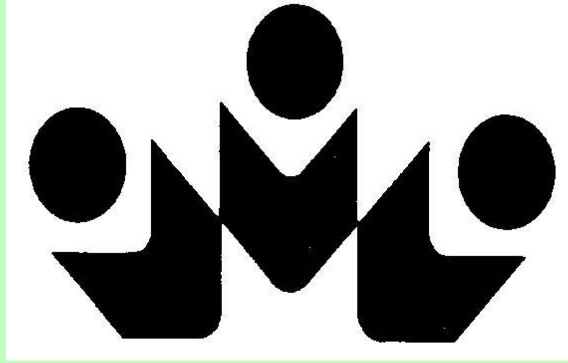

NORTHSHORE SCHOOL DISTRICT

Guide to Benefits

Plan Year 2019

Key Contacts

Kaiser Permanente
https://wa.kaiserpermanente.org
Plan # 004500, Hours 8am-5pm,M-F
PO Box 34585
Seattle, WA 98124-1585
(206) 901-4636 or (888) 901-4636

Regence Choice, Standard, Value, High Deductible Plan
www.regence.com
Plan # 10005292, Hours 6am – 6pm, M-F
PO Box 21267
Seattle, WA 98111-9124
(866) 240-9580

Northshore Vision & Hearing Plan
Ameritas Life Insurance Corp.
www.ameritas.com
P.O. Box 82520
Lincoln, NE 68501
(800) 487-5553

Express Scripts
https://www.express-scripts.com/
RxBIN 003858, RxPCN A4
RxGrp NOSHORE
Customer Service (800) 282-2881
1 Express Way
St. Louis, MO 63121

MetLife Dental Plan
www.metlife.com
Plan # 174616
(800) 942-0854
PO Box 981282
El Paso, TX 79998-1282
Fax Claims: (859) 389-6505, Attn: Claims

Willamette Dental Plan
www.willamettedental.com
Customer Service (800) 360-1909
Hours 8am – 5pm, M-F
Appointments (800) 359-6019
Hours 7am – 8pm, M-Th, 7am-6pm F

Optional Salary &/or Cancer Insurance
American Fidelity Assurance
565 Andover Park West Suite 102
Tukwila, WA 98188
(206) 575-8400 or (866) 576-0201

Flexible Spending/Section 125/ Health Savings Account
Navia Benefit Solutions
www.naviabenefits.com
(425) 452-3500 or (800) 669-3539
PO Box 53250 Bellevue, WA 98015-3250
Fax Claims: (425) 451-7002 or (866) 535-9227

Credit Union
Inspirus Credit Union
Formerly School Employees Credit Union of WA
www.inspiruscu.org
5200 Southcenter Boulevard
Seattle, WA 98188
(206) 628-4010 or (888) 628-4010

Retirement Contacts
WA State Dept of Retirement
www.drs.wa.gov
(800) 547-6657

PEBB, Health Care Authority
www.pebb.hca.wa.gov
(800) 200-1004

TRS/SERS Plan 3
savewithwa.empower-retirement.com
(888) 327-5596
Fax: (866) 745-5766

Worker's Compensation
Eberle Vivian
206 Railway Ave Kent, WA 98032
Claims: Royalee Watson
(253) 854-6323, ext. 139
Fax: (253) 854-6404
Hours: 8am – 3pm, M-F

Benefit Resource Center (BRC)
Kibble & Prentice Benefit Assistance Program
BRCWest@usi.com
(866) 468-7272

Employee Assistance Plan
Far West Family Service
www.farwestfamilyservices.com
Appointments: (206) 682-8149 or (800) 398-3440
Log-in: NSD password: NSD

2019 HEALTH BENEFITS COMMITTEE

Bus Drivers
Tamera Guthrie
Transportation
Tamera9001@hotmail.com
406-241-2322

NASA
Open

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NSEA
Open

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rhertzog@nsd.org
Ext. 7637

Pacific Northwest Regional Council of Carpenters
Ryan Ota
Support Services / Maintenance Dept.
rota@nsd.org
206-786-8391 (work cell)

United Classified Workers (Food Service)
Open

Warehouse Employees
Dave Wood
Support Services / Warehouse
Ext. 7870

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Siobhan Reid
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Benefits Effective January 1

This booklet provides a brief summary of information about your benefits program and enrollment requirements. You can contact the Benefits Office or visit our website to obtain additional information and brochures about each plan, including exclusions, conditions of coverage, etc. which may affect your benefits. The Benefits Office is available 8:00 AM to 4:30 PM.

Questions?

Our website at Northshore contains a variety of benefit information that is updated regularly. If you prefer speaking to someone, please call us. If you need to speak to us in person, we encourage you to call to arrange a time in advance so that we may serve you better.

⇨ **Audrey Martin at (425) 408-7612**

- Medical/Dental/Vision/Hearing
- Short and Long Term Disability
- Basic and Optional Life Insurance
- Workers' Compensation
- COBRA

⇨ **Toni Damron at (425) 408-7610**

- State Retirement, Deferred Compensation, 403(b) Plan
- Section 125 Flexible Spending Accounts, Health Savings Account
- VEBA
- Credit Union Membership

⇨ **Lisa McLean, Manager of Benefits and HRIS at (425) 408-7611**

Open Enrollment

Open Enrollment runs from *November 1 through November 30 each year*. Enrolled employees need not re-enroll unless a change in enrollment is desired, with the exception of the Flexible Spending Account Section 125 plan. Annual re-enrollment is required for the Flexible Spending Account Section 125 plan. Most additions and changes can only be made during Open Enrollment once a year. Under certain circumstances (a change in status), mid-year changes are permitted outside Open Enrollment. Changes submitted to the Benefits Office and approved by the 15th of the month will become effective on that month's payroll. Contributions to the Health Savings Account can only be made if enrolled in the qualified High Deductible Health Plan (HDHP).

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and provide proof that coverage ended.

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 your dependents, provided that you request enrollment within 30 days after the marriage, 60 days following birth, adoption, or placement for adoption. Additional Special Enrollment information can be found on page 25.

