Ellensburg School District

Your Benefits

Effective Nov 1, 2018

WELCOME TO YOUR BENEFITS!

Ellensburg School District is proud to offer a comprehensive benefits package to our employees and their families. This package is designed to provide choice, flexibility, and value.

This Benefit Guide will help you learn more about your benefits, review highlights of the available plans, and make selections that best fit your lifestyle, needs, and budget. In addition, you can contact Human Resources, or call a Benefit Specialist from Gallagher. Online access links and phone numbers are listed in the back of this Guide under "Your Benefits Contacts." Important insurance plan booklets that provide more detailed information on each of the programs you select will be available after open enrollment.

To help you make decisions regarding your healthcare coverage, a Summary of Benefits and Coverage (SBC) is available. The SBC summarizes important information about any health coverage options in a standard format as required by Healthcare Reform regulations.

IMPORTANT:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 29 for more details.

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ENROLLMENT CHECKLIST

THE BENEFIT PLANS OFFERED ARE:

- Medical: Premera PPO Plans 2, 3, 5, EasyChoice A, B, Basic, QHDHP, and Kaiser Permanente HMO Plans 3 and 4
- Dental : Certificated - WEA Select Dental Plan A
  Classified – WEA Select Dental Plan C
- Vision: WEA VSP Vision Plan C
- Group Term Life – Symetra (included in Premera medical plans)
- Voluntary Term Life: American Fidelity and AFLAC
- Voluntary Short-term Disability: American Fidelity and AFLAC
- Voluntary Long-term Disability: American Fidelity
- Flexible Spending Account: American Fidelity and AFLAC
- Health Savings Account: AFLAC
- Dependent Day Care Account: AFLAC
- VEBA Health Reimbursement Arrangement (HRA): Gallagher VEBA

PREPARE EVERYTHING YOU WILL NEED

- ✓ Social security numbers for you and your family members whom you want to enroll in your benefits
- ✓ Dates of birth for your family members
- ✓ ID cards for any other medical plans under which you or your family members are covered

CHOOSE YOUR BENEFITS

Take the time to review the benefit outlines provided in this Guide. This will help you understand the plans that are offered and how they will fit your lifestyle, needs, and budget. To make sure specific providers are covered by the plans you are considering, check the Provider Directory online or call the insurance carrier's customer service (see "Your Benefits Contacts" in the back of this Guide).

DECIDE HOW MUCH TO CONTRIBUTE TO FLEXIBLE SPENDING ACCOUNTS

Use the online calculator at fsacalculator.com to determine how much in taxes you could save by contributing to a Flexible Spending Account (FSA), used for paying medical and dependent care expenses. (Please see the Flexible Spending Accounts section in this Guide for more details.)

FILL OUT YOUR ENROLLMENT FORM(S)

Forms will be available on the District Website (www.esd401.org, Departments, Human Resources, Benefit Information Tab) or be picked up at the District office in the Human Resources Department. You will only need to complete a new enrollment form if you are changing your elections. Certain plans may require online enrollment.

YOU ARE DONE!

Please return your completed forms to the Human Resources Department by: **September 28, 2018.**

OPEN ENROLLMENT

EMPLOYEES ALREADY ENROLLED

Open Enrollment is **August 27 – September 28, 2018.** You are able to change your elections during the Open Enrollment period. Unless you experience a qualified status change, you will not be able to change your enrollment election until the next Open Enrollment period. Only under certain circumstances, may you add or drop dependents outside of Open Enrollment, which are referred to as qualified changes in family status. These include:

- ✓ Birth or adoption of a child
- ✓ Loss of your or a dependent's coverage under another plan
- ✓ Change in marital status
- ✓ Relocation out of the service area
- ✓ If you or your spouse become eligible for other group coverage
- ✓ Open Enrollment through spouse's employer

2018 – MAJOR PLAN DESIGN CHANGES

Premera

- Rates increased approximately 4.6%.

Kaiser Permanente HMO

- The district is adding HMO Plan 4 to its offering.
- Rates decreased approximately 3.8%.

WHO IS ELIGIBLE?

Employees

- All regular EEA members are eligible for benefits.
- All regular classified employees working 10 or more hours each week are eligible for benefits.
- Coverage will begin on the first of the month following date of hire.

Dependents

You may enroll your eligible dependents for medical, dental, and vision. Your eligible dependents include:

- Your legal spouse or domestic partner
- Your children up to age 26
- Any dependent child who is incapable of self-support because of a physical or mental disability

Ellensburg School District extends health benefits to employees' domestic partners. However, the value of these benefits must be included in employee's gross income, subject to federal income tax and FICA tax, unless the domestic partner is the employee's tax dependent. This means a portion of your benefit contribution, the difference between the cost to cover you plus your domestic partner and the cost to cover just you, is deducted from your pay after taxes have been applied (referred to as "post tax"). It also means the premium of your employer is paying on your behalf when you choose to cover your domestic partner is added to your taxable income. If you would like specific information on this, you may contact Payroll.

MAKING CHANGES TO YOUR BENEFITS

You may make changes to your healthcare and insurance benefit choices once a year during the Open Enrollment period. All coverage you select will be effective for the entire plan year, unless you have a "qualified change in status" or leave employment. Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

If you have a change in status, you can make changes to your benefits by contacting Payroll within 30 days of the change. The change to your benefits must be consistent with the change in family status. For example, if you have a new baby, you can enroll the child as a dependent under your current health plans, but you may not remove another dependent who is already covered.

