delta Dental of Washington and Willamette plans.

PREMERA BLUE CROSS

- Plan 5 is no longer offered. Those who are on Plan 5 will automatically be moved to Plan 2 if no selection is made during open enrollment. For questions regarding impacts to previously met deductible and out-of-pocket maximum please contact Premera Blue Cross.
- Easy Choice B now uses the Prime Network. Please check the Premera website for your provider listings.
- **EASY CHOICE B AND THE BASIC PLAN WILL NOT INCLUDE FRANCISCAN OR PROVIDENCE/SWEDISH IN THE NETWORK AS OF 1/1/17.**
- Deductibles and out-of-pocket maximums are increasing on most plans.
- Office visit copays for specialists are increasing on most plans
- Mail Order Pharmacy copays are increasing on most plans.
- Easy Choice A diagnostic lab and x-ray is changing from the first $1,000 covered in full to the first $250 subject to coinsurance, then 80% after deductible.
- Outpatient Rehabilitation, Massage Therapy and Occupational Therapy treatments now require prior authorization through EviCore.
- Please see next page for additional plan changes

GROUP TERM LIFE AND LONG TERM DISABILITY

- Group Term Life Carrier is changing from Mutual of Omaha to The Standard on 10/1/16.
- Long Term Disability Carrier is changing from Dearborn to The Standard on 10/1/16.

VOLUNTARY SHORT TERM DISABILITY

- Short Term Disability Carrier is changing from Mutual of Omaha to The Standard on 10/1/16.
- The Standard will cover 60% of your loss of income (up to a maximum of $1,400 weekly). Sick leave can only be used to cover up to the remaining 40% of your salary when on claim.

DELTA DENTAL

- Delta Dental will now cover composite fillings rather than amalgam fillings.

VSP

- Frame allowance and contact lens allowance increasing from $130 to $150
- Progressive and Anti-reflective coating now covered in full at VSP provider
- Separate Contact Lens fitting fee not to exceed $60 at VSP provider

2016-2017 COST CHANGES

VSP Vision	Significant benefit enhancements resulted in a rate increase. See page 22 for details
MetLife Dental	No Change
Delta Dental of Washington (WEA)	1.5% decrease
Willamette Dental Willamette Dental (WEA)	No change No change
The Standard (Group Term Life)	28.6% decrease
The Standard (Long Term Disability)	10% decrease
The Standard (Vol Short Term Disability)	No change
Premera Blue Cross	0.7% to 13.8% increase
Group Health Cooperative	2.64% increase

Benefit Dollars and Rate Worksheet

The state benefit allocation will first be used to pay for base Life/AD&D and Long Term Disability Plans, then the balance can be used to help pay for Vision, Dental, and Medical coverage. No portion of the state allocation or pooling dollars can be applied to the purchase of other voluntary insurance programs.

(Certificated Staff) FTE Benefit Allocation

Contract FTE	Hours Per Day	Benefit Allocation
0.4	3.00	$312.00
0.5	3.75	$390.00
0.6	4.5	$468.00
0.7	5.25	$546.00
0.8	6	$624.00
0.9	6.75	$702.00
1.0	7.5	$780.00

(Classified Staff) FTE Benefit Allocation

Hours Per Day	Benefit Allocation
2.1 – 5.99	$390.00
6.00 – 8.00	$780.00

Retiree Carve-out is $64.39

IMPORTANT CHANGES FOR 2016/2017

ENROLLMENT DEADLINE IS SEPTEMBER 30TH

Open enrollment is the time for you to make changes to your medical, dental and vision plans for the 2016/2017 plan year. You must make changes no later than September 30th. There is **no** opportunity to make changes to your plan after that date. This is important if you wish to add/drop a dependent who is not currently enrolled on your plan or move to a different plan.

Online enrollment system – There is one open enrollment period this year. Those who want to change their enrollment must go online before September 30th. Access Your Benefits Resources at http://resources.hewitt.com/wea (or call 1-855-668-5039) to complete enrollment for Premera, Delta Dental of Washington and WEA (CPEA/IUOE) Willamette Dental plans. Changes are effective 11/1/16.

Flexible Spending Plan – Flex Plan contract year runs from 11/1/16 through 10/31/17. Those making to change their enrollment must notify Payroll before October 31st. Your plan offers a carryover feature for your health FSA. This feature allows you to roll over up to $500.00 of unused health FSA funds to the following plan year. Unused funds from the 11/1/16 through 10/31/17 plan year will be applied to the 2017 plan year following the end of the claims run-out period. The carryover feature does not apply to unused daycare FSA funds.

More information on these changes will be available at the Health & Wellness Fair on September 14th. For help, you may also contact the Payroll Department (ext. 5120) or our benefit broker, OneDigital. Jessica Carr and Toni Gore are the district's contact at OneDigital and may be contacted at 253-858-5115 or jcarr@onedigital.com or tgore@onedigital.com.

Specific Plan Changes

Along with the overall changes on the previous page, the following plan changes will be in effect 11/1/16:

PREMERA PLAN 2

- Deductible increasing from $200 to $300 individual and from $600 to $900 family
- Office visit copay increasing from $25 to $30 for specialists.
- Out-of-pocket maximum increasing from $1,700 to $2,000 individual and from $5,100 to $6,000 family
- Mail order pharmacy copay increasing from $15 to $20 generic, from $30 to $40 preferred brand and from $45 to $65 non-preferred brand.

PREMERA PLAN 3

- Deductible increasing from $300 to $500 individual and from $900 to $1,500 family
- Office visit copay increasing from $30 to $40 for specialists.
- Out-of-pocket maximum increasing from $2,950 to $3,000 individual and from $8,850 to $9,000 family
- Mail order pharmacy copay increasing from $20 to $30 generic, from $35 to $50 preferred brand and from $50 to $70 non-preferred brand.

PREMERA EASY CHOICE PLAN A

- Deductible increasing from $1,000 to $1,250 individual and from $3,000 to $3,750 family
- Office visit copay increasing from $15 to $25 Primary Care Physician and from $15 to $35 for specialists.
- Diagnostic lab and x-ray changing from the first $1,000 covered in full then 80% after deductible to first $250 covered at 80% deductible waived, then 80% after deductible
- Generic pharmacy copay increasing from $5 to $10
- Mail order pharmacy copay increasing from $10 to $20 generic, from 25% to 30% preferred brand and non-preferred brand.

PREMERA EASY CHOICE PLAN B

- **NOW USES THE PRIME NETWORK WHICH WILL NOT INCLUDE FRANCISCAN OR PROVIDENCE/SWEDISH IN THE NETWORK AS OF 1/1/17.**
- Office visit copay increasing from $30 to $40 for specialists.

PREMERA BASIC PLAN

- **THE PRIME NETWORK WILL NOT INCLUDE FRANCISCAN OR PROVIDENCE/SWEDISH IN THE NETWORK AS OF 1/1/17.**
- Deductible increasing from $1,250 to $2,100 individual and from $2,500 to $4,200 family
- Office visit copay increasing from $30 to $35 Primary Care Physician and from $30 to $50 for Specialists.
- Out-of-pocket maximum increasing from $4,500 to $6,600 individual and from $9,000 to $13,200 family (including Rx).
- Rx deductible increasing from $500 to $750 individual and from $1,000 to $1,500 family
- Rx copay increasing from $45 to $50 non-preferred brand
- Mail order pharmacy copay increasing from $15 to $30 Generic and from $90 to $100 non-preferred brand.

PREMERA HIGH DEDUCTIBLE HEALTH PLAN

- Deductible increasing from $1, 500 to $1,750 individual and from $3,000 to $3,500 family
- Out-of-pocket maximum increasing from $4,000 to $5,000 individual and from $8,000 to $10,000 family. Insurance will pay 100% of cost of coverage for an individual once they've met the individual out-of-pocket maximum.