Eligibility and Funding

Employee Eligibility

Benefits are generally available to employees of the school district who work a minimum of 20 hours per week on a regularly assigned basis and are not excluded by bargaining agreement. Coverage for employees hired on or before the 15th of the month begins the first day of the next month (i.e., hired September 13, benefits begin October 1). Coverage for employees hired after the 15th of the month begins the first of the following month (i.e., hired September 18, benefits begin November 1).

New benefit-eligible employees have 30 days to enroll in all the benefit options. Employees not enrolling within 30 days of their eligibility date will next be able to enroll during Open Enrollment. For some benefits, there may be eligibility requirements and a medical review that must be met to participate outside of the first 30 days of eligibility. Participation would not be guaranteed.

Benefit changes, including adding dependents or changing insurance plans, can only be done during Open Enrollment, unless there is a qualifying event. Current employees need not re-enroll during Open Enrollment unless a change in enrollment is desired. Plan booklets are available through the district website.

Dependent Eligibility

Eligible dependents include:

1. The employee's lawful spouse. If your spouse has coverage with an employer and loses that coverage, they may be eligible for COBRA through their employer. In lieu of COBRA coverage through their employer, they may be eligible to be added to the district employee's coverage, without waiting until the next open enrollment. They must show proof of lost coverage, through no fault of their own (Insurance Certificate).
2. Dependent children are eligible for coverage until attainment of age 26. A natural child, adopted child or child legally placed for adoption (including a child for whom the employee has assumed a total or partial legal obligation for support in anticipation of adoption), stepchild, legally designated minor ward or when required by a court order.
3. Children who are incapacitated due to a developmental disability or physical handicap and chiefly dependent upon the employee, spouse, or non-covered legal parent for support and maintenance are also eligible for benefits, provided the dependent was covered immediately prior to the 26th birthday and the incapacity occurred prior to the 26th birthday if enrolled. Benefits will be provided for the duration of the incapacity unless coverage terminates. Proof of the incapacity will be required for each year of coverage.
4. The domestic partner of the subscriber. If all requirements are met, as stated in the signed "Affidavit of Qualifying Domestic Partnership," all plan provisions stated as applicable to a spouse will also be applicable to a domestic partner with the exception of COBRA eligibility. Domestic Partners are not eligible for COBRA continuation coverage. For domestic partners who do not qualify as dependents under Section 125 of the Internal Revenue Code, associated premiums will be paid by the employee with after-tax dollars.

A subscriber who covers a domestic partner may also cover the dependent children of the domestic partner. The child must meet the age requirements for dependent children as specified above. Except as stated under the "COBRA" provision, a domestic partner's child who is not a legal dependent of the subscriber may not be covered as the subscriber's dependent if the domestic partner is not also covered as the subscriber's dependent. The subscriber may continue enrollment of a domestic partner's incapacitated child as long as the domestic partner remains covered by this plan and the child remains chiefly dependent upon the domestic partner for support and maintenance.

Funding

Northshore School District contributes funds for each benefit eligible full time employee (FTE) to help cover the cost of employees' health care. The amount for the 2019 calendar year is $843.97. This amount is first applied to offset premiums for employees' dental, vision, hearing, long term disability, and basic life premiums. The remaining dollars are then used for medical premiums for employees and their dependents. If a particular employee's medical premium is less than the remaining available funds from the state, the excess dollars are allocated to a pool, which is used to reduce other employee premium deductions, which have a higher premium. If an employee selects a lower cost dental plan, the difference in premiums is applied to their out-of-pocket dependent medical premium.

No portion of the state allocation or pooling dollars can be applied to the purchase of other voluntary insurance programs.

Job Share Funding

Northshore School District contributes funds for each benefit eligible full time employee (1 FTE) to help cover the cost of employees' health care. In a job share situation, two people share one FTE. The amount for a job share employee for the 2019 calendar year is $421.99.

This amount is first applied to offset premiums for employees' dental, vision, hearing, long term disability, and basic life premiums. Any remaining dollars are then used for medical premiums for employees and their dependents.

Dental Plans

Enrollment in dental, vision and hearing plans are mandatory for benefit-eligible employees. Each employee can choose between two dental plans for their family, MetLife Dental Plan or Willamette Dental Plan. Both dental plans offer a flat monthly rate that covers the employee and their eligible dependents. Employees who choose the lower cost managed plan, Willamette Dental, will have the premium savings applied to any out-of-pocket premium they may have for the medical plan they choose. Employees who do not choose a dental plan within their first 30 days of eligibility will automatically be placed in the MetLife Dental Plan. Changes in dental plans are permitted during Open Enrollment.

Willamette Dental Plan

Willamette Dental is provided at a family rate of $91.75 per month. The premium is paid out of the district contribution. This is a managed care dental plan offering additional savings. Coverage for dental services is provided exclusively at one of several clinics in Washington State as part of the Willamette Dental Group (WDG). Appointments are scheduled by calling an 800 number and will be arranged at one of the clinics. New patients may have a few weeks wait for their first appointment. This is a managed care plan and it's possible you may see a different dentist for subsequent visits.

A list of clinics can be obtained in the Benefits Office or on the Willamette Dental website, www.willamettedental.com. Coverage is provided through a network of specific clinics therefore wait times for services may be longer. After the $15 per visit co-pay, most Class I, II, and III services are paid in full. There is a $50 co-payment per item for crowns, dentures, and bridge work. There is no deductible or annual maximum for this plan. Orthodontia (Class IV) has a separate co-pay. There is a non-refundable pre-orthodontic consultation fee of $150. This fee covers consultations, x-rays, study models and other services. This initial $150 payment is deducted from the total orthodontia co-payment should the patient undergo the prescribed orthodontia treatment. After the initial co-payment has been satisfied, the only additional out-of-pocket expense is an office visit co-payment per visit when treated at a Willamette Dental clinic. Orthodontic services are available for adults and children.

MetLife Dental Plan

The MetLife Dental Plan is a fully-insured program provided at a family rate of $126.72 per month for you and your eligible dependents. The premium is paid out of the district contribution. Covered dental services are available from any licensed dentist. You will have the greatest level of benefits when you see a contracted PPO dentist within the MetLife Network.