IMPORTANT

Enrollment time line may vary in certain situations. See "Special Enrollment Rights" on page 22.

SPECIAL ENROLLMENTS

Event	Sample Documents	Medical, Dental & Vision	Flexible Spending Accounts (FSA)	Voluntary Life	Voluntary AD&D
Marriage	Marriage certificate	May enroll newly eligible spouse or you may drop coverage if enrolling in spouse's plan (additional documentation required if dropping plans)	Healthcare FSA or Limited Purpose FSA: Same as Medical Dependent Care FSA: May enroll, increase, decrease or cease election	May enroll, increase, decrease or cease coverage	May enroll, increase, decrease or cease coverage
Gain dependent • Birth/Adoption • Foster child	Birth certificate	May enroll or increase coverage for newly-eligible dependent	May enroll or increase election	No change	No change
Spouse gains employment	Notification from new employer *(Additional documentation required if dropping plans)*	May drop or decrease coverage for self and dependents who become eligible for, and elect coverage under, spouse's plan	May enroll, increase or decrease election	May increase or decrease coverage	No change
Spouse loses employment	Notification from prior employer	May enroll self, spouse or dependents who lose eligibility under spouse's prior plan	May enroll or increase election	May increase or decrease coverage	May increase or decrease coverage
Loss of spouse	Divorce settlement, death certificate, etc.	May drop election only for spouse. May elect for self or dependents who lose eligibility under spouse's plan	May decrease election	May enroll, increase, decrease or cease coverage	May drop election only for spouse

BENEFIT ALLOCATION

State/District Benefit Allocation Funding
The State allocation for benefits is $843.97 per month per 1.0 FTE or 1,440 hour employee. The allocation is pro-rated if the certificated employee is less than 1.0 FTE or the classified employee is less than 1,440 hours. The employee benefit allocation may be utilized to purchase basic benefits, which includes medical, dental, life & AD&D, LTD insurance for each employee group and/or bargaining unit, based on the benefits negotiated by each group. In all groups, dollars are first applied to benefits requiring 100% participation and the balance is available for medical insurance.

STEP ONE - Basic Benefits
Each employee group chooses which basic benefits are mandatory for eligible employees. The choices allowed under state law are: medical, dental, vision, life, and long-term disability (LTD).

EEA Members:	• Dental, Vision	$843.97
PSE Members:	• Dental, Vision	$843.97

STEP TWO - Enrollment
After the employee group has selected its basic benefits, individual employees need to enroll in the mandatory plans (if eligible) and may decide whether they want medical for themselves and their dependents. Employees may also elect no medical coverage.

STEP THREE - Pooling
All employees' unused benefit dollars go into a pool. This pool is then reallocated to all employees with payroll deductions for basic benefits. Employees are not eligible to receive pooled funds that would reduce out of pocket cost below the required minimum contribution of the medical premium. These "pooled dollars" will help reduce employees' final payroll deduction. The amount available from the pool is calculated annually in October.

Benefit Plan	BASIC BENEFITS 100% required participation (as per employee group negotiated agreements). The cost is paid 100% from State Allocation.	OPTIONAL CHOICES Uses the balance remaining from State Allocation (as per employee group negotiated agreements). Benefits you can enroll in upon your benefit eligibility date. You share the cost.	VOLUNTARY CHOICES Benefits you can enroll in upon your benefit eligibility date. You pay 100% of the cost through payroll deductions.
Medical		X	
HSA *(available with HDHP only)*			X
Dental	X		
Vision	X		
Life and AD&D			X
Long Term Disability			X
Flexible Spending Accounts (FSA)			X
Other Voluntary Products			X

BENEFIT COSTS

Medical Plans

Premera Blue Cross PPO Plans

Monthly Cost	Plan 2 $300 Ded	Plan 3 $500 Ded	Plan 5 $200 Ded	EasyChoice A $1,250 Ded	EasyChoice B $750 Ded	Basic $2,100 Ded	HDHP w/HSA $1,750 Ded
Employee only	$953.30	$871.54	$1,102.72	$641.72	$641.72	$517.99	$502.66
Employee plus Spouse	$1,745.25	$1,595.73	$2,119.46	$1,166.23	$1,166.23	$940.54	$912.60
Employee plus Child(ren)	$1,272.95	$1,163.87	$1,504.76	$851.55	$851.55	$687.02	$666.67
Employee plus Family	$2,092.41	$1,913.34	$2,553.36	$1,397.46	$1,397.46	$1,126.83	1,078.34

Kaiser Permanente HMO Plan

Monthly Cost	Plan 3 $250 Ded	Plan 4 $750 Ded
Employee only	$752.50	$529.32
Employee plus Spouse	$1,459.85	$1,026.87
Employee plus Child(ren)	$1,053.51	$741.06
Employee plus Family	$1,760.86	$1,238.61

Dental - EEA	WEA Dental Select Plan A	$99.79 per family
Dental - PSE	WEA Dental Select Plan C	$80.07 per family
Vision	WEA VSP Plan C	$30.80 per family
Vol Life **Vol STD** **Vol LTD**	American Fidelity	See benefit summary
Other Vol Benefits	AFLAC	See benefit summary

