Nooksack Valley
Employee Benefit Guide

Important Open Enrollment Information

Open Enrollment Period:

- Enrollment/Change forms must be turned in to the District Office. New staff and staff returning from annual leave need to turn in forms by September 7th for coverage start date of October 1st. The majority of staff need to turn in forms by September 28th for coverage date of November 1st (start of the new benefit contract year).
- WEA Select Plans (Delta Dental of WA and Willamette Dental) open enrollment date begins Aug 24th. Plans can be viewed at http://digital.alight.com/wea/ .

Benefits Fair

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

Date: Thursday, August 30th 2018
Time: 2:30 PM - 5:00 PM
Location: Nooksack Valley High School Commons
3326 E. Badger Rd
Everson, WA 98247

2018-2019 School Year

If you are unable to attend the Nooksack School District Benefits Fair, many of our vendors will be attending the following Whatcom County School District benefits fairs.

Bellingham School District: Wednesday, August 22nd, 2:00 PM - 6:00 PM
Bellingham High School 2020 Cornwall Ave. Bellingham, WA 98225

Blaine School District: Tuesday, August 28th, 7:30 AM - 8:30 AM
Blaine Middle / High School Cafeteria 975 H St. Blaine, WA 98234

Ferndale School District: Wednesday, August 22nd, 1:00 PM - 4:00 PM
Vista Middle School Cafeteria 6051 Vista Dr. Ferndale, WA 98248-0428

Lynden School District: Thursday, September 6th, 2:30 PM - 5:00 PM
Lynden High School Cafeteria 1203 Bradley Rd. Lynden, WA 98264

Meridian School District: Tuesday, August 28th, 3:30 PM - 5:30 PM
Meridian High School 194 W. Laurel Rd. Bellingham, WA 98226-9699

Mount Baker School District: Monday, August 27th, 2:30 PM - 5:00 PM
Mount Baker High School 4936 Deming Rd. Deming, WA 98244-0095

Premera, Aetna, UHC, Kaiser Medical Plans Only: Monday, August 27th, 2:00-6:00 pm
Sehome High School – 2700 Bill McDonald Parkway, Bellingham, WA 98226

Premera Blue Cross and Kaiser Plans Only: Monday, September 17th, 3:30-6:00 pm
Fisher Elementary School – 501 N. 14th St, Lynden, WA 98264

Premera Blue Cross and Kaiser Plans Only: Tuesday, September 18th, 3:30-5:30 pm
Mt. Baker High School Commons - 4936 Deming Road, Deming, WA 98244

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

Welcome to Your Benefits!

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

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

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Enrolling or Making Changes to your Benefits

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

You have the following time periods to enroll:

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

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

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

Types of Qualifying Events

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

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

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

Dropping Coverage

You may only drop coverage for yourself and/or dependents after open enrollment if there is a qualifying event as defined under Section 125. Please contact Human Resources/Payroll for additional information.

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

The information herein is not a contract. It is a summary of the benefits available. It is not intended to be an all-inclusive description of Plan benefits, limitations or exclusions, and should not be used in lieu of a Plan book. Be sure to consult your Plan booklet available in the Payroll Office, or consult with the insurance company representative before making your selection. If there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets prevail. For questions regarding plan features or options, please contact Emily Austin at The Partners Group (877-455-5640 ext. 2311). For questions regarding current coverage, please contact your current carrier's representative listed in this brochure. This summary was printed on August 14, 2018. Any information not provided by that time or revisions by bargaining units or by insurers after this date could change or modify the information contained herein

Major Insurance Plan Changes for 2018-2019

State Allocation for Benefits

Employee benefits allocation depends on your bargaining group.

All Regence Blue Shield Plans Have Been Discontinued

Plans Offered by Premera Blue Cross

- Heritage Plus Plan 3 (most comparable to Regence Innova 500)
- Heritage Plus EasyChoice A (most comparable to Regence Innova 1000)
- Heritage Plus EasyChoice B (most comparable to Regence Engage 70)
- Heritage Plus Basic Plan (most comparable to Regence Innova 2500)
- Heritage Plus QHDHP Plan (most comparable to Regence HSA 2.0)

Kaiser Permanente - Welcome 500 Plan

- Premium rates increased 10.43%.