Class I and Class II expenses are subject to a 70/80/90/100% based on years of employment. Class III expenses are limited to an 80% maximum. For employees whose coverage begins after October 1, 2003, reimbursement will be paid at 70% of the schedule during the first year, 80% of the schedule during the second year, 90% of the schedule during the third year, and 100% of the fee schedule during the fourth year.

Plan Booklets outlining coverage reimbursement are available on the Benefit Office's website.

	MetLife Dental		Willamette Dental
Rates-paid out of district contribution	**$126.72/month family rate**		**$91.75/month family rate**
Providers Available	**MetLife PPO Dentist**	**Out-of-Network Dentist**	Non-Emergency care is available at 25 clinics in Washington. See your Plan Booklet
Deductible	None		None
Co-Pay	None		Office Visit $15 Pre-Orthodontic Service $150 Orthodontia $1,650 & Office Visit $15
Annual Maximum Benefit Class I, II, III	$2,500 per person per calendar year		No Annual Maximum
Class I Diagnostic and Preventative	70% for the first year (Increases 10% each sub-sequent year to a maximum of 100%)	70% of allowable expense for the first year (Increases 10% each subsequent year to a maximum of 100% of allowable)	$15 office visit co-pay
Class II Basic	70% for the first year (Increases 10% each sub-sequent year to a maximum of 100%)	70% of allowable expense for the first year (Increases 10% each subsequent year to a maximum of 100% of allowable)	$15 office visit co-pay
Class III Major	70% for the first year (Increases 10% each sub-sequent year to a maximum of 80%)	70% of allowable expense for the first year (Increases 10% each subsequent year to a maximum of 80% of allowable)	$50 co-pay per item (Crowns, Bridges, Dentures)
Class IV Orthodontia	Covered at 80% Limited to $500 for each calendar year up to a $2,500 lifetime maximum	Covered at 80% Limited to $500 for each calendar year up to a $2,500 lifetime maximum	Pre-Orthodontic Consultant Fee: $150 Includes consultations, x-rays, study models and other services Orthodontic Service Co-pay: $1,650 & $15 per Visit
Orthodontia Waiting Period	None		None

MetLife Dental Claims
PO Box 981282
El Paso, TX 79998-1282

Willamette Dental of Washington, Inc
6950 NE Campus Way
Hillsboro, OR 97124

Vision and Hearing Plans

Family Rate	$13.00/month

Vision Insurance

The vision coverage is a self-insured program of the district. This is a mandatory benefit. The premium is paid out of the district contribution. Ameritas administers the plan and processes claims. This coverage is for hardware, such as eyeglass frames, lenses, and contact lenses. **Eye exams for employees and covered dependents are covered under your medical insurance plan.** Claim forms for the Vision Insurance are available on our website at www.nsd.org/benefits or in the Benefits Office.

VISION PLAN	
Deductible	None
Basic Eye Examination	Covered under your health care plan
Lenses (one pair every 12 months) Single Vision Bifocal Vision Trifocal Vision Lenticular	 $ 77 $ 116 $169 $186
Contact Lenses Allowance once every 12 months in lieu of eyeglasses	 100% up to $150
Frames (once every 12 months)	100% up to $150
Corrective Surgery	$500/lifetime/per person

Hearing Devices

Coverage for hearing devices is a self-insured program of the district. This is a mandatory benefit. Ameritas administers the plan and processes claims. Claim forms can be obtained on our website or by contacting the Benefits Office. Coverage provides for hearing devices once each 24 months up to $1,500. The audiology exams for a hearing device are covered under your medical insurance plan. An audiology examination and hearing evaluation may be included in conjunction with the purchase of a hearing aid. Prices for similar hearing devices can vary significantly from one provider to another. Participants are encouraged to compare costs among providers prior to purchase.

HEARING DEVICES PLAN	
Deductible	None
Basic Hearing Test	Covered under your health care plan
Hearing Device Benefit	100% up to $1,500 maximum every 24 months

Ameritas Life Insurance Corp.
P O Box 82520
Lincoln, NE 98501

Medical Plans

Enrolling in a medical plan can only be done during your initial eligibility or during Open Enrollment. If you do not wish to make a change during Open Enrollment, your current coverage selection continues automatically. The district offers five separate medical plans. These plans offer you a choice between "managed care" and Preferred Provider Organization (PPO) coverage, which allows you a greater choice of doctors and services, but at higher out-of-pocket costs. Enrollment may require a payroll deduction based on the medical and dental plan you choose. Choosing Willamette Dental Plan will reduce your payroll deduction up to an additional $34.97.

It is important to review the programs carefully. This booklet may not include important coverage information including definitions, conditions of coverage, exclusions, pre-existing conditions, and other limitations on the medical plans. **Please refer to the specific plan book for information applicable to coverage.** Plan books are available on our website, from the Benefits Office, or through the carrier. Reduce your out-of-pocket costs by utilizing mail order prescription drug plans or generic medications. Forms are available in the Benefits Office, on our website, or through the insurance carrier.

Kaiser Permanente

Kaiser Permanente acquired Group Health Cooperative effective February 1, 2017. Kaiser Permanente's "Health Maintenance Organizations (HMO)" plan provides access to care from more than 1,000 Kaiser Permanente physicians and more than 9,000 additional in-network community providers around Washington State. Services must be provided or authorized by KP to be covered, with the exception of emergency care. Members may self-refer to many KP staff model specialists. This is the only purchased medical plan coverage offered by the district.

Regence BlueShield

Regence BlueShield has been providing health care coverage and plan administration in Washington since 1917. They have a roster of more than 19,000 participating physicians, dentists, and other providers—and a workforce of more than 2,000 employees, serving more than 1 million members. Benefits illustrated on the following pages assume that services are provided by practitioners from Regence's current list of "preferred providers" in Washington State, or a physician member of his/her local BlueShield organization outside Washington State. Please refer to the plan booklet for limitations, exclusions, and other conditions of coverage.

Four plans are administered through Regence. Benefits are ***self-insured*** by the Northshore School District. We contract with Regence to provide the provider network and administrative services for these plans. ***We encourage employees to order maintenance prescriptions via mail order where you'll receive three months of medication for the co-pay price of two months. Another way to save money is through the use of generic medications or ½ tablet prescription programs.*** Additional information and forms for these programs can be obtained from the Regence website, the Northshore website, or from the Benefits Office.