MEDICAL BENEFITS – PREMERA PLAN HIGHLIGHTS

PREMERA BLUE CROSS – PPO PLANS

PCY = Per Calendar Year	Plan 2	Plan 3	Plan 5	Basic	QHDHP
Network	**Heritage**	**Heritage**	**Heritage**	**Heritage**	**Heritage**
Calendar Year Deductible (Ded) Per Person / Per Family	$300/$900	$500/$1,500	$200/$350	$2,100/$4,200	$1,750/$3,500
Calendar Year Out-of-Pocket Maximum† Per Person / Per Family	$2,000/$6,000	$3,000/$9,000	$1,000/$3,000	$6,600/$13,200	$5,000/$10,000
Coinsurance (coins) % Cost Share	20%	20%	10%	30%	20%
Preventive Care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Physician Services Primary care services, specialist visits, outpatient mental health and chemical dependency services	P-$25, S-$35	P-$30, S-$40	P-$20, S-$30	P-$35, S-$50	Ded + coins
Outpatient Diagnostic Lab & X-ray	Ded + coins	Ded + coins	Ded + coins	Ded + coins	Ded + coins
Hospital/Facility Services Including inpatient mental health, chemical dependency and maternity services	$150 copay/day, $450 max PCY + ded + coins	$300 copay/day, $900 max PCY + ded + coins	$150 copay/day, $450 max PCY + ded + coins	Ded + coins	Ded + coins
Emergency Room Services Copay waived if admitted	$75 + ded + coins	$100 + ded + coins	$50 + ded + coins	$200 + ded + coins	Ded + coins

These plans meet the Minimum Essential Benefits and Minimum Actuarial Value requirements as outlined in The Patient Protection and Affordable Care Act of 2010

Prescription Drugs					
At Participating Pharmacies Only – up to 30-day supply – Deductible (waived for generics)	$0	$0	$0	$750/$1,500	Shared with medical
Generic	$10	$15	$10	$15	20%
Brand Name Formulary	$20	$25	$15	$30	20%
Brand Name Non-Formulary	$35	$40	$30	$50	20%
Specialty	$50	$60	$50	30%	20%
Through Participating Mail Order Pharmacies ONLY – up to 90-day supply					
Generic	$20	$30	$20	$30	20%
Brand Name Formulary	$40	$50	$30	$60	20%
Brand Name Non-Formulary	$65	$70	$60	$100	20%
Specialty	Not available	Not available	Not available	Not available	Not available

†Effective 2015: The out-of-pocket maximum includes deductibles, coinsurance, copayments, or similar charges and that is a qualified medical expense with respect to essential health benefits covered under the plan. This excludes pre only.

MEDICAL BENEFITS – PLAN HIGHLIGHTS

PREMERA BLUE CROSS – PPO PLANS

PCY = Per Calendar Year	EasyChoice A	EasyChoice B
Network	**Heritage**	**Heritage**
Calendar Year Deductible (Ded)		
Per Person / Per Family	$1,250/$3,750	$750/$2,250
Calendar Year Out-of-Pocket Maximum†		
Per Person / Per Family	$4,000/$8,000	$3,500/$7,000
Coinsurance (coins)		
% Cost Share	20%	25%
Preventive Care	Covered in full	Covered in full
Physician Services Primary care services, specialist visits, outpatient mental health and chemical dependency services	P-$25, S-$35	P-$30, S-$40
Outpatient Diagnostic Lab & X-ray	First $1,000 covered in full, then subj to ded + coins	Ded + coins
Hospital/Facility Services Including inpatient mental health, chemical dependency and maternity services	Ded + coins	Ded + coins
Emergency Room Services Copay waived if admitted	$100 + ded + coins	$150 + ded + coins

These plans meet the Minimum Essential Benefits and Minimum Actuarial Value requirements as outlined in The Patient Protection and Affordable Care Act of 2010

Prescription Drugs		
At Participating Pharmacies Only – up to 30-day supply – Deductible (waived for generics)	$500 per person PCY	$250 per person PCY
Generic	$10	$5
Brand Name Formulary	30%	$30
Brand Name Non-Formulary	30%	$45
Specialty	30%	30%
Through Participating Mail Order Pharmacies ONLY – up to 90-day supply		
Generic	$20	$10
Brand Name Formulary	30%	$75
Brand Name Non-Formulary	30%	$112
Specialty	Not available	Not available

†Effective 2015: The out-of-pocket maximum includes deductibles, coinsurance, copayments, or similar charges and any other required expenditure that is a qualified medical expense with respect to essential health benefits covered under the plan. This excludes prescription copays for Premera only.

KAISER PERMANENTE®

MEDICAL BENEFITS – KAISER HMO PLAN HIGHLIGHTS

KAISER PERMANENTE - HMO PLAN

PCY = Per Calendar Year	HMO 3	HMO 4
Network	**Core**	**Core**
Calendar Year Deductible (Ded) Per Person / Per Family	$250/$500	$750/$1,500
Calendar Year Out-of-Pocket Maximum† Per Person / Per Family	$2,000/$4,000	$6,000/$12,000
Coinsurance (coins) % Cost Share	20%	20%
Preventive Care	Covered in full	Covered in full
Physician Services Primary care services, specialist visits	$20 + coins	$20 + ded + coins
Outpatient Diagnostic Lab & X-ray	Coins	Covered up to $500 PCY, then ded + coins
Hospital/Facility Services Including inpatient mental health, chemical dependency and maternity services	Ded + coins	$200 copay/day (up to 5 days), ded + coins
Emergency Room Services Copay waived if admitted	$150 + ded + coins	$150 + ded + coins

These plans meet the Minimum Essential Benefits and Minimum Actuarial Value requirements as outlined in The Patient Protection and Affordable Care Act of 2010

Prescription Drugs		
At Participating Pharmacies Only – up to 30-day supply		
Generic Brand Name Formulary Brand Name Non-Formulary	$15 $30 $50	$20 $40 $60
Through Participating Mail Order Pharmacies ONLY – up to 90-day supply	2X	2X

PRESCRIPTION DRUGS

All of the medical plans include a comprehensive prescription drug program. The level of coverage depends on whether the drug is generic or brand, and whether it is on your chosen healthcare provider's formulary, or preferred drug list. Your out-of-pocket cost is lowest when you buy generic drugs, and highest when you buy brand drugs that are not on the formulary.