Willamette Dental Group

- Premium rates increased 5.8%

Delta Dental of Washington

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

Northwest Benefit Network

- No changes in plan benefits or premium rates.

Cigna

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

Medical Insurance

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

Preferred Provider Organization (PPO)

These type plans contact with a large number of providers. If you chose to receive your care through an in-network provider, the insurance company will pay a higher percentage of the charges. If you chose to receive your care through an out-of-network provider, then the insurance company will pay a lower percentage of the charges.

Your PPO plan options are available through Premera.

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

High Deductible Health Plan (QHDHP)

These type plans operate almost like the PPO plans. If you choose to receive care through a preferred provider, the insurance company will pay a higher percentage of the charges than if you receive care from a non-preferred provider. ***Unlike a PPO plan, the deductible must be satisfied before the QHDHP plan will pay for any care (except preventive care), including prescriptions. Also, unlike a PPO plan, if there is more than one person enrolled on your plan, the family deductible must be satisfied before the plan will pay benefits (except for preventive care) for any enrolled member.*** **However, a single member on family coverage will not pay more than $5,000 OOPM for annual cost sharing. When a single member on family coverage reaches the $5,000 OOPM, benefits will be paid at 100% of the allowed amount for that member.**

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

Your QHDHP plan option is available through Premera and is the QHDHP plan.

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

Health Maintenance Organization (HMO)

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

Your HMO plan option is available through Kaiser Permanente.

To find a Kaiser Permanente provider, visit www.kp.org.

Special Note about Hospitals and Emergency Rooms

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

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

Things to be Aware of Regarding Your Medical Plans:

Plan Year vs. Contract Year

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

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

Changing from One Provider to Another

When changing to a Kaiser plan from another carrier, Kaiser WILL CREDIT deductibles met in 2018 (Explanation of Benefits -EOBs and Deductible Credit forms are required by Dec. 31, 2018). Beyond the deductible, any portion of the out-of-pocket maximum met in 2018 will not be credited by Kaiser. **Premera will be crediting all deductibles and out-of-pocket maximums previously met on Regence plans.**

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

If you are on a Premera plan and any or all of your deductible is met in October -December, that amount counts toward the deductible you will have to meet when the plan year resets on January 1st. For example, in October you meet $200 of the $500 deductible. In the new plan year starting January 1st you only have to meet $300 instead of $500. 4th quarter carry-over does not apply to out-of-pocket maximums on any plan. **4th quarter carry over does not apply to the HSA plan or Kaiser.**

Preexisting Condition Waiting Periods

There are no waiting periods for preexisting conditions under any of the school district medical plans.

Coverage for Self-Employed

Premera Blue Cross covers on-the-job injuries for self-employed individuals and their spouses IF the enrolled employee or spouse is exempt from state or federal workers' compensation law. Effective November 1, 2018 there are no benefit maximums for work-related conditions for those who qualify (the only benefit limitation is the usual limitation of the medical plan the member is covered under).

Kaiser does not cover on-the-job injuries.

Generic Drug Usage Saves Money!