Regence PPO (Preferred Provider Organization) Choice, Standard, Value and High Deductible Health Plan (HDHP)

Regence PPO plans provide coverage for providers who maintain a special contractual relationship with Regence and appear on its list as:

Category 1 - Preferred Providers
Category 2 - Participating Providers
Category 3 - Non-contracted Providers

Category 1. If you choose to see a preferred provider, you will save the most on your out-of-pocket expenses. Choosing this category means you will not be billed for a balance beyond any deductible, co-payment, and/or coinsurance for covered services. You can find a list of providers at www.regence.com or by calling customer service.

Category 2. If you choose to see a participating provider, your out-of-pocket expenses will be higher than if you choose Category 1. You will not be billed for a balance beyond any deductible, co-payment, and/or coinsurance for covered services in this category.

Category 3. If you choose to see a provider that does not have a participating contract with Regence, your out-of-pocket expenses will generally be higher than Category 1 or 2. Also, choosing this category means you may be billed for balances beyond deductible, co-payment, and/or coinsurance. This is sometimes referred to as “balance billing.”

Our PPO plans include participation in a National “Blue Cross Blue Shield Global Core” system. This allows access to Blue Cross and BlueShield PPO networks nationwide.

Pharmacy Plan

Express-Scripts (ESI) is the largest independent manager of pharmacy benefits in the United States and one of the country's largest pharmacies, serving more than 85 million people. Express-Scripts is available for employees under the Regence Blue Shield plans.

Your Prescriptions drugs are dispensed by Express Scripts, Inc. The plan requires pharmacies to fill the prescription with a generic product whenever it is available, unless the prescription is written as "Dispense as Written". If the prescription is not specified as "Dispense as Written" and the prescription is filled with a name brand prescription at the Plan participant's request, then the copay plus the difference between the ingredient cost of the generic \ and the brand name drug will be charged.

Mail Order Program: The mail-order program allows you to save time on long term prescriptions. By participating in this easy program, you can avoid waiting in long lines at the pharmacy and best of all the shipping is FREE!

Many people request to have Express-Scripts contact their doctor to get a new 90-day prescription for home deliver. Then you can visit **Express-Scripts.com/Activate**, sign in and choose which of your current maintenance medications you would like to receive through home delivery.

Please Note: You can enjoy the convenience of home delivery, please follow these steps to get your prescriptions filled by the ESI Mail Service Pharmacy:

1. Ask your physician to write a new prescription for a 90-day supply of your medication, plus 3 refills for up to one year, if appropriate.
2. Complete, sign and attach an ESI Mail Order Form
3. Insert the original prescription and your appropriate copay into the completed mail order form and mail it.
4. When you fill a prescription through the Express Scripts Pharmacy for the first time, you can expect delivery of your order within two weeks from the time we receive the prescription from your doctor. We recommend that you have a 30-day supply of your medication on hand at the time of your order. Refills typically take three to five days to process and ship. Included with each prescription is a form that indicates the date when any remaining prescription refills should be reordered.
5. For your convenience refills can be processed by calling the mail order program or via the internet.
   Phone: (888) 201-5853
   Fax: (800) 396-2171
   Mailing Address: Express Scripts, Inc.
   P.O. Box 52123
   Phoenix, AZ 85072-2123
   Website Address: www.express-scripts.com

Mobile App: The Express-Scripts App allows you to access and manage your prescriptions anywhere. You can download for free from your device's app store. Express-Scripts.com/mobileapp.

Glossary of Health Care Terms

TYPES OF PLANS

Fully insured Plans: In a fully insured plan, the employer pays a per-member premium to an insurance company, and the insurance company assumes the risk of providing health coverage for insured events.

Self-insured Plans: In a self-insured plan, instead of purchasing health insurance from an insurance company and paying the insurer a per-member premium, the employer acts as its own insurer. In the simplest form, the employer uses the money that it would have paid the insurance company to instead directly pay health care claims to providers. Self-insured plans often contract with an insurance company or other third party to administer the plan, but the employer bears the risk associated with offering health benefits.

PROVIDERS

Preferred Provider Network: Providers (such as hospitals and physicians) who agree to charge a pre-negotiated rate for everyone on a particular health plan. Preferred providers are covered as Category 1 providers.

Participating Provider Network: Providers (such as hospitals and physicians) who have agreed to provide services to patients at rates pre-negotiated by the patient's health plan. Participating providers are covered as Category 2 providers.

Non-Network Providers: Providers (such as hospitals and physicians) who are not part of a particular Regence provider network. Some health plans cover non-network providers, but your costs will be higher. Non-network providers are covered as Category 3 providers.

MEMBER COSTS

Copay: A fixed dollar amount the member pays the provider when they receive a medical service.

Deductible: A fixed, annual dollar amount per calendar year that a member pays for medical services before the plan begins paying for covered medical services.

Coinsurance: The percentage a member pays toward the total negotiated charges for medical services.

Out-of-Pocket Maximum: A maximum amount you'll be responsible for paying toward your covered medical expenses in a calendar year. This amount varies by plan, and includes the deductible, coinsurance, and co-pays. After you have reached your out-of-pocket maximum, the plan pays 100% of remaining covered medical expenses in a calendar year.

PRESCRIPTION COVERAGE

Generic Drugs: Prescription medications that have the exact same active ingredients and strength as brand-name medications. Generics, as they're often called, are equal in therapeutic power to their brand-name counterparts. Health plans often encourage use of generics because they are usually much less expensive.

Formulary: A list of prescription medications covered by a health plan. Formularies can be open, meaning you may get some coverage for medications not on the list, or closed, meaning only medications on the list are covered. Formularies are also called "Preferred Medication Lists."

Non Formulary: Prescription medications that are not on the list of prescriptions covered by a health plan. Medications not on the list are covered but at a higher cost to members.

Closed Formulary: When formularies are closed, only medications on the formulary list are covered. Medications not on the list are not covered.