ENROLLMENT INFORMATION

BENEFIT ELIGIBILITY

Insurance plans for newly eligible employees hired on or before the 15th of the month will be effective on the first day of the month following date of hire. If hired after the 15th of the month plans are effective the first of the next month following 30 days. Employees must complete all enrollment forms and return to Payroll for benefits to become effective.

> For example: If an employee is hired on September 2nd, coverage will be effective October 1st. If an employee is hired on September 16th, coverage will be effective November 1st.

Employees must work at least 10 days in a month to be eligible for benefits.

OPEN ENROLLMENT

September 1st through September 30th is your Open Enrollment period. During Open Enrollment you may choose the benefit plans for yourself and eligible dependents. Benefit or enrollment changes made by September 30th are effective November 1st. Please call the Payroll Department for more information.

INSURANCE OPEN ENROLLMENT DEADLINE FOR CHANGES

August 22nd - September 30th

November 1st effective date

Flexible Spending Account paperwork due on October 31st for a November 1st plan year.

REQUIRED ACTIONS PRIOR TO THE ENROLLMENT DEADLINES:

If you are currently enrolled and wish to keep your current plans, *no action is required*.

Flexible Spending Accounts must be renewed yearly. The deadline to submit paperwork to Payroll is October 31st.

If you wish to change Medical or Dental plans, add or delete dependents, or change coverages:

1. For Premera, Delta Dental of Washington and WEA Willamette plans you must access Your Benefits Resources at http://resources.hewitt.com/wea (or call 1-855-668-5039)
2. For Group Health, MetLife, non-WEA Willamette and VSP plans, return completed enrollment forms to the Payroll Department by September 30th for November 1st coverage. Complete the online enrollment process by September 30th for Premera, Delta Dental of Washington and WEA Willamette plans for November 1st coverage. If you fail to return your enrollment forms by the appropriate deadlines, your current benefit elections will continue throughout the 2016-2017 benefit plan year.

CHANGING YOUR ELECTIONS AFTER OPEN ENROLLMENT

Once Open Enrollment is over on September 30th, you cannot change your elections unless you have a legally defined "change in status", such as:

- You get married or divorced;
- You add a dependent child to your family through birth or adoption;
- An enrolled family member dies;
- You or your spouse go on an unpaid leave of absence;
- You or your spouse have a change in employment status (for example, you go from part-time to full-time or vice versa);
- You waived medical coverage for yourself or your family members because you were enrolled in other medical plan coverage – and you lose that other coverage for certain reasons.
- If you or your dependents declined coverage when you were eligible to enroll in the group plan you may subsequently apply for coverage in the event that the Department of Social and Health Services (DSHS) has determined that it is cost-effective to enroll you or your eligible dependents in your employer's medical plan. Applications must be submitted within 60 days following the determination by DSHS.

To initiate a change, you must complete the enrollment process within 30 days of the change (60 days for newborns and adoption). Coverage begins the first day of the month following the change in family status (newborns are effective date of birth).

WHO IS ELIGIBLE?

Employees who work 2.1 hours or more per day have up to 30 days to elect and submit completed enrollment forms to Payroll from the first day of either 1) date of hire or 2) return from unpaid leave, or 3) rehired employee who had a break in coverage.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (Mandatory)

GROUP LIFE INSURANCE

Group Life/Accidental Death and Dismemberment (AD&D) insurance is offered by The Standard. This benefit is mandatory for all contracted employees. The benefit maximum is dependent on your bargaining unit.

	Benefit Amount		Cost per Month
	Basic Life	**AD&D**	
Classified/Certificated	$ 50,000	$ 50,000	$7.50

ADDITIONAL FEATURES

Accelerated Benefit: If you have a medical condition which is diagnosed by a doctor as life threatening and which results in an expected life span of 12 months or less, you may elect to receive a portion of your life insurance benefit immediately. (Does not apply to those age 60 and older.)
Accidental Dismemberment Definition: If due to an accident a member loses a hand, a foot or the sight in an eye, the member will receive half of the AD&D benefit.
Age Reduction: Benefits are reduced for those aged 65 and over. Benefit reductions apply based on age.
Waiver of Premium: You may be able to continue Life insurance until age 65, without payment of premium, if you become Totally Disabled while insured under the Policy prior to age 60. It is the employees' responsibility to file a request for waiver of premium.

VOLUNTARY TERM LIFE INSURANCE (EMPLOYEE PAID)

Voluntary Life is an optional benefit through The Standard and is available in increments of $10,000. Spouse coverage is equal to half of employee supplemental coverage. Employees may purchase amounts to $50,000, spouse to $20,000 and children to $10,000 without answering health questions. Benefits will reduce based on a schedule beginning at age 70.

Benefit Amount

Employee Supplemental Life	Rates are determined based upon the age of the employee ($500,000 maximum, not to exceed 5 times your basic annual earnings)
Spouse Supplemental Life	Rates are determined based up on the age of the spouse (50% of employee election amount to $100,000 maximum)
Children (to age 26 regardless of student status)	$0.40 for $2,000; $1.00 for $5,000; $2.00 for $10,000

Age	Employee rate per $10,000	Spouse rate per $10,000	Age	Employee rate per $10,000	Spouse rate per $10,000
0-29	$0.62	$0.98	55-59	$6.92	$9.28
30-34	$0.72	$1.12	60-64	$9.01	$14.48
35-39	$0.90	$1.36	65-69	$15.71	$25.32
40-44	$1.43	$2.10	70-79	$34.73	N/A
45-49	$2.51	$3.58	80 +	$89.48	N/A
50-54	$4.24	$5.94			

Please note that if the application is received more than 30 days after your initial employment date, The Standard reserves the right to decline coverage and/or bill for medical testing. If you and your spouse work for the same employer and are both eligible for this insurance as employees, you cannot cover each other as dependents and only one of you may insure any dependent children.

DISABILITY INSURANCE (Mandatory / Voluntary)

Disability benefits offer income in situations where you are unable to work due to accident or illness. A brief description of the benefits follows:

Voluntary Short Term Disability - The Standard will cover 60% of your loss of income (up to a maximum of $1,400 weekly). Sick leave can only be used to cover up to the remaining 40% of your salary when on claim.

PRINCIPALS/ESPCP/CLASSIFIED/NON-BARGAINING/CERTIFICATED/IUOE/CPEA

Your Long Term Disability benefits are offered by The Standard and are mandatory. Your Short Term Disability benefits are offered by The Standard on a voluntary basis.

	Mandatory Long Term: The Standard (District Paid)	**Voluntary Short Term: The Standard (Employee Paid)**
Eligibility	10.5 hrs per week minimum	17.5 hours per week minimum
Minimum Benefit	$100 per month	$25 per week
Maximum Benefit	$6,000 per month	$1,400 weekly benefit
Covered Earnings	60% of pre-disability earnings	Not to exceed 66 2/3% of regular monthly earnings
Waiting Period	90 Days	7th day accident; 7th day illness
Benefit Period	To normal Social Security retirement age	13 weeks
Monthly Cost:	.00351 times base monthly salary	See calculation below:

SHORT TERM DISABILITY (STD) CALCULATOR Monthly Premium & Weekly Benefit Amounts			
	Step	Example	Your Calculation
1.	Annual Base Salary	$47,332.00	
2.	66 2/3% of Annual Base Salary	0.6666	0.6666
3.	Multiply Line 1 by Line 2	$31,551.51	
4.	Divide Line 3 by 52 (weeks per year)	$606.76	
5.	Maximum Weekly Benefit Amount (cannot exceed $1,400)	*$1,400.00*	*$1,400.00*
6.	Enter lesser of Line 4 or Line 5. This is your weekly STD benefit	$606.76	
7.	Divide Line 6 by 10	$60.68	
8.	Multiply Line 7 by $0.69. This is your Monthly Premium	$41.87	

A pre-existing waiting period may apply when first enrolling on the plan. A pre-existing condition means any injury or sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken prior to the day you become insured under the policy.

