San Juan Island School District #149

Employee Benefit Guide

2018-2019 School Year

Important Open Enrollment Information

Open Enrollment Period:

- All lines of coverage are effective November 1, 2018 for rate changes to all medical, dental and vision plans, effective with the October 31st payroll.
- WEA Select Dental, and Vision Plans can be previewed beginning August 27th at http://digital.alight.com/wea/.
- If you are enrolled in our WEA Select Dental or Vision plans and do not wish to make any changes, (i.e. add or remove dependents), you will automatically stay in your current plan.
- For Dental and Vision, if you are a new hire or wish to make changes, you will need to enroll or make changes using the online system at http://digital.alight.com/wea/ or by calling the WEA Select Benefits Center at 1-855-668-5039. You will need to complete a paper enrollment form to enroll or make changes to your Premera or Kaiser Permanente medical plan.

Enrollment forms are to be returned to Cynthia McVeigh, at the school district office no later than Friday, September 28th 2018.

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: Wednesday, September 12th, 2018

Time: 3:30 PM - 5:30 PM

Location: Friday Harbor High School Commons

45 Blair Ave

Friday Harbor, WA 98250

Come to the fair for questions and answers and sign up for DOOR PRIZES from our benefit partners and vendors!

The information herein is not a contract. It is a brief summary of the benefits available. It is not intended to be an all-inclusive description of Plan benefits, limitations or exclusions, and should not be used in lieu of a Plan book. Be sure to consult your Plan booklet, or consult with the insurance company representative before making your selection. If there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets prevail. Please direct any questions to **Human Resources** or **The Partners Group at (877) 455-5640.** This summary was printed on August 16, 2018 . Any further information, revision by bargaining units or by insurers after this date could change or modify the information contained herein.

Welcome to Your Benefits!

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

This Benefits Guide will help you learn more about your benefits, review highlights of the available plans and make selections that best fit your lifestyle and budgetary needs. This information is also available on our 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

New Employees: Employees starting to work BY THE 10th of the month are eligible to receive benefits on the 1st of the following month. Employees starting to work AFTER THE 10th of the month are eligible to receive benefits on the 1st of the second month.

Current & New Employees: 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.

Dependents

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.

Benefit Changes for the 2018-2019 School Year

Washington State Allocation

- State allocation for employee benefits will remain at $843.97. The Retiree Medical Carve-out amount will increase from $64.39 to $71.08.

Kaiser Permanente

- No benefit changes.
- 16.67% increase.

Premera Blue Cross

- No Benefit Changes
- 4.6% Rate Increase

WEA – Delta Dental of Washington

- The annual maximum will increase to $2,300 when a Delta Dental PPO dentist is used and to $2,000 when a Delta Dental Premier dentist is used.
- The annual maximum will be effective 11/1/2018 through 12/31/2019.
- Member cost shares for pediatric dental needs for children aged 14 and under will be eliminated when a Delta Dental provider is used.
- 1.8% rate decrease.

WEA – Vision Plan C

- The in-network frame allowance will increase to $150 and the In-network contact allowance will DECREASE to $180.
- The contact lens frequency will change to once each calendar year (in lieu of frames/lenses).

CIGNA- Long Term Disability

- No benefit changes.
- 2% rate increase.

WEA-Select Voluntary Short Term Disability Plans – American Fidelity Assurance Company (AFA)

- No benefit changes.
- No rate change.

Medical Insurance

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

Preferred Provider Organization (PPO)

These type plans contract with a large number of providers. If you choose to receive your care through a preferred provider, the insurance company will pay a higher percentage of the charges. If you choose to receive your care through a non-preferred provider, then the insurance company will pay a lower percentage of the charges.

Your PPO plan options are available through Premera.

To find a preferred provider through Premera, visit www.premera.com. For all plans, search under the Heritage network.

Qualified 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.***

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 options are available through Premera.

Search under the Heritage network for providers on the QHDHP plan.