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

Prescriptions by Mail

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

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

Medical Plan Options

Plan	Kaiser Permanente Welcome 500	Premera Blue Cross PPO 3 (Heritage)	
Network	**At a Kaiser facility/Provider only**	**In Network**	**Out of Network**
Medical Deductible	$500 person / $1,500 family	$500 person / $1,500 family	
Rx Deductible	None	None	
4th Qtr. Carry Over	Does not apply	Nov & Dec Only	
Carrier Coinsurance	80%	80%	60%
Medical Out of Pocket Max	$2,000 person / $6,000 family	$3,000 person / $9,000 family	$5,900 person / $17,700 family
Rx Out of Pocket Max	Included in Medical	Included with Medical	
Office Visit *Primary/Specialist*	Visits 1-4 - $20 copay (dw) Visits 5+ - $20 copay then ded & coin	$30/$40 copay (dw)	$40/$50 copay (dw)
Preventive Care*	100% (dw)	Covered in full	Coinsurance only
Diagnostic Lab & X-Ray	Covered in full up to $500 per year then ded & coins	Deductible & Coinsurance	
Advanced Diagnostic Imaging		Deductible & Coinsurance	
Emergency Care**	$100 copay + ded and coin	$100 copay + ded & coins	
Ambulance	80%	Deductible & Coinsurance	
Hospital (Inpatient)	80% deductible	$300 copay per day / $900 max PCY then ded & coins	
Hospital (Outpatient)	$20 copay (dw) then ded & coin	Surgery - $150 copay then ded & coin All other services - Ded & coin	
Spinal Manipulations	10 manipulations PCY without prior authorization	$30 copay (dw)	$40 copay (dw)
		Unlimited Maniplulations	
Vision Care	One exam every 12 months	Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	45 visits (PT, Speech, Massage, OT)	45 visits Unlimited visits for PT	
	See Office Visit limits	$40 copay (dw) PT: ded & coin	$50 copay (dw) PT: ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	30 visits (PT, Speech, Massage, OT)	30 days PCY	
	80%+ deductible	See Hospital Inpatient	
Prescriptions	**Generic / Brand / Non-Formulary - At Participating Pharmacies**		
Retail Cost Share	$15 / $30 (30 day supply)	$15 / $25 / $40 (34 day supply)	
Mail Order Cost Share	$30 / $60 (90 day supply)	$30 / $50 / $70 (100 day supply)	
Specialty Cost Share	Subject to applicable retail copay through GHC Specialty Medication Pharmacy Only (30 day supply)	$60 copay through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)	
Life/AD&D Insurance	None	None	

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

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

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

To locate a Kaiser provider, visit www.kp.org/wa.

Medical Plan Options

Plan (Network)	Premera Blue Cross EasyChoice A (Heritage)		Premera Blue Cross EasyChoice B (Heritage)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$1,250 person/ $3,750 family	$2,000 person/ $6,000 family	$750 person/ $2,250 family	$1,500 person/ $4,500 family
Rx Deductible	$500		$250	
4th Qtr. Carry Over	Nov & Dec Only		Nov & Dec Only	
Carrier Coinsurance	80%	50%	75%	50%
Medical Out of Pocket Max	$4,000 person/ $8,000 family	None	$3,500 person/ $7,000 family	None
Rx Out of Pocket Max	Shared with Medical		Shared with Medical	
Office Visit *Primary/Specialist*	$25/$35 copay (dw)	Ded & coin	$30/$40 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Not covered except Screenings-ded & coin	Covered in full	Not covered except Screenings-ded & coin
Diagnostic Lab & X-Ray	Paid in Full to $1,000 then Ded & Coin		Deductible & Coinsurance	
Advanced Diagnostic Imaging			Deductible & Coinsurance	
Emergency Care**	$100 copay + ded & coin		$150 copay + ded & coin	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Inpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Outpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Spinal Manipulations	$25 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin
	12 manipulations PCY		12 manipulations PCY	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits		45 visits	
	$35 copay (dw)	Ded & coin	$40 copay (dw)	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY		45 days PCY	
	Ded & coin		Ded & coin	
Prescriptions	**Generic / Preferred / Non - Preferred - At Participating Pharmacies**			
Retail Cost Share	$10 (dw) / 30% / 30% (30 day supply)		$5 (dw) / $30 / $45 (30 day supply)	
Mail Order Cost Share	$20 (dw) / 30% / 30% (90 day supply)		$10 (dw) / $75 / $112 (90 day supply)	
Specialty Cost Share	30% through Accredo or Walgreens Specialty Pharmacy only (30 day supply)		30% through Accredo or Walgreens Specialty Pharmacy only (30 day supply)	
Life/AD&D Insurance	$25,000 Life and AD&D for Employee Only			

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

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

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

Medical Plan Options

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

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

†Premera QHDHP, the deductible must be satisfied before benefits are payable. If more than one person is enrolled, the family deductible must be satisfied before benefits are payable for ANY enrolled person.
To locate a Premera provider, visit www.premera.com

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

High Deductible Health Plan and HSA Questions and Answers

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

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

What is a Health Savings Account (HSA)?