Medical Plans at a Glance

Note: Benefits outlined are based on use of Category 1, Preferred Providers

	Kaiser Permanente Group #0045000	**Choice PPO** Group #10005292	**Standard PPO** Group #10005292
Deductible **Per Calendar Year (PCY)**	$250 per person $750 per family	$250 per person $750 per family	$500 per person $1,500 per family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum **Per Calendar Year (PCY)** (includes annual deductible, coinsurance, and co-pays)	$2,000 per person $6,000 per family	$3,250 per person $6,750 per family	$4,500 per person $9,500 per family
Office or Home visits	(deductible applies) $30 co-pay, then 100%	(deductible waived) $30 co-pay, then 100%	(deductible waived) $40 co-pay, then 100%
Professional Services	(deductible applies) 100%	(deductible applies) 90%	(deductible applies) 80%
Outpatient Lab & X-ray	(deductible applies) 100%	(deductible waived) 90%	(deductible waived) 80%
Preventive Care	(deductible waived) 100%	(deductible waived) 100%	(deductible waived) 100%
Hearing (exam only)	(deductible applies) $30 co-pay, then 100%	(deductible waived) 100%	(deductible waived) 100%
Vision (exam only)	(deductible waived) $30 co-pay, then 100%	(deductible waived) $30 co-pay, then 100%	(deductible waived) $40 co-pay, then 100%
Prescription Drugs **Mail order**	(deductible waived) $20 generic, $40 brand, $60 non-formulary **Available**	$100 deductible (waived for generic) $15 generic, $40 brand formulary, $65 non-formulary, $150 specialty **90 day supply for 2 co-pays**	$150 deductible (waived for generic) $15 generic, $40 brand formulary, $65 non-formulary, $150 specialty **90 day supply for 2 co-pays**
Hospital Inpatient Room & Board, Intensive Care Medically Necessary Extras	(deductible applies) 100% (semi-private) 100%	(deductible applies) 90%	(deductible applies) 80%
Hospital Outpatient Emergency Room (co-pay waived if admitted) Outpatient Surgery Radiation and Chemo	(deductible applies) $75 co-pay, then 100% $30 co-pay, then 100% $30 co-pay, then 100%	(deductible applies) $150 co-pay, then 90% 90%	(deductible applies) $150 co-pay, then 80% 80%
Acupuncture **Limits are per calendar year**	(deductible applies) $30 co-pay, then 100% 8 visits per year	(deductible waived) $30 co-pay, then 100% 12 visits per year	(deductible waived) $40 co-pay, then 100% 12 visits per year
Spinal Manipulations	(deductible applies) $30 co-pay, then 100%, maximum of 10 visits per year	(deductible waived) $30 co-pay, then 100% 15 visits per year	(deductible waived) $40 co-pay, then 100% 15 visits per year
Inpatient Rehabilitation Services (includes occupational, speech, and physical therapy)	(deductible applies) 100% 60 days PCY	(deductible applies) 90% 30 days PCY	(deductible applies) 80% 30 days PCY
Outpatient Rehabilitation Services (includes occupational, speech, and physical therapy)	(deductible applies) $30 co-pay, then 100%, 60 visits PCY	(deductible waived) $30 co-pay, then 100%, 40 visits PCY	(deductible waived) $40 co-pay, then 100%, 40 visits PCY
Miscellaneous Durable Medical Equip & Supplies	(deductible waived) 100%	(deductible applies) 90%	(deductible applies) 80%
Chemical Dependency, Alcoholism, and Mental Health (inpatient, outpatient)	(deductible applies) Inpatient: 100% Outpatient: $30 co-pay	Outpatient (deductible waived) $30 co-pay, then 100% Inpatient (deductible applies) 90%	Outpatient (deductible waived) $40 co-pay, then 100% Inpatient (deductible applies) 80%

Kaiser Permanente: Customer Service Center 1-888-901-4636 Hours: Monday-Friday, 8:00am-5:00pm
Regence BlueShield PPO Plans: Customer Service Center 1-866-240-9580 Hours: Monday-Friday, 6:00am-6:00pm
[1] Plan may include coverage restrictions and limits for some services—see Plan Certificate for actual provisions.
Please refer to Plan Booklets for detailed coverage information. Plan Booklets are available on our website or by contacting the Benefits Office.

Medical Plans at a Glance

Note: Benefits outlined are based on use of Category 1, Preferred Providers

	Value PPO Group #10005292	**High Deductible PPO** Group #10005292
Deductible **Per Calendar Year (PCY)**	$1,000 per person $3,000 per family	$1,500 Individual enrollment $3,000 Family enrollment[2]
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Maximum **Per Calendar Year (PCY)** (includes annual deductible, coinsurance, and co-pays)	$6,350 per person $13,700 per family	$4,250/Individual $8,500/Family[2]
Office or Home visits	(deductible waived) $40 co-pay, then 100%	(deductible applies) 80%
Professional Services	(deductible applies) 80%	(deductible applies) 80%
Outpatient Lab & X-ray	1st $1,000 PCY covered at 100%, then deductible applies, 80%	(deductible applies) 80%
Preventive Care	(deductible waived) 100%	(deductible waived) 100%
Hearing (exam only)	(deductible waived) 100%	(deductible waived) 100%
Vision (exam only)	(deductible waived) $40 co-pay then 100%	(deductible waived) 100%
Prescription Drugs **Mail order**	$200 deductible (waived for generic) $15 generic, $50 brand formulary, brand non-formulary not covered **90 day supply for 2 co-pays**	(deductible applies) 80%
Hospital Inpatient Room & Board, Intensive Care Medically Necessary Extras	(deductible applies) 80%	(deductible applies) 80%
Hospital Outpatient Emergency Room (co-pay waived if admitted) Outpatient Surgery Radiation and Chemo	(deductible applies) $150 co-pay then 80% 80%	(deductible applies) 80% 80%
Acupuncture **Limits are per calendar year**	(deductible waived) $40 co-pay, then 100% 12 visits per year	(deductible applies) 80% 12 visits per year
Spinal Manipulations	(deductible waived) $40 co-pay, then 100% 15 visits per year	(deductible applies) 80% 15 visits per year
Inpatient Rehabilitation Services (includes occupational, speech, and physical therapy)	(deductible applies) 80% 30 days PCY	(deductible applies) 80% 30 days PCY
Outpatient Rehabilitation Services (includes occupational, speech, and physical therapy)	(deductible waived) $40 co-pay, then 100% 40 visits PCY	(deductible applies) 80% 40 visits PCY
Miscellaneous Durable Medical Equip & Supplies	(deductible applies) 80%	(deductible applies) 80%
Chemical Dependency, Alcoholism and Mental Health (inpatient, outpatient)	Outpatient (deductible waived) $40 co-pay, then 100% Inpatient (deductible applies) 80%	(deductible applies) 80%

Kaiser Permanente: Customer Service Center 1-888-901-4636 Hours: Monday-Friday, 8:00am-5:00pm
Regence BlueShield PPO Plans: Customer Service Center 1-866-240-9580 Hours: Monday-Friday, 6:00am-6:00pm

[1] Plan may include coverage restrictions and limits for some services—see Plan Certificate for actual provisions.