Health Maintenance Organization (HMO)

HMO type plans provide you with managed benefits and usually at 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 PCP will then either provide or coordinate all of your care (except in the case of medical emergency)

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

Special Note about Hospitals and Emergency Rooms

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

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

Medical Plan Options

Plan (Network)	Premera Blue Cross PPO 2 (Heritage)		Premera Blue Cross PPO 3 (Heritage)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$300 person / $900 family		$500 person / $1,500 family	
Rx Deductible	None		None	
4th Qtr. Carry Over	Nov & Dec Only		Nov & Dec Only	
Carrier Coinsurance	80%	60%	80%	60%
Medical Out of Pocket Max	$2,000 person / $6,000 family	$3,400 person / $10,200 family	$3,000 person / $9,000 family	$5,900 person / $17,700 family
Rx Out of Pocket Max	Shared with Medical		Shared with Medical	
Office Visit *Primary/Specialist*	$25/$35 copay (dw)	$30/$40 copay (dw)	$30/$40 copay (dw)	$40/$50 copay (dw)
Preventive Care*	Covered in full	Coinsurance only	Covered in full	Coinsurance only
Diagnostic Lab & X-Ray	Deductible & Coinsurance		Deductible & Coinsurance	
Advanced Diagnostic Imaging	Deductible & Coinsurance		Deductible & Coinsurance	
Emergency Care**	$75 copay + ded & coin		$100 copay + ded & coins	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Inpatient)	$150 copay per day / $450 max PCY then ded & coin		$300 copay per day / $900 max PCY then ded & coin	
Hospital (Outpatient)	Surgery- $100 copay then ded & coin All other services- Ded & coin		Surgery- $150 copay then ded & coin All other services- Ded & coin	
Spinal Manipulations	$25 copay (dw)	$30 copay (dw)	$30 copay (dw)	$40 copay (dw)
	Unlimited Manipulations		Unlimited Manipulations	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	45 visits Unlimited visits for PT		45 visits Unlimited visits for PT	
	$35 copay (dw) PT: ded & coin	$40 copay (dw) PT: ded & coin	$40 copay (dw) PT: ded & coin	$50 copay (dw) PT: ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	120 days PCY		30 days PCY	
	See Hospital Inpatient		See Hospital Inpatient	
Prescriptions	**Generic / Preferred / Non - Preferred - At Participating Pharmacies**			
Retail Cost Share	$10 / $20 / $35 (34 day supply)		$15 / $25 / $40 (34 day supply)	
Mail Order Cost Share	$20 / $40 / $65 (100 day supply)		$30 / $50 / $70 (100 day supply)	
Specialty Cost Share	$50 copay through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)		$60 copay 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

(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 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			

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(dw)= Deductible Waived
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OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

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

Medical Plan Options

Plan (Network)	Premera Blue Cross Basic (Heritage)		Premera Blue Cross QHDHP (Heritage)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$2,100 person/ $4,200 family	$2,500 person/ $5,000 family	$1,750 person/ $3,500 familyŧ	$3,000 person/ $6,000 familyŧ
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

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

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

Medical Plan Options

Plan (Network)	Kaiser Permanente
Network	**At a Kaiser Facility/Provider Only**
Medical Deductible	$200 person / $600 family
Rx Deductible	None
4th Qtr. Carry Over	Applies
Coinsurance	100%
Medical Out of Pocket Max	$2,000 person / $6,000 family
Rx Out of Pocket Max	Included in Medical
Office Visit	$20 copay after deductible
Preventive Care*	100% (dw)
Diagnostic Lab & X-Ray	100% after deductible
Advanced Diagnostic Imaging	100% after deductible
Emergency Care**	$75 copay + deductible
Ambulance	80% after deductible
Inpatient	100% after deductible
Outpatient	$20 copay after deductible
Spinal Manipulations	10 manipulations PCY
Vision Care	One exam every 12 months
Rehab - Outpatient (Speech, Massage, OT, PT)	45 visits PCY
	$20 copay after deductible
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY
	100% after deductible
Prescriptions	**Generic / Formulary At Kaiser Pharmacies Only**
Retail Cost Share	$10 / $20 (30 day supply)
Mail Order Cost Share	$20 / $40 (90 day supply)
Specialty Cost Share	Subject to applicable retail copay through GHC Specialty Medication Pharmacy Only (30 day supply)
Life/AD&D Insurance	None

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(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 Permanente provider, visit www.kp.org/wa

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 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

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

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

Delta Dental of WA Incentive Plan A (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).