To determine whether your drug is on your provider's formulary, please check online at the provider's website. A list of in-network pharmacies is also available on the website. The drug list is updated periodically to ensure that newer, more effective drugs are listed.

When filling a prescription, present your member ID card to any participating pharmacy. Out-of-network pharmacies may not be covered or result in higher costs.

MAIL ORDER PRESCRIPTION DRUGS

If you take prescription drugs on an ongoing, maintenance basis, you may be able to save money by using the Mail Order program and ordering a 90-day supply at a time. See your summary of benefits and coverage in the attachments section of this booklet for more details.

PRIOR AUTHORIZATION

Did you know that certain services and procedures may require an OK from your provider before they are provided to you? This is called a Prior Authorization, and it helps you:

- Find out if you're covered by your benefits before you have your scheduled procedure
- Save money and avoid extra costs
- Get an estimate of your out-of-pocket costs before you go
- Avoid unnecessary services
- Your doctor should request a Prior Authorization on your behalf as they are familiar with the process.

WHAT HAPPENS IF YOUR DOCTOR DOESN'T REQUEST A PRIOR AUTHORIZATION?

If your doctor gives you a service that requires a Prior Authorization without requesting one, you may have to pay extra costs. You may have to pay up to the full cost of your services:

To avoid extra costs always ask your healthcare provider to request a Prior Authorization before you have a planned medical service.

CALENDAR YEAR DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses. The family deductible applies if you have family members enrolled in your plan along with you. The deductible runs from Jan. 1 - Dec. 31

COPAY & COINSURANCE

A copay is a flat dollar amount you pay for a medical service.

Coinsurance is when you pay a percentage of the cost.

OUT-OF-POCKET MAXIMUM

This is the maximum amount you can pay out-of-pocket in one year, including all copays.

WELLNESS TIPS

You're covered for preventive care services including immunizations, and a range of health screenings for you and your family. Access the health and wellness resources for more information.

CUSTOMER SERVICE

Representatives can help you with just about anything, from replacing a lost ID card, helping you obtain a language interpreter, and addressing your compliments and concerns to answering questions about benefits, referrals, coordination with other insurers, coverage in temporary situations (for example, students, temporary residents), and much more.

ONLINE INFORMATION

There is a ton of useful information online, including the Provider and Facility Directory, preventive care schedules, and many handy tools that make getting care easy. See the back of this Guide under "Your Benefits Contacts" for links to the website.

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QUESTIONS

Call customer service at the number on the back of your member ID card.

DENTAL BENEFITS - EEA

Good oral care is very important to your health and general well-being. Ellensburg School District provides comprehensive dental coverage. Under this plan, you may access dental care services from any dentist you wish. However, if you obtain services from an in-network dentist, you will save money on your out-of-pocket expenses.

Delta Dental offers a comprehensive provider network both locally and across the nation. All participating dentists agree to provide services to you at discounted, negotiated fees. If you use out-of-network dental providers, your charges will be based on the maximum allowable fee for your area, as determined by the carrier.

You can find network providers online – please see the information in "Your Benefits Contacts" in the back of this Guide.

Calendar Year Deductible			
In-network	Individual/Family		$0/$0
Out-of-network	Individual/Family		$0/$0
Calendar Year Maximum Benefit			
In-network PPO Dentist		Per Person	$2,300
In-network Premier Dentist		Per Person	$2,000
Out-of-network		Per Person	$1,750

After the deductible is satisfied, your cost shares will be as follows:

	In-network	Out-of-network
Diagnostic and Preventive exams, x-rays, cleanings, topical fluoride application, space maintainers, sealants	70% / 80% / 90% / 100% Incentive level	
Basic Services fillings, extractions, oral surgery, periodontics, endodontics, crowns	70% / 80% / 90% / 100% Incentive level	
Major Services bridges, dentures, implants	50%	

DELTA DENTAL

USUAL AND CUSTOMARY RATE

When you use out-of-network services, your plan will pay a percentage of the maximum allowable fee. If your dentist charges more than the maximum allowable fee, you may be responsible for the difference.

BEFORE TREATMENT BEGINS

You should have your dentist's office contact your carrier if you expect the charges to be larger than a standard expense.

Your dentist's office will coordinate with your carrier to determine how much of the cost will be covered under the plan, and how much will be your responsibility.

DENTAL BENEFITS - PSE

Good oral care is very important to your health and general well-being. Ellensburg School District provides comprehensive dental coverage. Under this plan, you may access dental care services from any dentist you wish. However, if you obtain services from an in-network dentist, you will save money on your out-of-pocket expenses.

Delta Dental offers a comprehensive provider network both locally and across the nation. All participating dentists agree to provide services to you at discounted, negotiated fees. If you use out-of-network dental providers, your charges will be based on the maximum allowable fee for your area, as determined by the carrier.

You can find network providers online – please see the information in "Your Benefits Contacts" in the back of this Guide.