[2] The full family deductible must be met before benefits are paid at 80%. Coinsurance maximum for the family must be met before benefits are paid at 100%.

Please refer to Plan Booklets for detailed coverage information. Plan Booklets are available on our website or by contacting the Benefits Office.

Payroll Deductions and Premiums

Listed below are the 2019 estimated monthly deductions for each plan. The amount deducted from your paycheck will be reflected in the December payroll. Payroll deductions are determined from final pooling numbers that are calculated after the changes in enrollment are known. The pooling may cause a change in the amount of money applied toward your premium reductions and, as a result, may change your out-of-pocket deduction. Along with pooling and enrollment, your basic life insurance premium will affect your payroll deduction.

Medical Monthly Payroll Deductions for Kaiser Permanente

With Selection of **MetLife Dental** Plan	Kaiser	With Selection of **Willamette Dental** Plan	Kaiser
Employee Only	$106.00	Employee Only	$88.17
Employee + 1 Child	$153.49	Employee + 1 Child	$135.66
Employee + 2 or more Children	$301.11	Employee + 2 or more Children	$283.27
Each Additional Child	$ n/a	Each Additional Child	$ n/a
Employee + Spouse	$373.14	Employee + Spouse	$355.30
Employee + Spouse + 1 Child	$520.75	Employee + Spouse + 1 Child	$502.92
Employee + Spouse + 2 or more Children	$668.37	Employee + Spouse + 2 or more Children	$650.53
Each Additional Child	$ n/a	Each Additional Child	$n/a

Medical Monthly Payroll Deductions for Regence

Deduct $30 if you are eligible for the wellness incentive

Employees who obtain preventive care services prior to September 30, 2018 qualify for wellness premium discount in 2019.

With selection of **Willamette Dental** Plan

	Regence Choice	Regence Standard	Regence Value	Regence High Deduct
Employee Only	$191.45	$90.17	$65.17	$40.17
Employee + 1 Child	$397.12	$174.01	$67.08	$65.57
Employee + 2-8 Children	$616.32	$366.99	$175.31	$219.72
Each Additional Child	$61.20	$48.45	$38.25	$38.25
Employee + Spouse	$598.06	$350.90	$181.38	$206.87
Employee + Spouse + 1 Child	$835.53	$559.97	$333.60	$373.88
Employee + Spouse + 2-8 Children	$1,054.73	$752.97	$469.87	$528.03
Each Additional Child	$61.20	$48.45	$38.25	$38.25

With selection of **MetLife Dental** Plan

	Regence Choice	Regence Standard	Regence Value	Regence High Deduct
Employee Only	$209.29	$108.00	$83.00	$58.00
Employee + 1 Child	$414.95	$191.84	$84.92	$83.41
Employee + 2-8 Children	$634.16	$384.83	$193.15	$237.56
Each Additional Child	$61.20	$48.45	$38.25	$38.25
Employee + Spouse	$615.89	$368.74	$199.21	$224.71
Employee + Spouse + 1 Child	$853.37	$577.81	$351.43	$391.71
Employee + Spouse + 2-8 Children	$1,072.57	$770.80	$487.71	$545.86
Each Additional Child	$61.20	$48.45	$38.25	$38.25

Full Medical Premium (The full cost of the plan as paid by district. See above for your payroll deduction)

	Kaiser	Regence Choice	Regence Standard	Regence Value	Regence High Deduct
Employee Only	$692.14	$976.00	$683.68	$530.52	$548.28
Employee + 1 Child	$981.59	$1,494.26	$1,056.79	$792.13	$844.17
Employee + 2-8 Children	$1,271.03	$1,924.07	$1,435.19	$1,059.35	$1,146.43
Employee + Spouse	$1,412.27	$1,888.26	$1,403.64	$1,071.24	$1,121.22
Employee + Spouse + 1 Child	$1,701.71	$2,353.90	$1,813.58	$1,369.71	$1,448.69
Employee + Spouse + 2-8 Children	$1,991.15	$2,783.70	$2,192.00	$1,636.91	$1,750.95
Each Additional Child	$0.00	$120.00	$95.00	$75.00	$75.00

Section 125 Flexible Spending and Health Savings Accounts

Premium Only Plan (POP)

A Section 125 POP converts your payroll deduction for medical insurance premiums to a pre-tax savings payroll reduction. Employees are automatically signed up for a POP when they enroll for medical coverage, unless they opt out. Employees do not have to re-enroll in the POP during Open Enrollment or if there is a change in their benefit selection. Pre-tax premiums continue to be automatic. If you would like your premiums deducted on an after-tax basis, please contact the Benefits Office. For Domestic Partners who do not qualify as dependents under Section 125 of the Internal Revenue Code, associated premium will be paid by the employee with after-tax dollars.

Section 125 Flexible Spending Account (FSA)

Section 125 of the Internal Revenue Code allows an employee to set aside a certain amount of their paycheck on a pre-tax basis to pay for medical, dental, vision, and dependent care expenses not covered by your insurance. During the Plan Year you would be reimbursed from the account to pay these expenses.

The Plan runs from January 1 through December 31 each year. Elections can only be changed during Open Enrollment. Once you have completed the enrollment election, it will remain in effect until the end of the Plan Year. You must re-enroll during Open Enrollment each year to remain in the Plan. If you terminate employment prior to the end of the Plan Year, you will be able to request reimbursement only for expenses that you incurred prior to your termination.