MEDICAL BENEFIT COMPARISON (Voluntary)

Rates	Group Health Cooperative Managed Care		WEA Premera Blue Cross Select Plan 2	
Employee Only	$ 907.77		$ 979.90	
Employee & Spouse	$1,660.86		$1,793.75	
Employee, Spouse & Child	$1,991.08		$2,150.55	
Employee, Spouse & Children	$1,991.08		$2,150.55	
Employee & Child	$1,211.71		$1,308.40	
Employee & Children	$1,211.71		$1,308.40	
BENEFITS AT A GLANCE				
Provider Network	Except as noted, all care and services must be approved by and provided through GHC staff or contracted facilities		To receive the benefit shown below you must use a provider from the Premera **Heritage Provider network**	
Annual Deductible (Deductibles run on a calendar year)	$200 per individual / $400 per family		$300 per individual / $900 per family per calendar year	
Office Calls and Urgent Care	$20 copay		$25 copay, $35 copay specialist	
Out-of-pocket Maximum (Out-of-pocket maximums run on a calendar year)	$2,000 per individual / $4,000 per family (Includes deductible, coinsurance and copays)		$2,000 per individual / $6,000 per family (Includes deductible, coinsurance and medical copays)	
Out-of-Network Benefits	Not covered		$30 copay, $40 copay specialist. Services generally covered at 60% of allowed amount after deductible. Out-of-pocket maximum $3,400 individual / $10,200 family	
Prescription Drugs	Retail	Mail Order	Retail	Mail Order
Annual out-of-pocket maximum			$2,000 individual / $4,000 family	
Generic	$10	$30	$10	$20
Preferred Brand Name	$20	$60	$20	$40
Non-Preferred Brand Name			$35	$65
Specialty Rx			$50 copay 30-day supply	
Days Supply	30	90	34	100
Spinal Manipulations (Chiropractic)	$20 copay, deductible applies; 10 visit limit		$25 copay, unlimited	
Diagnostic X-Ray / Lab	Covered in full after deductible (High-end imagery requires prior authorization)		80% after deductible	
PREVENTIVE CARE				
Well Child Care	Covered in full		Covered in full	
Routine Physicals	Covered in full		Covered in full	

*HDHP – Individual out-of-pocket maximum applies to each individual, the entire family amount does not have to be met
All benefits are paid on a calendar year basis.

MEDICAL BENEFIT COMPARISON (Voluntary)

WEA Premera Blue Cross Select Plan 3	WEA Premera Blue Cross Qualified High Deductible Health Plan
$ 895.85 $1,640.10 $1,966.50 $1,966.50 $1,196.30 $1,196.30	$ 516.80 $ 938.05 $1,108.40 $1,108.40 $ 685.30 $ 685.30
To receive the benefit shown below you must use a provider from the Premera **Heritage Provider network**	To receive the benefit shown below you must use a provider from the Premera **Foundation Provider network** (does not include Seattle Cancer Care Alliance)
$500 per individual / $1,500 per family per calendar year	$1,750 if enrolled as employee only / $3,500 if enrolled as employee and dependent per calendar year
$30 copay, $40 copay specialist	80% after deductible
$3,000 per individual / $9,000 per family (Includes deductible, coinsurance and medical copays)	$5,000 if enrolled as employee only / $10,000 if enrolled as employee and dependent (Includes deductible, and coinsurance)*
$40 copay, $50 copay specialist. Services generally covered at 60% of allowed amount after deductible. Out-of-pocket maximum $5,900 individual / $17,700 family	Generally covered at 50% after separate $3,000 individual / $6,000 family deductible. No out-of-pocket maximum applies. Preventive screenings covered at 50%.
Retail Mail Order $2,000 individual / $4,000 family $15 $30 $25 $50 $40 $70 $60 copay 30-day supply 34 100	80% after deductible Retail – 30-day supply Mail Order – 90-day supply
$30 copay, unlimited	80% after deductible, 12 visit limit
80% after deductible	80% after deductible
Covered in full	Covered in full
Covered in full	Covered in full

before benefits will pay at 100% for an individual member.

MEDICAL BENEFIT COMPARISON (Voluntary) cont.

	Group Health Cooperative Managed Care	WEA Premera Blue Cross Select Plan 2
HOSPITAL		
Inpatient Care	Covered in full after deductible	80% after deductible and $150 per day copay ($450 maximum copays collected per calendar year)
Emergency Care	$75 copay; deductible applies	80% after deductible and $75 copay
OTHER BENEFITS		
Acupuncture	$20 copay, deductible applies; 8 visits per medical diagnosis	$25 copay, 12 visits per calendar year
Ambulance Services	80%	80% after deductible
Chemical Dependency	Inpatient: covered in full after deductible Outpatient: $20 copay, deductible applies	Inpatient: 80% after deductible and $150 inpatient copay per day ($450 maximum copays collected per calendar year) Outpatient: $25 copay
Maternity	$20 copay per visit, delivery covered in full after deductible	80% after deductible; $150 copay per day ($450 maximum copays collected per calendar year)
Mental Health	Inpatient - covered in full after deductible Outpatient - $20 copay, deductible applies	Inpatient – 80% after deductible and $150 copay per day ($450 maximum copays collected per calendar year) Outpatient - $25 copay per visit
Naturopathic	$20 copay, deductible applies; 3 visits per medical diagnosis	$25 copay, unlimited
Outpatient Surgery	$20 copay, deductible applies	$100 copay and 80% after deductible
Rehabilitation (includes Physical Therapy)	$20 copay, deductible applies; 60 visit limit	Inpatient: 80% after deductible and $150 inpatient copay per day ($450 maximum copays collected per calendar year), 120 maximum days Outpatient: $35 copay, 45 visit limit Physical Therapy: 80% after deductible, unlimited
Dependents covered to age	26 regardless of student or marital status	26 regardless of student or marital status
Organ Transplant Waiting Period	None	None
Life Insurance	None	$12,500
Deductible Carryover	Not Included	Deductible met in Nov/Dec will carryover to the next year

MEDICAL BENEFIT COMPARISON (Voluntary) cont.

WEA Premera Blue Cross Select Plan 3	WEA Premera Blue Cross Qualified High Deductible Health Plan
80% after deductible and $300 per day copay ($900 maximum copays collected per calendar year)	80% after deductible
80% after deductible and $100 copay	80% after deductible
$30 copay, 12 visits per calendar year	80% after deductible, 12 visit limit per calendar year
80% after deductible	80% after deductible
Inpatient: 80% after deductible and $300 inpatient copay per day ($900 maximum copays collected per calendar year) Outpatient: $30 copay	80% after deductible
80% after deductible; $300 copay per day ($900 maximum copays collected per calendar year)	80% after deductible
Inpatient – 80% after deductible and $300 copay per day ($900 maximum copays collected per calendar year) Outpatient - $30 copay per visit	80% after deductible
$30 copay, unlimited	80% after deductible, unlimited
$150 copay and 80% after deductible	80% after deductible
Inpatient: 80% after deductible and $300 inpatient copay per day ($900 maximum copays collected per calendar year), 30 maximum days Outpatient: $40 copay, 45 visit limit Physical Therapy: 80% after deductible, unlimited	Inpatient: 80% after deductible, 30 maximum days Outpatient: 80% after deductible, 15 visit limit
26 regardless of student or marital status	26 regardless of student or marital status
None	None
$12,500	$12,500
Deductible met in Nov/Dec will carryover to the next year	Not Included

MEDICAL BENEFIT COMPARISON – PREMERA WEA EASYCHOICE & BASIC (Voluntary)