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

Who is eligible to participate in an HSA?

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

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

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

How much can I contribute to my HSA?

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

How do I use my HSA?

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

Important Information Regarding your HDHP and HSA

- The HSA is a bank account, in your name, that belongs to you. If you leave your employer, the account goes with you and you can continue to use it for qualified medical expenses. Any monthly banking fees for the HSA are your responsibility and will be deducted directly from your HSA.
- Over-the-Counter medications are not a qualified medical expense under an HSA.
- Any use of HSA funds for a non-qualified medical expense are subject to a 20% tax penalty and applicable income taxes. You should keep all your receipts for purchases made with your HSA in case you are audited by the IRS.

High Deductible Health Plan and HSA Questions and Answers continued

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

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

Saving Money on Your Medical Costs

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

Use The Emergency Room for Emergencies Only

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

Select Generic Prescription Drugs When Available

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

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

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

Participate in the Flexible Spending Account

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

Mandatory Dental Benefits

All eligible employees working an average of over 3.50 hours/day must be enrolled in either of the dental plans below. Please note that to cover your entire family on these plans, you must enroll each member of your family which may included dependent children up to age 26. If you are currently enrolled in a dental plan and do not wish to change plans, you will automatically stay in your current plan.

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

Delta Dental of WA Incentive (Group #186)	
Plan Year Maximum (Nov 1, 2018 - Dec 31, 2019)	$1,750 per person (Non-Delta providers) $2,300 per person (Delta PPO providers) $2,000 per person (Delta Premier providers)
Preventive Services (Exams, X-Rays, Cleanings, Fluoride, Sealants)	70% - 100% Incentive
Restorative Services (Fillings, Oral Surgery, Endo, Perio)	70% - 100% Incentive
Onlays, Crowns	70% - 100% Incentive
Major (Dentures, Bridges, Partials & Implants)	50%
Temporomandibular Joint Disorder	50% up to $1,000 Annual Maximum $5,000 Lifetime Maximum

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

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

Print out an ID card at www.deltadental.com/wea.

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

Willamette Dental	
Plan Year Maximum (Nov 1, 2018 - Dec 31, 2019)	No annual max
Preventive (Exams, X-Rays, Cleaning etc.)	$15 copay then covered at 100%
Restorative Services (Fillings, Extractions, etc.)	$15 copay then covered at 100%
Major Care (Crowns, Dentures, Partials Bridges, etc.)	$50 copay plus a $15 copay per visit, then covered at 100%
Temporomandibular Joint Disorder	$1,000 Annual Max Benefit $5,000 Lifetime Max Benefit
Nightguards	$15 copay then covered at 100%

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

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

Print out an ID card at www.willamettedental.com.

IMPORTANT NOTE: If you are currently enrolled in a WEA Select Dental Plan and do not wish to make any changes, you will automatically stay in your current plan. If you are a new hire or wish to make changes, you will need to enroll using the online system or by calling the WEA Select Benefits Center at 1-855-668-5039.

Mandatory Long Term Disability Insurance

All active employees working a minimum of **17.5 hours per week** will be covered by our District's Long Term Disability Policy provided by Cigna. This plan provides financial assistance if you are not able to return to work due to a qualified disabling condition. Plan benefits are below. **NOTE:** Premiums for this coverage are deducted each month - the premium can be found on the back cover of this booklet.

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

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

Employee Assistance Program (EAP)

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

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

You can set an appointment to meet with the EAP in person or it is possible to receive services via the phone or e-mail. The EAP is also intended as a resource for managers and supervisors to staff individual employee problems and team/work group intervention options. To learn more about the EAP or to schedule an appointment, call Health Promotion Northwest at:

1-800-244-6142

https://www.peacehealth.org/health-promotion-northwest

Vision Insurance

Vision coverage is provided by the Northwest Benefit Network. All new employees need to fill out an enrollment form to be covered for vision.