Renewal in the Flexible Spending Account (FSA) is not automatic and must be done each Plan Year. New employees can elect to participate during the first 30 days of employment. You may enroll for a minimum reduction of $10.00 per month. The IRS projected maximum that can be deducted pre-tax from your paycheck for calendar year 2019 is $2,700 for your health account and $5,000 for your dependent care account. The FSA plan includes a **Carryover Provision** which allows participating employees to carry over up to $500 of unused funds remaining in the health account at the end of the calendar year. Carryover funds do not affect your ability to elect the maximum annual election allowed in the subsequent year. Even with the inclusion of a $500 Carryover, it is still important to conservatively estimate your expenses to insure your use of the funds because amounts over $500 will be forfeited. Enrollment materials that will provide you with all the necessary information and specific IRS tax rules are available in the Benefits Office. Claim forms may be obtained from our website or by visiting the Benefits Office. This Plan is administered by:

Navia Benefit Solutions
P. O. Box 53250
Bellevue, WA 98015-3250
Phone: (425) 452-3500 or toll-free (800) 669-FLEX (3539)
www.naviabenefits.com
customerservice@naviabenefits.com

Health Savings Account (HSA)

An individual or family of one or more covered dependents must be enrolled in a Qualified High Deductible Health Plan (HDHP) to be eligible to participate in the Health Savings Account. The HDHP allows you to set up an HSA to make pre-taxed contributions to help pay for non-reimbursed medical expenses. All contributions are owned by the employee. The contributions can be invested with the earnings accumulate on a tax-free basis. The funds can be rolled over and accumulate year to year.

Contributions and investment options will be administered through Navia Benefit Solutions. Although anyone can enroll in the HDHP the following federal regulations identify those not eligible to contribute money in an HSA:

1. Individuals on Medicare Part A & B
2. Individuals 65 and older collecting Social Security even if not enrolled in Part B
3. Individuals enrolled in another comprehensive Medical Plan unless it’s a qualified HDHP
4. Individuals participating in a General Purpose Health FSA (including a Spouse’s FSA)
5. Individuals covered by Veterans Administration health care in the last 3 months
6. Individuals Covered by Tricare
7. Individuals on Medicaid

HSA Advantages

If you set aside part of your paycheck, you won't make less money. Your net take-home pay will increase by the amount of taxes you did not pay. The amount of money you have available to pay expenses for you and your eligible dependent medical, dental, and eligible non-reimbursed care will actually increase. The savings result from the decrease in taxable income. The reductions are exempt from income tax and social security tax now and in the future. If your earnings are below the social security maximum, social security taxes will be reduced. Because benefits from social security are based on taxable earnings, your social security benefits could be slightly smaller as a result of contributing to an HSA. Most financial advisers would recommend that the anticipated tax reduction would more than offset the slight reduction in social security benefits. Washington State Retirement benefits are still applied to your gross earnings and are thus unaffected by participation in an HSA.

HSA Eligible Health Care Expenses

For plan year 2019 you may contribute up to $3,500 if enrolled as a single and $7,000 if enrolled as a family with one or more dependents. These contributions can be used for eligible medical expenses that include deductible and coinsurance amounts under a group health plan, charges that are in excess of the amount reimbursed under a group health plan, and charges that are not covered by a group health plan such as certain corrective surgery, vision care, dental care and hearing aids. **There is a 20% penalty if funds are used for ineligible expenses on top of your normal taxes.**

Examples of eligible and ineligible medical expenses can be found in the Enrollment Guide, Employee HSA Educational Guide, the Navia Benefit Solutions website, or the Northshore website.

Life Insurance

Basic Life Insurance

The district pays the premiums for Basic Life Insurance. The coverage is mandatory for benefit-eligible employees. Employees who do not complete an enrollment form within 30 days of eligibility will automatically be enrolled in Basic Life, but a claim would be paid based on completion of an enrollment and beneficiary form. The coverage provides life insurance and accidental death & dismemberment insurance in the amount of base salary (as defined by the carrier). Accidental death pays an additional one times your base salary. Newly hired eligible employees must complete a group enrollment form within 30 days of eligibility. Beneficiary designations continue in effect from year to year unless a subsequent beneficiary form is completed. Beneficiary changes can be made at any time.

Optional Supplemental Life Insurance

Employees can elect to purchase additional Optional Supplemental Life Insurance. You may enroll for an amount that is one times or two times your base salary (as defined by the carrier). At age 70 the amount of benefit is reduced to 50%. The payroll deduction is based on your annual base salary. If your base earnings change, the premium will change automatically. Enrollment is guaranteed during your first 30 days of employment. After your initial eligibility, if you desire coverage, a medical questionnaire must be completed and accepted by the insurance company before coverage would be approved.

Employer Paid	Employee Paid
Basic Life Insurance & AD&D One (1) times annual base salary ($250,000 max) Reduces to 50% at age 70	Optional supplemental Life Insurance & AD&D One (1) X annual salary ($150,000 max) **OR** Two (2) X annual salary ($300,000 max) Reduces to 50% at age 70 Monthly rate of 14.5 cents per thousand of annual base salary

Dependent Life Insurance

Employees can purchase Dependent Life Insurance for their spouse and dependent children. Enrollment is guaranteed if purchased within the first 30 days of eligibility. If elected after 30 days, a medical questionnaire and proof of insurability may be required. The coverage is family rated and is the same amount regardless of the number of family members. The amount of Optional Spouse and Optional Child life insurance may not exceed 50% of the total Employee life insurance amount (Basic Life amount + Optional Life amount).