Calendar Year Deductible			
In-network	Individual/Family		$0/$0
Out-of-network	Individual/Family		$0/$0
Calendar Year Maximum Benefit			
In-network PPO Dentist		Per Person	$2,300
In-network Premier Dentist		Per Person	$2,000
Out-of-network		Per Person	$1,750

After the deductible is satisfied, your cost shares will be as follows:

	In-network	Out-of-network
Diagnostic and Preventive exams, x-rays, cleanings, topical fluoride application, space maintainers, sealants	100%	
Basic Services fillings, extractions, oral surgery, periodontics, endodontics, crowns	80%	
Major Services bridges, dentures, implants	50%	

DELTA DENTAL

USUAL AND CUSTOMARY RATE

When you use out-of-network services, your plan will pay a percentage of the maximum allowable fee. If your dentist charges more than the maximum allowable fee, you may be responsible for the difference.

BEFORE TREATMENT BEGINS

You should have your dentist's office contact your carrier if you expect the charges to be larger than a standard expense.

Your dentist's office will coordinate with your carrier to determine how much of the cost will be covered under the plan, and how much will be your responsibility.

VISION BENEFITS

To help you take care of your eyesight, Ellensburg School District provides vision care. VSP offers access to a large network of doctors nationwide. You may choose to obtain your vision care services from any provider you wish. When you access care from network providers, your benefits are greater and your out-of-pocket costs are less.

You can find network providers online – please see the information in "Your Benefits Contacts" in the back of this Guide.

Copays	
Exam	$5
Materials	$15

	Preferred Provider
Basic Examination *-once every calendar year*	Covered in full

Your cost shares will be as follows:

Lens Allowance *-once every calendar year* • Single Vision • Bifocals • Trifocals • Lenticular	Covered in full
Contact Lenses (in lieu of eyeglasses) *-once every 2 calendar years* • Medically Necessary • Elective	 Covered in full Covered in full up to $180
Frames *-once every 2 calendar years*	Covered in full up to $150

Enrollee pays:

- Copay amounts as noted
- All charges exceeding any amounts or maximum benefits
- All charges for non-covered benefits

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

BENEFITS ARE SUBJECT TO ALLOWABLE CHARGES

Network providers agree not to bill for amounts over the allowable charge.

IMPORTANT!

- Not all lenses are paid in full; some have additional features. Be sure to ask your provider if your choice is covered in full.
- Discuss your lens options with your provider
- Confirm that your lens options are paid in full by your plan
- If not, confirm with your provider whether or not you want to continue with their recommendations for lens options

VOLUNTARY INSURANCE BENEFITS

LIFE AND AD&D COVERAGE

You may choose to purchase additional voluntary life insurance to help mitigate the financial impact on your loved ones in the event of your death. In the event of an accidental death, this plan pays your beneficiary an additional benefit equal to your life insurance amount. If you are seriously injured as the result of an accident (e.g., lose your eyesight, paralysis), this plan will pay a partial benefit to you. For more detailed information phone numbers and contact information are listed in the back of this Guide under "Your Benefits Contacts."

IMPORTANT

Restrictions and limitations apply to these benefits. Please review the insurance booklet or certificate for complete details.

OTHER SUPPLEMENTAL BENEFITS

American Fidelity

- Disability Income Protection
- Life Insurance
- Accident Insurance
- Cancer Insurance

AFLAC

- Accident
- Cancer
- Critical Illness
- STD
- Hospital
- Term Life

FLEXIBLE SPENDING ACCOUNTS (FSA)

This benefit allows you to save taxes on your health and daycare expenses.

HOW THE FLEXIBLE SPENDING ACCOUNT (FSA) WORKS

- You can choose annual pre-tax payroll deduction of up to $2,650 into your Healthcare Account. This pre-tax money can be used to pay for qualified healthcare expenses not covered by your medical plan.
- You can also choose annual pre-tax payroll deduction of up to $5,000 into your Dependent Care Account. (If you are married and filing separately, your limit is $2,500.) This pre-tax money can be used to pay for qualified daycare expenses for your children or disabled spouse.
- The total amount you choose to pay into these accounts will be taken out of your paycheck in even portions over 12 months, starting January 1.
- Once you have made an election, you cannot make a mid-year change to the election unless there is a qualifying event. Examples of qualifying events are marriage, divorce, or the birth of a child.
- Please note that money cannot be transferred between accounts. For example, you cannot use your Dependent Care Account to reimburse yourself for healthcare expenses and vice versa.

HOW TO PAY FOR EXPENSES AND GET REFUNDS

- You can use your FSA Debit Card to pay for healthcare expenses. (You cannot pay for daycare expenses with this card.)
- When using the FSA Debit Card, keep the receipt for your expense in a safe place. You may receive an e-mail or letter asking you to send in your receipt to support your claim.
- Send in the receipt and a copy of the letter, as requested. If you do not send the receipt or if you used the card to pay for an expense that is not qualified, you will be asked to pay back the amount of the expense you put on the card.

EXAMPLES OF QUALIFIED HEALTHCARE EXPENSES:

- Copays for doctor visits and prescription drugs
- Coinsurance for your medical, dental and vision plans
- Deductible amounts for your medical, dental and vision plans
- Over-the-counter medicines require a prescription in order to be eligible for reimbursement.

QUALIFYING EVENTS:

- Marriage
- Divorce
- Birth of a child

HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA) AND HOW DOES IT WORK?