There is no co-payment required on materials or eye exams for either Panel (Participating) or Non-Panel Providers. Many benefits obtained from Panel Providers are covered at 100%, with a few of the exceptions listed below. For Non-Panel Providers, members pay all charges and are reimbursed up to the allowances listed below under "Non-Panel Providers". Either contacts or glasses may be obtained in a benefit period—not both. Children are eligible from birth to age 26.

Payment will be made on behalf of the subscriber as follows:

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

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

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

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

Please note: This is only a summary of the plan benefits. Actual benefits are based upon the plan agreement, which may contain plan details not specified in this summary. Please contact NBN at (800) 732-1123 if you have any questions about the plan benefits and/or your eligibility status; or register online at www.nwadmin.com to review your past claims history, eligibility status, view your plan brochure and print a claim form and more.

Voluntary Benefits

Our District offers a variety of voluntary benefits to eligible employees on the following pages. *Please be aware that these benefits cannot be paid for from monies from your state allocation*.

Voluntary AFLAC Supplemental Insurance

Employees have the opportunity to select supplemental insurance coverage through AFLAC. Most policies can be paid on a pre-tax basis through payroll deduction. AFLAC provides supplemental insurance policies to help with medical and living expenses associated with serious injuries or illnesses. Policy benefits are paid directly to you, unless assigned, regardless of any other coverage you may have and benefits cannot be reduced because of other insurance. Also, payroll rates may be retained upon retirement or job change. AFLAC policy lines include: Personal Short Term Disability, Accident, Intensive Care, Cancer Expense, Life Assurance, Dental and Personal Recovery (a policy for heart attacks, strokes and more). NOTE: Not all benefits available in every district. Contact AFLAC representative Andrew Rivas at 360-927-1642 for more information.

Section 125 Plan / Flexible Spending Account

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

American Fidelity Assurance Company:

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

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

The eligible insurance plans available under Section 125 include dental, health, and vision insurance. These benefits will automatically be pre-taxed under the plan. If an employee does not want to participate in this plan, they must sign and return a "Premium Payment Plan Refusal" form to Payroll by December 31, 2018. Elections made under the Section 125 plan must remain in place for the length of the plan year unless the employee experiences an allowable election change event mid-plan year (consult your employer for more details). An employee cannot change or revoke their Health FSA election during the contract year. Cancellation or changes for this account are allowed only during the next annual open enrollment period.

To take advantage of the savings on Medical or Dependent care expenses, you must meet with an American Fidelity Representative or complete and return a form to payroll prior to December 31, 2018. Employees currently participating in either of the Flexible Spending Accounts also need to submit a new election form for the 2019 plan year to Payroll.

Carryover: The Health FSA allows up to $500 of unused contributions to be carried over to the next plan year. This amount will be added to any contributions you elect for the next plan year. The plan allows for a 90 day runoff period after the end of the plan year during which the participant can submit eligible Health FSA or Dependent Day Care FSA claims incurred during the preceding plan year for reimbursement. Any amount over $500 remaining at the end of the runoff period will be forfeited.

To take advantage of the Flexible Spending Accounts, you must complete the appropriate election form with the American Fidelity Representative. All employees participating in the plan need to submit an application for 2019. All employees will need to either consult with the American Fidelity Representative or visit American Fidelity's website for online forms: https://americanfidelity.com/

Cancer, Life Insurance & Accident Insurance

For more detailed information and/or questions regarding these types of coverage, contact the American Fidelity home office at (206) 575-8400 or David McNair at david.mcnair@americanfidelity.com.

Helpful Information

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

Continuation of Coverage

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

GROUP MEDICAL INSURANCE - Medical insurance may be continued under COBRA. It is also convertible to a guaranteed individual policy. The benefits of the policy will vary and are usually less than provided by your group policy. Other medical plans are available on an individual basis.

GROUP DENTAL/VISION INSURANCE - Dental and/or Vision insurance may be continued under COBRA. This is not convertible to individual policies.