RATES	WEA Premera Blue Cross Select Plan EasyChoice A
Employee Only	$ 659.70
Employee & Spouse	$1,198.70
Employee, Spouse & Child	$1,436.35
Employee, Spouse & Children	$1,436.35
Employee & Child	$ 875.30
Employee & Children	$ 875.30
BENEFITS AT A GLANCE	
Provider Network	To receive the benefit shown below you must use a provider from the Premera **Heritage Provider network**
Annual Deductible (Deductibles run on a calendar year)	$1,250 per person/$3,750 per family
Office Calls and Urgent Care	$25 copay, $35 copay specialist
Out-of-pocket Maximum (Out-of-pocket maximums run on a calendar year)	$4,000 per person/$8,000 per family (Includes office visit copays, deductible and coinsurance)
Out-of-Network Benefits	$2,000 per person / $6,000 per family deductible; then covered at 50%. No out-of-pocket maximum
Prescription Drugs	
Deductible (Deductibles run on a calendar year)	$500 per person
Out-Of-Pocket Maximum (based on a calendar year)	$2,500 individual / $5,000 family
Retail	
Generic	$10 copay (deductible waived)
Preferred Brand Name	30% after deductible
Non-Preferred Brand Name	30% after deductible
Specialty Drugs	30% after deductible
Days Supply	30 day supply
Mail Order	
Generic	$20 copay (deductible waived)
Preferred Brand Name	30% after deductible
Non-Preferred Brand Name	30% after deductible
Days Supply	90 day supply
Spinal Manipulations (Chiropractic)	$25 copay, 12 visit limit
Diagnostic X-Ray / Lab	First $250 covered at 80%, then 80% after deductible
PREVENTIVE CARE	
Well Child Care	Covered in full
Routine Physicals	Covered in full

*The Prime Network will not include Providence/Swedish or the Franciscan Health System as of 1/1/17.
All benefits are paid on a calendar year basis.

MEDICAL BENEFIT COMPARISON – PREMERA WEA EASYCHOICE & BASIC (Voluntary)

WEA Premera Blue Cross Select Plan EasyChoice B	**WEA Premera Blue Cross Basic Plan**
$ 659.70 $1,198.70 $1,436.35 $1,436.35 $ 875.30 $ 875.30	$ 532.55 $ 966.80 $1,158.20 $1,158.20 $ 706.25 $ 706.25
To receive the benefit shown below you must use a provider from the Premera **Heritage PRIME Provider network***	To receive the benefit shown below you must use a provider from the Premera **Heritage PRIME Provider network***
$750 per person/$2,250 per family	$2,100 per person/$4,200 per family
$30 copay, $40 copay specialist	$35 copay, $50 copay specialist
$3,500 per person/$7,000 per family(Includes deductible and coinsurance and medical copays)	$6,600 per person/$13,200 per family(Includes deductible, coinsurance and Rx)
$1,500 per person / $4,500 per family deductible, then covered at 50%. No out-of-pocket maximum	$2,500 per person / $5,000 per family deductible, then covered at 50%. No out-of-pocket maximum
$250 per person $2,500 individual / $5,000 family $5 copay (deductible waived) $30 copay after deductible $45 copay after deductible 30% after deductible 30 day supply $10 copay (deductible waived) $75 copay after deductible $112 copay after deductible 90 day supply	$750 individual / $1,500 family shared with medical out-of-pocket maximum $15 copay after deductible $30 copay after deductible $50 copay after deductible 30% after deductible 30 day supply $30 copay after deductible $60 copay after deductible $100 copay after deductible 90 day supply
$30 copay, 12 visit limit	$35 copay, 12 visit limit
75% after deductible	70% after deductible
Covered in full	Covered in full
Covered in full	Covered in full

MEDICAL BENEFIT COMPARISON – PREMERA WEA EASYCHOICE (Voluntary) cont.

	WEA Premera Blue Cross Select Plan EasyChoice A
HOSPITAL	
Inpatient Care	80% after deductible
Emergency Care	80% after deductible and $100 copay
OTHER BENEFITS	
Acupuncture	$25 copay, 12 visit limit per calendar year
Ambulance Services	80% after deductible
Chemical Dependency	Inpatient: 80% after deductible Outpatient: $25 copay
Maternity	80% after deductible
Mental Health	Inpatient: 80% after deductible Outpatient: $25 copay
Naturopathic	$25 copay
Outpatient Surgery	80% after deductible
Rehabilitation (includes Physical Therapy)	Inpatient: 80% after deductible, 30 day limit Outpatient: $35 copay, 30 visit limit
Dependents covered to age	26 regardless of student or marital status
Organ Transplant waiting period	None
Life Insurance	$12,500
Deductible Carryover	Deductible met in Nov/Dec will carryover to the next year

MEDICAL BENEFIT COMPARISON – PREMERA WEA EASYCHOICE (Voluntary) cont.

WEA Premera Blue Cross Select Plan EasyChoice B	WEA Premera Blue Cross Basic Plan
75% after deductible	70% after deductible
75% after deductible and $150 copay	70% after deductible and $200 copay
$30 copay, 12 visit limit per calendar year	$35 copay, 12 visit limit per calendar year
75% after deductible	70% after deductible
Inpatient: 75% after deductible Outpatient: $30 copay	Inpatient: 70% after deductible Outpatient: $35 copay
75% after deductible	70% after deductible
Inpatient: 75% after deductible Outpatient: $30 copay	Inpatient: 70% after deductible Outpatient: $35 copay
$30 copay	$35 copay
75% after deductible	70% after deductible
Inpatient: 75% after deductible, 45 day limit Outpatient: $40 copay, 45 visit limit	Inpatient: 70% after deductible, 30 day limit Outpatient: $50 copay, 30 visit limit
26 regardless of student or marital status	26 regardless of student or marital status
None	None
$12,500	$12,500
Deductible met in Nov/Dec will carryover to the next year	Deductible met in Nov/Dec will carryover to the next year

IMPORTANT INFORMATION REGARDING PREMERA QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

During open enrollment you may enroll on the Premera QHDHP medical plan and participate in the Navia (formerly Flex-Plan Services) Health Savings Account (HSA) tax-advantaged bank savings account. When looking at this option the following are some important things to know:

In order to open an HSA tax advantaged bank savings account:

1. You must be enrolled in the District's High Deductible Health Plan insurance plan.
2. You may not be covered by any additional non-HDHP insurance plan, including unlimited Flexible Spending Arrangement (no double-coverage through a spouse's plan).
3. You must not be eligible to be claimed as a tax dependent by another person.
4. You must be under age 65 and not entitled to Medicare.

Important Items to Note:

1. If you enroll with any dependents covered on the plan, the individual deductible does not apply. Only the family deductible applies (even if only one person enrolled accesses care).
2. You will receive a Premera Blue Cross ID card for the HDHP medical plan which you will give to the provider at the time of service. You will also have a debit card for the HSA bank account which you can use to pay any out-of-pocket expenses. You must give the healthcare provider your Premera Blue Cross ID card first so that expenses will be applied towards your deductible for the year.
3. The IRS sets limits for how much you can contribute to the HSA bank account in a calendar year. For 2017 the limits increase to $3,400 for Individual (self only) and $6,750 for Family. For 2016 the limits are $3,350 Individual (self-only) and $6,750 Family. (There is a tax penalty if you over-contribute to the HSA). If you are over 55 you can contribute an additional $1,000 as a catch-up contribution. (As long as you are enrolled on the plan as of December 1, 2016, you may contribute up to the full annual limit for 2016, however you must remain on the HDHP through December 1, 2017.)
4. Distributions from your HSA account must be for IRS 213(d) medical expenses (see eligible expenses).
5. An administrative fee of $2.00 per month will automatically be deducted from the account. When you are on the HSA plan you can also participate in the Flexible Spending Plan (FSA) but on a limited basis. The FSA plan can be used only for dependent care expenses and expenses related to Orthodontia, Dental, Vision and Preventive care for yourself, spouse or dependents.
6. Investment opportunities are available once the balance in the HSA account reaches $1,000.