Mandatory Vision Benefits

Our District provides vision coverage for all employees working a minimum of **.5 FTE** through the WEA Select Vision Plan C via VSP. The below is a summary of **in-network** benefits provided by VSP contracted providers.
For out of network benefits, consult the plan booklet at www.vsp.com.

	Frequency	In-Network VSP Provider
Copayments for services		$5.00 exams $15.00 materials
Exams	Once per calendar year	Paid at 100%
Lenses (pair)	Once per calendar year	Paid at 100%
Frames	Once per two calendar years	$110.00 max allowance
Contacts - elective (in lieu of lenses and frames)	Once per two calendar years	$200.00 max allowance

This is a summary of In-Network benefits only. For Out-Of-Network benefits, please refer to the WEA Select Vision Plan C. Benefit Booklet located at www.vsp.com.

Mandatory Long Term Disability Insurance

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

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 62) If disabled after age 62, benefits end based on age when disabled. See plan documents for schedule.
Restrictions	Mental Illness/Drug & Alcoholism is covered only for 24 months

Please refer to the certificate/booklet for a complete description of benefits, available through Human Resources.

Employee Assistance Program

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

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

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

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

This program's unique advantages include:

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

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

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

Voluntary Benefits

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

Voluntary Short Term Disability/Salary Insurance

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

Eligible Class	**All Employees**
AmFi Brochure #	SB-25071-0717
Benefit Amount	Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month
Waiting Period	0 days for injury / 7 days for sickness (benefits begin on 8th day for sickness)
Benefit Period	90 days

These plans include a limitation to offset with other sources of income. Participants will be eligible to receive up to 70% of their monthly earnings, which includes other income received, such as sick pay or unemployment compensation. Injury or Sickness arising out of or in the course of any occupation for wage or profit for which you are entitled to Worker's Compensation will not be covered under this plan.

The above information does not constitute a contract. It only highlights some general information. These products contain limitations, exclusions, and waiting periods. Please be sure to consult the appropriate WEA Select American Short-Term brochure for a summary of the plan's rates, specific benefits, limitations, exclusions, and elimination period information before making your selection. The brochure is available in the human resource department and/or through an American Fidelity Assurance Company representative at 1-866-576-0201 between 8:00 AM and 5:00 PM or via the Internet at www.americanfidelity.com.

Voluntary Cancer Insurance and Voluntary Accident Insurance - WEA Select

The District offers Limited Benefit Cancer Insurance* and Limited Benefit Accident Insurance+ through American Fidelity. Premiums are paid through payroll deduction. The rates you pay are marketed through your employer for worksite employees only. If you leave your employer, you can maintain your same plan and the same rate. Benefits are paid directly to you and may be used however you need. For more information on voluntary Cancer Insurance, please contact the payroll office.

* This product may contain limitations, exclusions and waiting periods.
+ This product is inappropriate for people who are eligible for Medicaid coverage.

AFLAC Supplemental Insurance

AFLAC is supplemental insurance that pays in addition to other insurance. The benefits are paid directly to you, therefore, you may spend them as you see fit. The types of Insurance available are as follows:

*Accident/Disability *Short-Term Disability *Cancer *Personal Recovery Plus *Dental

AFLAC benefits are voluntary, payroll deducted plans.

For additional information please contact:
Tammy Cotton, (360) 378-4014

Section 125 Plan / Flexible Spending Account

San Juan Island 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 for pre-tax deductions from payroll under Section125 include dental, health, and vision insurance. The employee portion of the premiums for these benefits will automatically be pre-taxed under the plan. If an employee does not want to participate in this plan, they must inform Payroll by September 14, 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 payroll 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 12, 2018. Employees currently participating in either of the Flexible Spending Accounts also need to submit a new election form for the 2018 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 see the American Fidelity Representative as no manual forms will be accepted.