Federal law requires most group health plans maintained on behalf of 20 or more employees to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain cases. A "group health plan" includes any employer-provided medical, dental, vision care, or prescription drug coverage. If you or a qualifying family member wish to provide notice of any required events affecting your COBRA coverage, or have any questions about COBRA, please contact your employer representative: Yesenia Cisneros, Nooksack Valley School District (360) 988-4754.

Individual Health Coverage

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

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

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

Healthy Kids Now through Apple Health

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

Apple Health Hotline

1-877-KIDS-NOW

www.insurekidsnow.gov

Washington State Department of Retirement Systems

If you have questions regarding your retirement plan under School Employees' Retirement System (SERS) / Teachers' Retirement System (TRS), please contact:

Department of Retirement Systems

800-547-6657

www.drs.wa.gov

Workers' Compensation, Occupational Safety and Accident Prevention Program

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

- Immediately report any injury (treated or untreated) to your supervisor and complete the Accident Report Form.
- The Return to Work Release Form is to be completed by the doctor and returned to the district office prior to returning to work.
- If time loss is required or transitional work possible, a Physical Capacities Evaluation is to be completed by the doctor and returned to the district office prior to returning to work.
- Obtain the Washington State Fund Report of Industrial Injury or Occupational Disease form from the doctor and mail to the State. The employer portion is mailed to the district for completion of "Employer Information".

The Nooksack Valley School District's Return To Work Program is a team effort involving the injured employee, immediate supervisor, district personnel administrator and doctor. Should you become injured, it is important that you return to employment as early as it is medically safe for you to do so. We will stay in contact with you and your doctor to keep up to date on your recovery process. Transitional duty assignments may be provided for employees who are unable to return to their normal duties while recovering from their injuries. Medical studies show that transitional work speeds the healing process.

The Nooksack Valley School District has a sick leave buy back process available if you wish to participate. Please contact the Payroll Office for further information.

Women's Health and Cancer Rights Act Enrollment/Annual Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

all stages of reconstruction of the breast on which the mastectomy was performed;
surgery and reconstruction of the other breast to produce a symmetrical appearance;
prostheses; and
treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, call Yesenia Cisneros at 360-988-4754.

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? If you would like more information, call *Yesenia Cisneros* at 360-988-4754.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace.
For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx
Phone: 1-800-562-3022 ext. 15473

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, 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, Menu Option 4, Ext. 61565

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

Specialty Medication – Medications that treat serious health condition such as cancer and rheumatoid arthritis. They are complex and expensive, and may require intensive monitoring.

Insurance Committee

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

If you are interested in participating on this committee, please contact Human Resources. Your committee members are:

Tyler Mitchell - NVEA	Kurt DeVries - SEIU	Yesenia Cisneros - District Office
Alice Linterman - SEIU	Marta Johnston- District Office	

Insurance Contact Information

Carrier Name	Coverage	Group/Policy #	Phone Number	Website
Premera Blue Cross	Medical	4015729	855-756-0798	www.premera.com
Kaiser Permanente	Medical	Welcome - 1147800	888-901-4636	www.kp.org/wa
Delta Dental	Dental	186	800-554-1907	www.deltadentalwa.com
Willamette Dental	Dental	WDG	855-433-6825	www.willamettedental.com
NBN	Vision		800-732-1123	www.nwadmin.com
American Fidelity Flexible Spending Account	Flex plan	N/A	206-575-8400	www.americanfidelity.com
Health Promotion Northwest	Employee Assistance Program	N/A	800-244-6412 360-788-6565	www.peacehealth.org/whatcom/eap
VEBA Service Group	Health Reimbursement Plan	N/A	800-422-4023 800-828-4953	www.veba.org
AFLAC	Supplemental Insurance		360-676-4848	andrew_rivas@us.aflac.com
Dept. of Retirement Systems	Retirement	N/A	800-547-6657	www.drs.wa.gov

District Contact Information

Payroll Specialist	Marsha McInnis	360-988-4754	marsha.mcinnis@nv.k12.wa.us
Personnel/Benefits	Yesenia Cisneros	360-988-4754	yesenia.cisneros@nv.k12.wa.us