ELIGIBLE EXPENSES FOR FLEXIBLE SPENDING ACCOUNTS AND HEALTH SAVINGS ACCOUNTS

(Refer to IRS Publication 969 for a complete listing)

Acupuncture
Adaptive equipment (e.g. raised toilet seat)
Ambulance fees
Bandage tape
Bandages
Blood pressure monitor
Braces (knee, ankle, wrist)
Breast pumps & supplies
Chiropractic services
Co-insurance
Contact lens solution
Contacts
Contraceptives
Copays and deductibles
CPAP machine
Crutches
Dental services (excludes veneers and other cosmetic procedures)
Diabetes testing supplies
Diabetic supplies
Doctor visits
Doula services (must be licensed and some postpartum doula expense are excluded)
Drug addiction treatment
Eye drops
Eye exams
Fertility treatment
Flu shots
Hearing aid supplies
Hearing aids
Home medical equipment
Hormone therapy
Hypnosis
Individual Counseling
Lab work
Lactation consultants
Lamaze
Laser eye surgery
Medical abortion
Medical alert bracelet & current year membership fees
Mileage (to receive medical care)
Non-cosmetic surgery
Naturopathic Visits
Occupational Therapy
Orthotics
Physical exams
Physical therapy
Pregnancy test
Prenatal vitamins
Prescription drugs
Prescription glasses
Psychotherapy
Reading glasses
Saline Nasal Spray
Service animals
Speech Therapy
Sterilization procedures
Sunscreen SPF 30 or greater (proof of SPF required)
Thermometer
Vaccinations
Walker
Wheelchair & repair
X-rays

OVER-THE-COUNTER MEDICINES AND DRUGS REQUIRING A PRESCRIPTION:

Allergy medication
Analgesics
Antacids
Anti diarrheal
Antibiotic ointment
Antifungal foot cream
Anti-gas medication
Anti-itch cream/gel
Antiseptic
Asthma relief
Burn cream
Chloraseptic sprays
Cold Sore Treatment
Cold/cough medication
Diaper rash ointment
Ear Wax Removal Kits
First aid supplies
Hemorrhoid medication
Hydrogen Peroxide
Ipecac syrup
Lactose intolerance pills
Laxative
Lice Treatment Products
Motion Sickness pills/bracelet
Pain relievers
Parasitic Treatment
Rubbing Alcohol
Smoking cessation products
Stool softener
Throat lozenges
Urinary Tract Infection Treatments
Wart treatment

OTHER MEDICAL INSURANCE OPTIONS

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

INDIVIDUAL MEDICAL COVERAGE OPTIONS

In some instances, you may be able to insure your dependent spouse and/or dependent children for medical coverage less expensively by applying for an individual medical policy. The Washington Healthplanfinder "The Marketplace" is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 15, 2016 for coverage starting January 1, 2017. Depending upon income, some people may receive paid-in-full insurance coverage through the Department of Social and Health Services (DSHS.). Applications must be submitted within 60 days following the determination by DSHS.

To talk with someone about individual medical plans, or if you or your spouse is 65 to review Medicare plans you can contact Jill Krueger at 253-341-4393 When calling, mention that you are a CPSD employee.

STATE SPONSORED COVERAGE

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

APPLE HEALTH FOR KIDS PROGRAM

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

Qualification for the APPLE HEALTH FOR KIDS program is as shown below:

The Family's Income is:	**Up to 200% of "federal poverty level"***	**250% of "federal poverty level"***	**300% of "federal poverty level"***
Examples of Qualifying Income Levels	For a family of 2 people, 200% of federal poverty level is $2,804 monthly. For a family of 4, 200% is $4,253 monthly.	For a family of 2 people, 250% of federal poverty level is $3,471 monthly. For a family of 4, 250% is $5,265 monthly.	For a family of 2 people, 300% of federal poverty level is $4,166 monthly. For a family of 4, 250% is $6,318 monthly.
Monthly Cost to the Family	Free	$20 per child per month ($40 per month maximum).	$30 per child per month ($60 per month maximum).

Notes:

- Income is figured on gross monthly wages minus $90 per person working. Monthly childcare expenses (and child support payments for a child not living in the home) may also be deducted from monthly income when determining eligibility.
- A pregnant woman counts as a family size of two. Other programs with different eligibility requirements are available for families and pregnant women.

If you have questions Apple Health for Kids and other programs you might qualify for, please call **877- 543-7669**.

CHIPRA NOTIFICATION

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

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

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

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

WASHINGTON – Medicaid

Website: www.wahealthplanfinder.org
Phone: 1-855-923-4633

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

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

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

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

VISION BENEFITS (Voluntary)

BENEFIT FREQUENCIES

Examinations	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months

	VSP PROVIDER	NON-VSP PROVIDER
Rate (covers employee and all dependents)	$19.66 per month	
$25 COPAY APPLIES TO EXAM AND HARDWARE		
Examination	Covered in full	Up to $50 allowance
Lenses		
Single Vision Lenses	Covered in full	Up to $50 allowance
Lined Bifocal Lenses	Covered in full	Up to $75 allowance
Lined Trifocal Lenses	Covered in full	Up to $100 allowance
Lenticular Lenses	Covered in full	Up to $125 allowance
Progressive Lenses	Covered in full	Not covered
Anti-reflective Coating	Covered in full	Not covered
Frames	$150 allowance	Up to $70 allowance
Contact Lenses		
Necessary	Covered in full	$210 allowance
Elective (in lieu of lenses and a frame)	$150 allowance for contacts and contact lens exam	$105 allowance
	Contact lens exam and fitting fee copay is no more than $60.	

To obtain a list of VSP member doctors call VSP at **800-877-7195**, or visit their website at **www.vsp.com**. VSP does not distribute ID cards. To receive benefits from a member doctor, call a participating provider and identify yourself as a VSP member and provide the doctor's office with the covered employee's social security number, date of birth and employer's name. The member doctor will call VSP to verify eligibility and plan coverage.

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

VSP Claims
PO Box 997105
Sacramento, CA 95899-7105

Note: Some non-participating vision providers will submit claims directly to VSP on your behalf, including Wal-Mart, Sam's Clubs and some Costco locations.

Your individual benefit information is available to view at **www.vsp.com**. Once you are registered, you can view when to schedule your next eye exam as well as when you are eligible for new frames and lenses or contact lenses.

HEARING AID DISCOUNT PROGRAM

TruHearing MemberPlus Membership is available to all VSP members and their covered dependents.

The program includes:

- Members save up to $1,300 per hearing aid purchase
- 3 visits with hearing professional after purchase of hearing aids for fitting, adjustments, and cleanings.
- 3-year repair warranty
- 48 batteries per purchased hearing aid.

To learn more visit www.truhearing.com
or call 877-372-4040

DENTAL BENEFITS - Principals/ESPCP/Non-Bargaining (Voluntary)

	METLIFE DENTAL	WILLAMETTE DENTAL
Rate		
Employee	$ 70.96	$ 66.65
Employee and Spouse	$141.09	$124.25
Employee and Child	$141.09	$124.25
Employee and Children	$231.66	$124.25
Employee, Spouse and Child	$231.66	$181.45
Employee, Spouse and Children	$231.66	$181.45
Provider Network	Use any licensed dentist. Use of a MetLife PPO Network dentist may provide additional benefits.	Use a Willamette Dental Group Provider.
Annual Individual Benefit Maximum	$2,250 per calendar year	No maximum benefit, except TMJ
Annual Deductible	$25 individual ($75 family maximum)	None
Diagnostic and Preventive Care – Exams, x-rays, cleanings, sealants, fluoride application	Covered at 100%	100% after $10 copay ($30 copay for Specialty office visit)
Routine Care – Fillings, oral surgery, root canals, periodontics, endodontics, extractions	Covered at 100%	100% after $10 copay
Crowns	Covered at 100%	100% after $10 copay
Dentures, Bridges, Partials	Covered at 50%	100% after $10 copay
Implants	Covered at 50%	Not covered
Emergency Treatment	Covered as any other service	Covered after $50 copay or up to $100 for out-of-area emergency treatment.
Orthodontia	50% to $1,000 lifetime maximum (for dependents to age 26)	Treatment paid in full after co-pay of $400. $10 office visit copays apply
TMJ	Not covered	$1,000 annual maximum, $5,000 lifetime maximum
Definition of Dependent Children	To age 26 regardless of student or marital status	To age 26 regardless of student or marital status

Note for **MetLife new enrollees**:

Late entrant waiting period applies for anyone coming on the plan outside of open enrollment without prior coverage (6 months for Fillings, 12 months for Basic Services, 24 months for Major Services and Orthodontia). Those coming on during the annual open enrollment period do not have to satisfy the late entrant waiting period.