- Health Savings Accounts (HSA) are tax exempt accounts where funds grow to pay for medical expenses.
- They were created to help give control back to consumers and help lower healthcare costs.
- An HSA is your account. If you switch jobs, the HSA goes with you. As long as you are enrolled in a qualified High Deductible Health Plan (HDHP) you can still make contributions into your account.
- If you terminate employment or are no longer enrolled in a HDHP you cannot make any more contributions, but you can still make qualified withdrawals from your account.
- Your money rolls over every year. There is no "use it or lose it" rule.

ELIGIBILITY / YOU ARE ELIGIBLE IF YOU:

- Are covered by a qualified High Deductible Health Plan (HDHP);
- Are not covered by any other health insurance, including through a spouse's health plan or HRA;
- Are not enrolled in or covered by Medicare or Tricare benefits, and have not used Veterans or Indian Health Services coverage within a three month period;
- Are not covered by or eligible to make claims for a non-limited Flexible Spending Plan;
- Cannot be claimed as a dependent on another person's tax return.

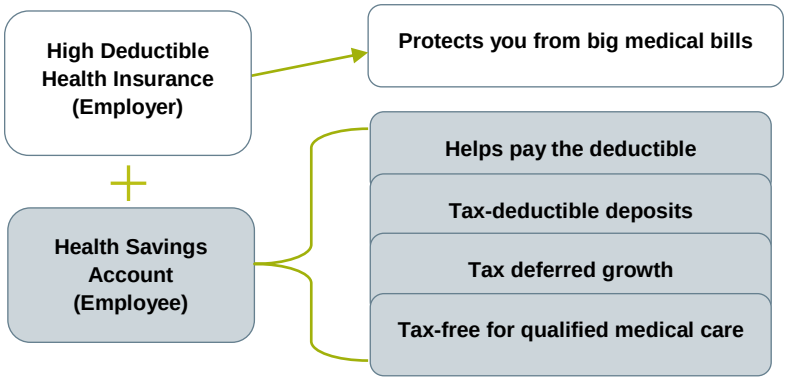
CONTRIBUTIONS

- You may contribute the annual maximum amount as determined by the IRS, regardless of your plan's deductible. Total contributions cannot exceed $3,450/Individual or $6,900/Family in 2018.
- For individuals age 55 or older an additional amount of $1,000 "catch-up" contributions are allowed for 2018.
- You may contribute the annual maximum amount, regardless of when your coverage begins, if you maintain coverage for the 12 month period beyond the calendar year in which you first became eligible. Pro-rating of contributions only occurs when the status of an HSA changes from family to single or if your medical coverage with the HSA qualified health plan is terminated.
- Your contributions are tax deductible and any payroll deductions for premiums through the Section 125 plan for your HSA are made on a pre-tax basis.

DISTRIBUTIONS

- You can use your money tax-free at any time for eligible medical expenses.
- If you are under age 65 and use your money for non-eligible medical expense, you will be subject to income tax and a 20% tax penalty.
- When you turn 65, you are not limited to using the money for eligible medical expenses. If you choose to use the money for purposes other than eligible medical expenses the money is subject to income tax, and there are no IRS penalties.
- You are responsible to determine if the distributions are qualified.
- You should keep records of your medical expenses to show that distributions are used exclusively for qualified expenses, in case the IRS requests them.

WHAT IS AN HSA?



The intent of this guide is to provide general information about HSA regulations. It is not intended to address specific situations or provide tax advice. Questions regarding specific issues should be discussed with a tax advisor.

VEBA HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

WHAT IS THE VEBA PLAN?

Funded with Leave Cash-Out Funds & Monthly Contributions
The VEBA Plan is defined by the IRS as a health reimbursement arrangement (HRA). When you become eligible to participate, your employer will make tax-free contributions to the VEBA Plan on your behalf. Typically, employers contribute funds that would otherwise be paid to you as taxable wages, such as sick leave cash out amounts. Your bargaining unit or employee group could also adopt a mandatory employee contribution, such as a monthly group salary reduction, that would be deducted from your paycheck and contributed by your employer to your VEBA Plan account. You can use your accumulated VEBA Plan (HRA) funds to reimburse qualified medical, dental, and vision expenses and premiums you may incur on behalf of yourself, your legal spouse, dependents, and adult children through the end of the calendar year in which they turn age 26. Depending on your plan, you can use your account during employment and after you separate from service or retire. For more information, go to **veba.org**.

HOW DO I BENEFIT FROM THE VEBA PLAN?

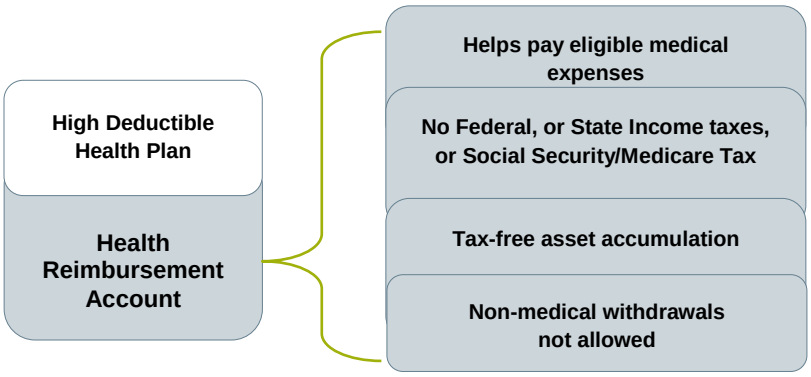
By participating in the VEBA Plan, you avoid paying federal income tax (15-25%, depending on your tax bracket) and Social Security and Medicare (FICA) taxes (up to 7.65%) on all contributions. In addition, all investment earnings and withdrawals (claims) for qualified healthcare expenses and premiums are tax-free. You can self-direct the investment of your account among the available investment options, which include several individual funds and pre-mixed portfolios.