If you have any questions regarding your benefits please contact the numbers above, or you can contact our Insurance Consultants:

The Partners Group
Emily Austin
877-455-5640 x 2311 or eaustin@tpgrp.com

Estimating Your Benefit Allocation

This year the state will provide **$843.97** per full time employee to be used to pay for health benefits offered by the district. This rate is effective November 1, 2018. The District is required to reimburse the state a portion of that allocation for retiree benefits. Nooksack Valley School District pays for that portion of your allocation so that you have the full allocation available to you. Benefits that must be purchased from those monies are dental, vision, and the Employee Assistance Program. The remaining funds after those benefits are purchased may be used to purchase medical insurance if you wish to purchase it. The below table illustrates your available funds from your state allocation, based on bargaining unit, to purchase your benefits.

	NVEA and SEIU Employees
Full FTE State Allocation	$843.97
(-) Less Retiree Carve Out	$71.08*
(+) Plus Retiree Carve Out	$71.08
Additional District Contribution	$25.00
Total Available (based on 1.0 FTE)	**$868.97**

* Retiree carve out increases to $71.08 effective 11/1/18.

Please note that this calculation is based on an employee with a 1.0 Benefit FTE.

How much do I have to apply to medical insurance?

From the above amount, you must choose a dental and vision plan as well as purchase the Employee Assistance Program. The below chart calculates the amount of funds available from your allocation if you are 1.0 Benefit FTE, less the mandatory benefits you must elect, that you have to apply towards a medical plan election. If the medical plan that you elect premium is greater than your available allocation, those funds will be deducted from your paycheck. If your Benefit FTE is less than 1.0, the amount remaining for medical will be less. Mandatory dental is only offered if you work over an average of 3.50 hours/day or higher than a .50 FTE.

	NVEA and SEIU Employees
Estimated Benefit Allocation (from above)	$868.97
(-) Mandatory Dental Insurance	-$99.79 (Delta Dental) OR -$82.95 (Willamette)
(-) Mandatory Vision Insurance	-$24.00
(-) Mandatory Employee Assistance Program	-$2.09
$ Estimated Amount Available for Medical Insurance	**$743.09 (Delta Dental) OR $759.93 (Willamette)**

Please note that this calculation is based on an employee with a 1.0 Benefit FTE.

Notes

Monthly Insurance Rates for 2018-2019

MEDICAL	Premera EasyChoice A	Premera EasyChoice B	Premera Plan 3	Premera Basic	Premera QHDHP (HSA)
Employee Only	$711.09	$711.09	$965.95	$573.93	$707.92
Employee & Spouse	$1,292.70	$1,292.70	$1,768.99	$1,042.48	$1,183.83
Employee & Child(ren)	$943.78	$943.78	$1,290.13	$761.35	$898.32
Family	$1,549.14	$1,549.14	$2,121.20	$1,249.02	$1,376.32

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

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

DENTAL	Delta Dental	Willamette Dental
Composite/Family Rate	$99.79	$82.95

Dental plan rates are composite rates, The rate is the same for a single employee enrolled or an employee and his/her family. Also, employees working greater than 3.50 average hours per day are **required** to enroll in a dental plan.

VISION	NBN Vision
Composite/Family Rate	$24.00

Vision plan rates are composite rates just like our dental plans, meaning the rate is the same for a single employee enrolled or an employee and his/her family.

LONG TERM DISABILITY	CIGNA - Eligible Employees Only
Employee Only	$12.80

EMPLOYEE ASSISTANCE PROGRAM	Health Promotion Northwest
Rate	$2.09

This information is not a contract. It is a summary of the benefits available. Each plan described herein excludes certain conditions and types of treatment from coverage or payment. Be sure to consult your benefit booklet available in the Payroll Office and/or the insurance company representative before making your selection. Questions may be directed to the Payroll/Benefits Office or **The Partners Group at 1-877-455-5640.** This summary was printed on August 14, 2018. Any information not provided by that time or revisions by bargaining units or by insurers after this date could change or modify the information contained herein.