Note for **Willamette Dental** subscribers:

- Office visit copays are waived after three consecutive years of being on the Willamette Dental plan (except for Orthodontia). You must request the waiver of copays; it is not automatic in Willamette's computer system. (Emergency Treatment copays still apply.)
- Willamette Dental is an exclusive provider network. Benefits are covered under a Willamette Dental group provider. To find a provider in your area, please visit their website at www.willamettedental.com or call 1.855.433.6825 to speak to a member services representative.

DENTAL BENEFITS - IUOE/CPEA (Mandatory)

	Delta Dental of Washington Core Dental Plan (IUOE and CPEA)	Willamette Plan 1 (IUOE/Certificated)
Rate (covers employee and all eligible dependents)	$118.35	$82.85
Provider Network	Use any licensed dentist. Use of Delta Dental of Washington member dentists provides the best benefits.	Use a Willamette Dental Group Provider.
Annual Individual Benefit Maximum (Plan year runs 11/1-10/31)	$1,750 ($2,000 if Delta Dental of Washington PPO Provider is seen)	No maximum benefit, except TMJ
Annual Deductible	None	None
Diagnostic and Preventive Care – Exams, x-rays, cleanings, sealants, fluoride application	70% year 1, 80% year 2, 90% year 3, 100% year 4	100% after $15 copay
Routine Care – Fillings, oral surgery, root canals, periodontics, endodontics, extractions	70% year 1, 80% year 2, 90% year 3, 100% year 4	100% after $15 copay
Crowns	70% year 1, 80% year 2, 90% year 3, 100% year 4	100% after $50 copay and $15 office visit copay
Dentures, Bridges, Partials	50%	100% after $50 copay and $15 office visit copay
Implants	50%	Not covered
Emergency Treatment	70% year 1, 80% year 2, 90% year 3, 100% year 4	Covered after $15 copay.
Orthodontia	50% to $1,000 lifetime benefit maximum	Treatment paid in full after co-pay of $2,000 and $15 office visit copays.
TMJ	50% up to $1,000 per year, $5,000 lifetime maximum	$1,000 annual maximum, $5,000 lifetime maximum
Definition of Dependent Children	To age 26 regardless of student or marital status	To age 26 regardless of student or marital status

DELTA DENTAL OF WASHINGTON

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

WILLAMETTE DENTAL

Willamette Dental does not contract with local independent dental offices, and instead offers the use of company owned clinics in certain locations. You may have to travel to another Willamette Dental office for some services.
If you have a concern about your Willamette Dental service, ask to speak to the dental Office Manager or email your concerns to memberservices@willamettedental.com.

OTHER BENEFITS

GUIDANCE RESOURCES EAP

EVERYONE NEEDS A LITTLE HELP NOW AND THEN
Change can create stress. Routine can create stress. Life is full of challenges and surprises, ups and downs, highs and lows. It's natural to sometimes feel like there's just too much to handle. You're not alone.

YOUR EAP PROGRAM CAN HELP
Easy to find confidential assistance is available every hour of every day. This service is offered by your employer at no cost to you.

HOW TO ACCESS HELP - CALL (888) 293-6948 and reference Company ID is standard, password is eap4u

You can call the toll free number any time, day or night, to speak confidentially with a trained, compassionate professional. If after speaking with one of the licensed clinicians you decide that you would benefit from seeing a counselor face-to-face, you will receive a referral to a provider in your area. Each family member can receive up to three face-to-face visits per calendar year, in addition to the unlimited telephone resources.

You can also access information through their website at www.eapdbda.com with Company ID is standard, password is eap4u.

VEBA

VEBA accounts are used to reimburse out-of-pocket healthcare costs and premiums for yourself, spouse and dependents.

The VEBA plan saves you money in that your contribution amounts go in tax-free, any investment earnings are tax-free and the claim reimbursements are tax-free.

Withdrawals can only be made for qualified out-of-pocket expenses (such as copays, deductible, prescriptions, etc.) and premiums (such as Long Term Care, Medicare Part B, Medicare Part D and Medicare supplement plans).

For more information call 800-422-4023 or visit the website at www.veba.org.

OTHER BENEFITS – CONTACTS

Department of Retirement Systems
Website: www.drs.wa.gov
Phone: 360.664.7000 or 800.547.6657
TTY phone: 711
Email: recep@drs.wa.gov

Deferred Compensation Program (DCP)
Website: www.drs.wa.gov/dcp
Phone: 888.327.5596
Email: dcpinfo@drs.wa.gov

Empower Retirement
Website: www.drs.wa.gov/Plan3
Phone: 888.327.5596
Email: savewithwa@empower-retirement.com

Social Security Administration (SSA)
Website: www.socialsecurity.gov
Phone: 800.772.1213

Internal Revenue Service (IRS)
Website: www.irs.gov
Phone: 800.829.1040

Public Employees Benefits Board (PEBB)
Website: www.hca.wa.gov/pebb
Phone: 360.725.0440 or 800.200.1004

SECTION 125 PLAN / FLEXIBLE SPENDING ACCOUNTS

PLAN YEAR CHANGES

Your election period now runs from 11/1/16 through 10/31/17. Enrollment forms will be sent out in October to eligible employees (10.5 hour per week). Forms are due back to the Payroll Department by 10/30/16.

Your plan offers a carryover feature for your health FSA. This feature allows you to roll over up to $500.00 of unused health FSA funds to the following plan year. Unused funds from the November 1, 2016 through October 31, 2017 plan year will be applied to the 2017 plan year following the end of the claims run-out period. The carryover feature does not apply to unused daycare FSA funds.

PREMIUM CONVERSION PLAN

Clover Park School District's premium conversion plan allows employees to avoid Social Security and Federal Income Tax on monthly amounts that are deducted for group insurance premiums (medical, dental, vision and life). Payroll will automatically adjust your monthly contribution for qualifying insurance premiums from an "after-tax" to a "pre-tax" basis. There are no forms to fill out. Participation in the program is automatic.

HEALTHCARE FLEXIBLE SPENDING ARRANGEMENT

This program allows the enrollee to avoid taxes on many medical, dental and other health care expenses that are not paid for by medical insurance, buy using pre-tax dollars to pay for healthcare expenses. Your contribution will be deducted from your paycheck on a pre-tax basis in equal amounts for the plan year. You may set aside **up to $2,500** each plan year in your Healthcare Flexible Spending Arrangement through automatic payroll deductions.

Eligible Expenses

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

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

Non-eligible Expenses

- Expenses reimbursed through any insurance policy or plan
- Expenses incurred before you enroll in the plan
- Expenses you claim as a deduction or credit for income tax purposes

DEPENDENT CARE FLEXIBLE SPENDING ARRANGEMENT

The Dependent Care Flexible Spending Arrangement is a tax-effective way to pay for childcare or other dependent care services that enable you or you and your spouse to work outside the home. You may use this account to pay for eligible daycare expense incurred for:

- A child up to age 13 for whom you claim a deduction on your income tax form; or
- A spouse or disabled dependent age 13 or older (your parent, for instance) who is physically or mentally incapable of self-care, who normally spends at least eight hours in your home each day, and for whom you pay more than half the cost of support.
- Eligible daycare expenses include costs for nursery schools, daycare providers, babysitters and other types of daycare. A provider cannot be another dependent of yours, such as an older child. Nursery schools and daycare centers must comply with state and local regulations if their expenses are to be eligible for reimbursement.

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

Dependent Care Flexible Spending Arrangement vs. the Dependent Care Tax Credit

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

SECTION 125 PLAN / FLEXIBLE SPENDING ACCOUNTS (cont.)