HOW CAN I PARTICIPATE?

You may become a VEBA Plan participant when you become eligible to receive an unused leave cash out (either annually or at separation from service/retirement, so long as your employee group has agreed that, during the term of your annual employment contract, the District shall contribute such funds to the VEBA Plan. Your employee group could also agree to a mandatory employee contribution (group salary reduction), which would require each eligible employee within the group to participate by having a uniform, flat-dollar amount deducted from their paychecks and contributed to the VEBA Plan. IRS rules do not permit individual choice; all employee group members defined as eligible must participate. Employee groups vote annually to decide whether or not they will participate in the VEBA Plan. Check with your employee group leadership or the District's human resources department to find out whether your employee group has voted to participate in the VEBA Plan.

If you want a plan brochure or have a specific question, call the Gallagher VEBA Regional Office at (509) 838-5571 or visit the VEBA website at **veba.org**.

WHAT IS AN HRA?



STANDARD HRA PLAN

- The Standard HRA Plan accepts contributions only for participants who are enrolled in or covered by their employer's group medical plan. VEBA accounts for such participants are considered to be "integrated" with their employer's group medical plan.

POST-SEPARATION HRA PLAN

- The Post-separation HRA Plan is for participants who are not enrolled in or covered by a qualified group health plan and for whom VEBA accounts cannot be integrated. So, if you are receiving VEBA contributions and are not enrolled in or covered by your employer's group medical plan, you will likely have two VEBA accounts: your Standard HRA account with accumulated funds and a new Post-separation HRA account.

HEALTHCARE REFORM & YOUR BENEFITS

Under the Patient Protection and Affordable Care Act (PPACA) most individuals are required to have healthcare insurance or pay a penalty. You may have heard information from the media in recent months – some of it may seem confusing or conflicting. To help navigate the road ahead, we have highlighted the key changes you need to know.

YOU AND PPACA

As of January 1, 2014, individuals are required to have a minimum essential healthcare coverage. Very few exceptions apply. You can elect to obtain coverage through your employer, through your spouse's employer (if offered) or through a public exchange or "marketplace." If you and your dependents do not obtain coverage, you will incur a penalty each month you are uninsured.

YOU AND YOUR EMPLOYER

Your employer will continue to offer health and wellness benefits to help you and your family stay healthy and offer you financial protection against high medical costs.

Our benefits and our contribution toward them exceed the standards mandated under PPACA making sure you meet your obligations by law and do not incur a penalty. If you are currently purchasing coverage under our plan, you should experience very little change.

YOU AND THE PUBLIC EXCHANGE/MARKETPLACE

The marketplace (called Washington Healthplanfinder in Washington State) lets individuals compare and purchase health insurance directly. Individuals who are not offered qualified healthcare coverage through their employer may be eligible for government subsidies to help pay for premiums purchased through the marketplace (based on their income and number of dependents). Due to the high standard of healthcare coverage offered by your employer, the majority of our employees will not be eligible for subsidies.

ADDITIONAL RESOURCES

Federal Healthcare Reform

healthcare.gov

Washington State Health Plan Finder

wahealthplanfinder.org

Kaiser Family Foundation

kff.org

Arthur J. Gallagher & Co. Reference Site

www.gbshealthcarereform.com

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PLEASE NOTE

This has been prepared to provide a high level overview of how healthcare reform may affect you and your dependents and may not answer questions related to your specific situation.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your employer.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Ellensburg School District	4. Employer Identification Number (EIN) 91-6001849	
5. Employer address 1300 E. 3rd Ave	6. Employer phone number 509-925-8007	
7. City Ellensburg	8. State WA	9. ZIP code 98926
10. Who can we contact about employee health coverage at this job? Kim Snider		
11. Phone number (if different from above)	12. Email address Kim.snider@esd401.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  - Employees working the minimum hours outlined in each group collective bargaining agreement. Coverage begins the first of the month following 30 days of employment.

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  - Subscriber's legal spouse
  - Subscriber's state-registered domestic partner
  - Children under the age of 26

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

- All stages of reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or co-pays and co-insurance amounts.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (Newborns' Act) includes important protections for mothers and their newborn children with regard to the length of the hospital stay following childbirth. The Newborns' Act requires that group health plans that offer maternity coverage pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of Cesarean section).

OUT-OF-AREA BENEFITS

If you are traveling outside of your service area and need emergency medical care, you are entitled to receive care at the same cost as an in-network hospital or provider. Please note that continuous care after emergency situations are subject to out-of-network cost shares.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources Department.

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

The HIPAA law requires your employer to notify its employees that a privacy notice is available from the Human Resources Department. To request a copy of our Privacy Notice or for additional information, please contact Human Resources.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN *(CONTINUED)*

EXTENSION OF DEPENDENT COVERAGE TO AGE 26

Under the healthcare reform law, young adults will be allowed to stay on their parents' plan until they turn 26.

PATIENT PROTECTION DISCLOSURE NOTICE

Your carrier generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your carrier's customer service line listed under "Your Benefits Contacts" in the back of this Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in your carrier's network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact your carrier's customer service line listed under "Your Benefits Contacts" in the back of this Guide.

PREVENTIVE CARE

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. A list of these preventive services can be found on the HHS website at: **healthcare.gov/what-are-my-preventive-care-benefits/**.