Helpful Information

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

Family Medical Leave Act of 1993 (FMLA)

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

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

For specific questions and/or qualifications, contact the Human Resources Department or contact the Department of Labor for a copy of the FMLA law.

COBRA and Continuation of Coverage.

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

José Domenech
San Juan Island School District
285 Blair Street
P.O. Box 458
Friday Harbor, WA 98250
(360) 370-7908

School Employees Retirement Systems

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

Department of Retirement Systems

800-547-6657

www.drs.wa.gov

Healthy Kids Now through Apple Health

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

Apple Health Hotline
1-877-KIDS-NOW
www.insurekidsnow.gov

Tax-Sheltered Annuity (TSA)

also known as a TAX-DEFERRED ACCOUNT (TDA) or 403(b)

A voluntary tax-deferred investment program established with certain insurance companies or mutual funds, referred to as a service provider, approved by the School District.

For more information, please contact TSA Consulting Group, Inc. (formerly Great American Plan Administrators):

(800) 695-1471 or recordkeeping@tsacg.com

Washington State Deferred Compensation Program (DCP)

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

With DCP, you decide how much money you want deducted from each paycheck. That can be as little as $360 per year or as much as the annual legal maximum of $18,500 if you are under age 50 and $24,500 if you are over age 50 for 2017.

How does Deferred Compensation Work?

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

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

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

Email: dcpinfo@drs.wa.gov

Mail: PO BOX 40931 Olympia, WA 98504-0931

Benefit Vendors Contact Information

Carrier Name	Coverage	Group/ Policy #	Phone Number	Website
Premera	Medical	4012499	855-756-0798	www.premera.com
Kaiser Permanente	Medical	1199200	888-901-4636	www.kp.org/wa
Delta Dental	Dental	186	800-554-1907	www.deltadentalwa.com
VSP	Vision	07113507	800-877-7195	www.vsp.com
Cigna	Long Term Disability	SDG600145	800-362-4462	www.cigna.com
Cigna	Employee Assistance Program	N/A	800-538-3543	www.cignabehavioral.com
American Fidelity	Flexible Spending Account		800-888-2461	www.afadvantage.com
AFLAC	Supplemental Insurance		360-378-4014	

District Contact Information

Human Resources	**Cynthia McVeigh**	**360-370-7904**
Business Manager	**José Domenech**	**360-370-7908**

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

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

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

Monthly Insurance Rates for 2018-2019

MEDICAL	Premera Plan 2	Premera Plan 3	Premera Easychoice A & B	Premera Plan Basic	Premera QHDHP (Certificated)	Premera QHDHP* (Classified)
Employee Only	$994.32	$908.99	$669.34	$540.28	$524.32	$649.32
Employee & Spouse	$1,820.32	$1,664.37	$1,216.40	$981.03	$951.84	$1,076.84
Employee & Child(ren)	$1,327.72	$1,213.94	$888.17	$716.58	$695.34	$820.34
Family	$2,182.45	$1,995.63	$1,457.57	$1,175.28	$1,124.74	$1,249.74

*Premera QHDHP - CLASSIFIED: Your premiums include a $125 contribution towards your HSA.

If you are currently enrolled in the FSA, YOU ARE NOT ELIGIBLE TO PARTICIPATE in the HSA plan until a limited FSA is available.

MEDICAL	Kaiser Permanente
Employee Only	$914.64
Employee & Spouse	$1,772.90
Employee & Child(ren)	$1,300.04
Family	$2,158.29

DENTAL	Delta Dental Incentive Plan
Composite/Family Rate	$99.79

VISION	VSP Plan C
Composite/Family Rate	$30.80

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

LONG TERM DISABILITY	Cigna
Employee Only Rate	$9.33 (LTD is paid for by the district)

2018-2019 State Allocation = $843.97 for full time employees. From the above state allocation come the following premiums: Dental & Vision Insurance. The amount remaining, depending on the pooling outcome goes toward medical premiums.

It is recommended that all employees read this sheet. Because of rate increases this year, you may now have payroll deduction costs or your current costs may increase with your present medical plan. Please Note: For Exclusions, Limitations, & Clarifications see the individual plan booklets. This comparison is not a contract.