EXAMPLE OF TAX SAVINGS WITH FLEXIBLE REIMBURSEMENT ACCOUNTS

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

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

THE FLEXICARD

The FlexiCard is a debit card for the Healthcare Flexible Spending Account. The card will pay for expenses at qualified merchant locations where MasterCard® is accepted. The FlexiCard enables you to pay for eligible expenses directly from your account so you don't have to wait for reimbursement.

The Flexible Spending Account is electronically debited whenever you use the card. IRS regulations still require you to send documentation to verify the eligibility of the expense. You'll receive a special claim form designed specifically for your FlexiCard swipes. This form is pre-populated with your information, service dates and transaction amounts. You can obtain these forms and additional information from the Payroll Department.

PLAN RULES

The IRS requires that you use all the money you contribute to your account or forfeit the remainder at the end of the plan year. Federal tax law says that any money left in your account at the end of the plan year must be forfeited. Also known as the "Use it or lose it" provision. Your plan offers a carryover feature for your health FSA. This feature allows you to roll over up to $500.00 of unused health FSA funds to the following plan year. Unused funds from the November 1, 2016 through October 31, 2017 plan year will be applied to the 2017 plan year following the end of the claims run-out period. The carryover feature does not apply to unused daycare FSA funds.

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

Medical and dental care expenses from a given year can only be paid with money deposited in your account that same year. You have 90 days from the end of the plan year to submit claims.

Making Changes

Your selection will be effective for the entire plan year. The plan year is November 1st through October 31st.

You may change your benefit selection during the plan year within 31 days of a qualifying event. These changes include: marriage, legal separation or divorce, birth, adoption or change in custody of a minor child, change in your spouse's employment status, death of your spouse or child, change between full-time and part-time status by an employee or spouse, unpaid leave of absence by employee or spouse, or significant change in coverage of employee or spouse due to spouse's employment.

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

Making Claims

When you incur an eligible expense during the year, file a request for reimbursement form (available from the Payroll Department). Enclose documentation from your provider that indicates what type of service was done, when the service was incurred and how much it cost.

403(b) INVESTMENT OPPORTUNITIES

This information is intended to provide employees of Clover Park School District with information regarding Internal Revenue Code ("IRC") Section 403(b). Omni is the firm to sign up for your 403(b) benefits. You can reach them at 1-877-544-OMNI or www.omni403b.com.

The 403(b) plan is often referred to as a TSA or a Tax Sheltered Account. The plan is named after the IRS code 403(b) which governs it.

If the employee is eligible, they can fund a 403(b) plan of their choice by authorizing the District to reduce their monthly salary on a pre-tax basis and to contribute that amount on their behalf to the vendor they have chosen. The employee's 403(b) plan can be a contract that is issued by an insurance company or a custodial account offered through a bank, credit union, savings and loan association, broker or mutual fund company that is invested in mutual funds. Generally, an employee's contributions to their 403(b) and the earnings are not taxed to the employee until they are distributed from the vendor, usually at retirement.

Employees who call with questions will be encouraged to obtain and read IRS Publication 571. They should also be advised to consult with a tax specialist prior to completing a salary reduction agreement. The decision whether to invest, how much to invest and which company to invest with is the employee's responsibility.

Note: To start an investment plan, you must have an established account or open an account with one of the approved companies, An approved vendor list is on page 29. Forms can be accessed on the Clover Park School District website (Department \ HR \ Employee Benefits \ 403(b) Plan) Once the account is established, the employee and the vendor representative must sign a Salary Reduction Agreement Form to submit to Sandy Ellis in the Payroll Department.

ROTH

A designated ROTH account is a separate 403(b) plan that allows the employee to set aside after-tax income up to a specified amount each year (follows 403(b) limits). Eligible distributions from the account (including earnings) are generally tax-free.

The OMNI Group is our third party administrator.

OMNI Group
Water Tower Park
1099 Jay Street, Building F
Rochester, NY 14611-1153
www.OMNI403b.com
877-544-OMNI (6664)

403(b) INVESTMENT VENDORS

NAME OF VENDOR	CONTACT NAME	PHONE NUMBER
Ameriprise Financial Services, Inc.	Lisa Nyen / Rich Anaya Scott Buser / Wain Miller / Thomas Baker	612-678-5787 / 206-322-6629 253-472-8200
*AXA Equitable	Justin Cyckler / Patrick Hyde / Nick Maguda / Brian Searle	206-956-6285 / 256-956-6275 / 256-956-6275 / 315-477-4140
*Commonwealth Annuity & Life Insurance Company	Greg Nelson / Dan Grimshaw	253-473-0656
*First Investors Corporation	Joe Cameron / Robert Leonardi / Jeffrey Downer / Dina Fassilis / Nicole Reif / Greg Nelson / Dan Grimshaw	732-855-2500 / 732-855-2500 / 425-251-9445 / 800-423-4026 / 800-394-6620 / 253-473-0656 / 253-473-0656
*Great American Financial Resources Inc.	Greg Nelson / Dan Grimshaw / Gary Weston / Ken Behm / Rich Anaya	253-473-0656 / 253-473-0656 / 888-315-5796 / 253-640-8437/ 206-322-6629
*Horace Mann Companies	Jason Shrum / James Perry	866-999-1945 / 253-365-4067 / 253-377-1726
*ING	Ken Behm	253-640-8437
*Lincoln Investment Planning Inc.	Greg Nelson / Dan Grimshaw / Rich Anaya	253-473-0656 / 206-322-6629
Mass Mutual Financial Group		800-767-1000
*MetLife		800-560-5001
*Oppenheimer Funds	Retirement Plans / Greg Nelson / Dan Grimshaw / Ken Behm	800-327-6143 / 253-473-0656 / 253-473-0656 / 253-640-8437
*Plan Member Service Corp		1-800-874-6910
*Security Benefit Group of Companies	Purchase Department / Greg Nelson / Dan Grimshaw / Ken Behm / Bryce Griffith	800-888-2461 / 253-473-0656 / 253-473-0656 / 253-640-8437 / 800-888-2461 ext 2799
*Symetra Financial	Ken Behm / Stephen Whittier	253-640-8437 / 253-988-8550
*The Variable Annuity Life Ins. Co. (VALIC)	William R. Pandiani	253-224-3112
Thrivent Financial for Lutherans	Julianne Fagerstrom / William Graves / Jonathan Edmonds / Maynard Hedegaard	800-847-4836
Waddell & Reed Financial Services	Alice Fowler / Beth Tribwell / Duane Cofer	913-236-1541 / 360-754-2725 / 360-692-0980
*Western United Life Assurance Company	Retirement Plans / Greg Nelson / Dan Grimshaw	800-247-2045 / 253-473-0656 / 253-473-2045

*ROTH available

WASHINGTON STATE DEPARTMENT OF RETIREMENT SYSTEMS (DRS)

RETIREMENT PLANNING "TO DO" LIST

- If you are within 10 to 15 years of retiring, plan to attend a retirement planning seminar every five years.
- If you have ever withdrawn your contributions, check with DRS to see if you can restore the contributions, and if so, what the benefit would be to you (this must be done in writing).
- Check your beneficiary listed with DRS, and if needed update. (This must be done in writing.)
- Two years prior to retiring, make sure your birth evidence, your spouse's birth evidence, and (if appropriate) your marriage evidence is in order.
- Within two years of retirement, attend a DRS Rights and Benefits presentation. Check with your employer on setting up a presentation for yourself and your co-workers.
- At age 61½ check on your Social Security benefits.
- During the year before your retirement, visit DRS and consult with a retirement benefits specialist to make sure your file is in order. Call to make an appointment.
- The last year before your retirement, check on your medical insurance as a retiree. Those under the Washington Health Care Authority program will get the forms from DRS. All others should check with their employer for insurance information.

Contact DRS at (800) 547-6657 or visit their website at www.drs.wa.gov and click on Member Services.