COBRA

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGE

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

PLAN CONTACT INFORMATION

Ellensburg School District
Kim Snider, Director of Human Resources
1300 E 3rd Ave, Ellensburg, WA 98926
509-925-8007

FAMILY MEDICAL LEAVE ACT (FMLA)

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

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

Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Whether an employee has worked the minimum 1,250 hours of service is determined according to FLSA principles for determining compensable hours for work.

For specific questions, contact the HR department or contact the Department of Labor for a copy of the FMLA law.

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)**.

I 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, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/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

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

IMPORTANT NOTICE FROM ELLENSBURG SCHOOL DISTRICT ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current employer's coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current employer's coverage, be aware that you and your dependents will be able to get this coverage back by enrolling back into the employer's benefit plan during the Open Enrollment period under the employer's benefit plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE *(CONTINUED)*

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. **Note:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer's changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **socialsecurity.gov**, or call them at 800.772.1213 (TTY 800.325.0778).

Date:	November 1, 2018
Name of Entity/Sender:	Ellensburg School District
Contact--Position/Office:	Kim Snider, Director of Human Resources
Address:	1300 E 3rd Ave, Ellensburg, WA 98926
Phone Number:	509-925-8007

YOUR BENEFITS CONTACTS

ELLENSBURG SCHOOL DISTRICT

Human Resources Department
Day to day employee/retiree contact and questions

Kim Snider
Kim.snider@esd401.org
509-925-8007

HR Specialist

Derek Stuart
Derek.Stuart@esd401.org
509-925-8448

GALLAGHER BENEFITS SPECIALISTS

Arthur J. Gallagher & Co.

Kevin Best, Client Manager
Kevin_best@ajg.com
509-818-3087

If you do not receive satisfactory service from your insurance carriers, a Benefit Specialist (a service provided by Arthur J. Gallagher & Co.), is available to help with issues pertaining to your health, life and disability benefits.

www.ajg.com

Please do not include any confidential or sensitive information, such as social security numbers or health information, via email. Once you are connected to a Benefit Specialist, more sensitive information can be shared.

YOUR CARRIER CONTACTS

Benefit	Administrator	Phone	Website
Medical Insurance	Premera Kaiser Permanente	1-800-722-1471 1-888-901-4636	**www.premera.com** **www.kp.org**
Dental Insurance	WEA Delta Dental of WA	1-800-544-1907	**www.deltadentalwa.com**
Vision Insurance	WEA VSP	1-800-877-7195	**www.vsp.com**
Life/AD&D, LTD,STD Insurance	American Fidelity	1-800-325-0654	**https://americanfidelity.com**
Life/AD&D	Symetra	1-800-796-3872	**www.symetra.com**
Flexible Spending Accounts (FSA)	American Fidelity	1-800-325-0654	**https://americanfidelity.com**
Health Reimbursement Arrangement (HRA)	VEBA	1-509-838-5571	**www.veba.org**
Voluntary Benefits	AFLAC	509-833- 1215	**Tricia_charles@us.aflac.com**

SUMMARIES

- Medical
- Dental
- Vision

DISCLAIMERS

The intent of this booklet is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It should not be construed as, nor is it intended to provide, legal advice. Laws may be complex and subject to change. This information is based on current interpretation of the law and is not guaranteed. Questions regarding specific issues should be addressed by legal counsel who specializes in this practice area.

This proposal (analyses, report, etc.) is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal (analyses, report, etc.) is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

This analysis is for illustrative purposes only, and is not a proposal for coverage or a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. See your policy or contact us for specific information or further details in this regard.

While GBS does not guarantee the financial viability of any health insurance carrier or market, it is an area we recommend that clients closely scrutinize when selecting a health insurance carrier or HMO. There are a number of rating agencies that can be referred to including, A.M. Best, Fitch, Moody's, Standard & Poor's, and Weiss Ratings (TheStreet.com). Generally, agencies that provide ratings of U.S. Health Insurers, including traditional insurance companies and other managed care (e.g., HMO) organizations, reflect their opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. However, these ratings are not a warranty of an insurer's current or future ability to meet its contractual obligations.

KEY TERMS

BRAND NAME PRESCRIPTION DRUG

A prescription drug that is sold under a trademarked name. An equivalent generic drug may or may not be available at lower cost, depending on whether the patent on the brand name drug has expired.

COPAY

A flat dollar amount you pay for a medical service.

COINSURANCE

The percentage of the charges you are responsible for paying. For example, the plan pays 70% and you pay 30%.

DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses not subject to a copay.

EXPLANATION OF BENEFITS

The statement you receive from your insurance company detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

GENERIC PRESCRIPTION DRUG

A prescription drug made and distributed after the brand name drug patent has expired, and available at a lower cost than brand name prescriptions.

OUT-OF-POCKET (OOP) MAXIMUM

The most you pay in a calendar year for covered medical services. Once the OOP maximum is met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for covered services.

IN-NETWORK

Services from a provider or facility that is contracted with the insurance company. In-network providers agree to accept set fees for covered medical services and not bill you for any amounts over those fees. In-network providers also agree to bill the insurance company directly, so you will not have to pay up front and submit your own claims to the insurance company.

OUT-OF-NETWORK

Services from a provider or facility that is not contracted with the insurance company. If you receive services out-of-network, then you will typically have a higher coinsurance and you will be responsible for the difference between the provider's billed charge and the allowable charge.

PREVENTIVE CARE

Measures taken to prevent diseases. This includes routine cancer screenings, exams and certain drugs and immunizations. Most preventive care is covered-in-full by the plan, with no cost to you.