DEFERRED COMPENSATION

The Deferred Compensation Program (DCP (http://www.drs.wa.gove/dcp)) is an Internal Revenue Code (IRC) Section 457 program that provides an opportunity for employees to set aside pretax dollars into a supplemental retirement account. Deferred compensation is an agreement between employee and employer to postpone part of the employee's income until separation from service.

DCP is a supplemental retirement savings program offered by DRS to public employees at no cost.

Amounts deferred are held in trust by the Washington State Investment Board (http://www.sib.wa.gov/) for the exclusive benefit of program participants and their beneficiaries. Income deferred reduces the taxable income reported on the employee's Form W-2 for the calendar year in which it was deferred.

Any state employee (full time, part time, working a regular schedule or career seasonal) and any elected or appointed official of the State is eligible to participate.

Start savings with as little as $30 per month, low fees, tax savings, portability, and no penalties for early withdrawals.

To enroll, complete the Participant Agreement in the Plan Choice Booklet or go to www.drs.wa.gov/dcp.

RETIREMENT PLANNING CHECKLIST

The earlier you begin planning for retirement, the better prepared you will be. If you haven't already sought financial planning advice, now is a great time. The checklist below can help you successfully transition into retirement. You might be able to increase your retirement income or even retire sooner than you had planned.

1-2 years before retirement

- Sign up to access your retirement account at www.drs.wa.gov. If you are a Deferred Compensation Program (DCP) and/or Plan 3 member, you can also view your defined contribution account(s) through online account access.
- Review your plan handbook for retirement eligibility rules.
- Use online account access to verify the accuracy of your service credit. If you find information you think is incorrect, contact DRS.
- Use the Online Benefit Estimator to estimate your future monthly benefit.
- If interested, sign up for DCP or another employer-sponsored voluntary retirement plan. You might also consider using a "catch-up" savings option, if your chosen plan offers one.
- If interested, contact DRS to find out whether you're eligible to purchase optional service credit.
- Plan for health care coverage during retirement. Note options that are available to you.
- Contact your employer to find out whether it participates in a health reimbursement arrangement with the Voluntary Employees' Beneficiary Association (VEBA).
- Register for a retirement seminar or watch a seminar video online.*

3-12 months before retirement

- Request an official estimate of your monthly benefit payment. You can do this securely through online account access or by calling DRS.
- Complete payment of any outstanding optional service credit invoices.
- Ask your employer about which health care coverage options are available to you when you retire. If you are covered by the Public Employees Benefits Board (PEBB) Program, or will be after you retire, contact PEBB Benefit Services.
- Decide when you should apply for Medicare and retirement benefits available through the Social Security Administration (SSA).

30-90 days before retirement

- Contact DRS if you need to make changes to your official estimate (for example, you want to change your retirement date or survivor option).
- Apply for retirement through online account access.
- Look over your acknowledgment letter to make sure it's accurate. This important letter summarizes the key options you picked. It also tells you which forms still need to be turned in so DRS can process your retirement application.
- Pay any outstanding optional service credit invoices.
- If you have Plan 3, decide when you want to begin receiving payments from your defined contribution account once you retire. Contact ICMA-RC to talk about your options.
- If you're eligible for PEBB health care, send your PEBB retiree coverage election form to the Health Care Authority (HCA).
- If you are a DCP member, consider contacting DCP to learn about deferring lump sum payments for any unused leave.
- Tell your employer your intended retirement date.

At and during retirement

- Make sure the retirement information on your benefit letter is correct. You will receive this letter once DRS calculates your monthly benefit.
- If you have a PEBB health plan, contact PEBB Benefit Services with any questions you have about health plan premium deductions.
- Keep your address and beneficiary information current with DRS.
- Enjoy your retirement!

403(b) Universal Availability Notice

The Opportunity
You have the opportunity to save 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.
We recommend that all employees view a brief, 3-minute video presentation called, '403(b). Why me?' explaining a 403(b) plan, and how to contribute. The video can be viewed on OMNI's website at www.omni403b.com.

How Can I Participate?
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 view on OMNI's website after submitting your Employer's name and state.

How Much Can I Contribute Annually?
You may contribute up to $18,000 for tax year 2016; this amount is subject to change annually. If you have at least 15 years of service with your employer or you are at least 50 years old, you may be entitled to make additional contributions. For appropriate limits for your particular circumstances, please contact OMNI's Customer Care Center at 877-544-6664.

What If I Already Have An Account?
If you are already contributing to the Plan, and you want to change your contribution amount or investment provider, simply complete and submit a new SRA. See directions above for on-line and paper submission options.

What If I Do Not Want To Contribute?
If you do not want to take advantage of this program, simply submit an SRA with the option "I do not wish to participate at this time" selected. See directions above for on-line and paper submission options.

How Can I Get More Information?
You can access further information at www.omni403b.com.

FAMILY AND MEDICAL LEAVE ACT

NOTIFICATION

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

FMLA applies to all employees who have:

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

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

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

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

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

A SERIOUS HEALTH CONDITION IS DEFINED AS

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

EMPLOYEE RESPONSIBILITIES

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

IT IS IMPORTANT TO REMEMBER

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

COBRA GENERAL NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan if tour hours of employment are reduced, or your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan if your spouse dies; your spouse's hours of employment are reduced; your spouse's employment ends for any reason other than his or her gross misconduct; your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or you become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because the parent-employee dies; the parent-employee's hours of employment are reduced; the parent-employee's employment ends for any reason other than his or her gross misconduct; the parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); the parents become divorced or legally separated; or the child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: the District Payroll office.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation

coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Jeanne Strong
Payroll Office
10903 Gravelly Lake Dr SW, Lakewood, WA 98499
253-583-5122

WORKERS' COMPENSATION FILING INFORMATION

IF A JOB INJURY OR DISEASE OCCURS:
Clover Park School District is subject to Washington Industrial Insurance laws and has been approved by the state to cover its own workers' compensation benefits. Self insured employers must provide all benefits required by law. The Department of Labor and Industries regulates your employer's compliance with these laws. If you become injured on the job or develop an occupational disease, you will be entitled to industrial insurance benefits. Your claim will be handled and your benefits paid by your employer.

IN CASE OF INJURY OR DISEASE:
REPORT YOUR INJURY OR DISEASE to your supervisor. Your employer will provide you with a "Self Insured Accident Report" (SIF-2). You must complete this form with your employer if you seek medical treatment.
GET MEDICAL CARE. *You have the right to go to the doctor of your choice.* Complete a "Physician's Initial Report" form at your doctor's office. Have your doctor mail this form to your employer's claims administration address listed below. The claims administrator will evaluate your claim for benefits. All medical bills that result from an allowable on the job injury or occupational disease will be paid by your employer. You may be entitled to wage replacement or other benefits. Your employer will explain this to you.

Clover Park School District
Attn: Loss Control Specialist
10903 Gravelly Lake Dr SW
Lakewood, WA 98499-1314
253-583-7357
(or district mail to "Attn: Loss Control")

IMPORTANT:
Your employer cannot deny you the right to file a claim, and your employer cannot penalize you or discriminate against you for filing a claim. Every worker is entitled to worker's compensation benefits for any injury or illness that results from his/her job.
Any false claim filed by a worker may be prosecuted to the full extent of the law.
If you have any questions or concerns, contact your employer's representative (at the claims administration address or phone number below), or call the Department of Labor and Industries, Self Insurance Section at 360-902-6901.

WOMEN'S HEALTH & CANCER RIGHTS

REGARDING THE WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

Under federal law, group health plans and health insurance issuers providing benefits for a mastectomy must also provide, in connections with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation between the attending physician and the patient.

These benefits may be subject to annual deductibles and coinsurance provisions that are appropriate and consistent with the other benefits under your plan or coverage.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered by your employer's medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Premera Blue Cross coverage will be affected. If you do decide to join a Medicare drug plan and drop your Premera Blue Cross coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact Payroll for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).


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