Dependents Covered	Plan 1 Amount	Plan 1a Amount	Plan 2a Amount	Plan 2 Amount
Spouse	$10,000	$15,000	$20,000	$25,000
Children 6 month to 19 years	$ 5,000	$ 5,000	$10,000	$10,000
Child – live birth to 6 months	$ 1,000	$ 1,000	$ 1,000	$ 1,000
RATE PER MONTH	**$3.95**	**$5.84**	**$7.73**	**$9.62**

Disability Plans

Long Term Disability Insurance

The district provides Long Term Disability Insurance. Coverage is employer-paid. The coverage is mandatory for all benefit-eligible employees, but is not available to dependents. If an employee does not complete an enrollment form within 30 days of eligibility, they will automatically be set up in the 180-day plan. Changes are permitted only during Open Enrollment. The employee may choose between two options, a benefit that commences after 90 days of disability pays 55% of your base salary to age 65, or a benefit that commences after 180 days of disability pays 66 2/3% of base salary to age 65. Both options have a maximum benefit of $8,000/month. Social security, retirement, workers' compensation payments, etc., will decrease the benefit paid.

Optional Short Term Disability Insurance

This is a voluntary group disability insurance program sponsored by WEA and provided through American Fidelity Assurance Company. This coverage insures a portion of your salary, up to a maximum, if you are unable to work due to a disability. Coverage is available to benefit eligible employees. Health statements are not required when enrollment occurs within 30 days of eligibility; however, a pre-existing condition limitation is imposed. Brochures explaining coverage and payroll deduction rates are located on the Benefits webpage, www.nsd.org/benefits.

Employees, who enroll outside Open Enrollment, or their initial eligibility, may be required to complete a medical questionnaire for insurability and coverage is not guaranteed. Employees may decrease their coverage mid-year, but increases in coverage are only permitted during Open Enrollment. If an employee's salary increases, they can purchase additional coverage during Open Enrollment at available rates. A decrease in coverage can be decided at any time.

Optional Insurance Plans

Cancer Insurance

Cancer Insurance is an optional insurance provided by American Fidelity Assurance Company. The policy provides wellness benefits to help with the costs of screenings for the early detection of some cancers as well as the financial aid you may need if diagnosed with cancer. American Fidelity's Cancer Policy may help with the indirect costs of cancer. Limited Benefit Cancer Indemnity Protection benefits are paid directly to you, so they can be used however you need.

Coverage is available to benefit eligible employees. Brochures explaining the coverage and payroll deduction rates are available in the Benefits Office. Employees can enroll during Open Enrollment or their initial eligibility by contacting American Fidelity Assurance Company:

American Fidelity Assurance Company
565 Andover Park West #102
Tukwila, WA 98188
Phone: 206-575-8400 or
1-866-576-0201

Financial Benefits

403(b) Plan - Tax Sheltered Annuities/Custodial Accounts

All employees are eligible to participate in the 403(b) retirement plan sponsored by Northshore School District. Contributing to a 403(b) plan will help provide peace of mind through financial security during retirement. A 403(b) plan will allow employees to contribute a portion of the current year's compensation as a pre-tax or after-tax (Roth) contribution in order to save toward retirement. The IRS regulates the amount you may set aside each year. Enrollment and changes can be made at any time during the year. Participation in the 403(b) plan is completely voluntary.

The Plan website, maintained by NBS, www.nbsbenefits.com/403b, will serve as a resource to obtain information about the plan. The website includes:

- Plan forms
- List of approved investment providers
- General information about 403(b) investing

An investment company must have at least five participants to remain on the approved provider list. The Northshore School District does not represent, imply, or offer recommendations on any particular tax-deferred account type nor the investment companies offering the contracts. Advice should be sought from your tax advisor or through other investment or 403(b) professionals. The list of investment companies and enrollment procedures are available on the National Benefit Services webpage, www.nsd.org/benefits or from the Benefits Office.

Deferred Compensation Plan

In addition to investing in a 403(b), employees can also participate in the Deferred Compensation Plan (DCP) under the Internal Revenue Code 457. It is a supplemental retirement plan that provides district employees control and flexibility over their individual investments while reducing federal taxes owed for the current year. The plan provides an option to employees to invest income from their monthly paycheck on a tax-deferred basis. DCP has low management and administrative fees, no penalties on withdrawals, and portability. Enrollment and changes can be made at any time during the year. The IRS regulates the amount an individual may invest yearly. Employees can invest in both a 403(b) and the DCP simultaneously. The Department of Retirement Systems (DRS) administers the plan. A brochure is available in the Benefits Office or by contacting DCP at (888) 327-5596 or through their website at drs.wa.gov/dcp. You would enroll by contacting DCP directly.

Credit Unions

All employees of the district, including substitutes, are eligible to join Inspirus Credit Union. Employees may have their paycheck automatically deposited into a credit union. If you wish to enroll in either of the two credit unions, you can do so by completing a direct deposit form through payroll.

Inspirus Credit Union: www.inspiruscu.org

Annual Sick Leave Buy Back

Each January, employees who have more than 60 days of unused sick leave are eligible for the Sick Leave Buy Back program. The amount available for buy back only includes sick leave that remained unused in the previous calendar year. For example, if an employee earned 12 days of sick leave during the previous calendar year and used 4 days, they would have 8 days available for buy back. Sick leave buy back is paid at rate of 25%. Therefore, if 8 days were available for buy back, the employee would be paid 25% of that, or 2 days. Employees cannot buy back an amount that would cause their balance to fall below the minimum 60 days. The Sick Leave Buy Back program is coordinated through the Payroll Office.

VEBA Trust – Option

A VEBA account provides you with a source of funds on a pre-tax basis to pay for your qualifying out-of-pocket medical expenses and medical premiums. If your bargaining group has agreed to participate in the VEBA Trust, you may be eligible to convert your unused sick leave into a VEBA account. Depending on your bargaining agreement, a VEBA account may be set up for annual sick leave cash out or for sick leave cash out at retirement. To be eligible for the annual sick leave cash out, you must have at least 180 days of unused sick leave available on the day prior to your new contract start date. Your sick leave cash out is paid at 25% of your per diem rate. For the annual sick leave cash out, the maximum contribution is 25% of 12 days. At retirement, the maximum cash out is 25% of 180 days. There is no minimum for retirement cash out, but your entire sick leave would be contributed at a rate of 25% when you leave employment. When you leave service, you may be eligible for either retirement contributions or separation from service contributions, but not both. To be eligible for contributions at retirement, you must immediately begin receiving a state pension benefit.

Each bargaining group determines their group's participation. Your enrollment is required if agreed to by your bargaining unit or employee group. An employee must sign a hold harmless agreement to participate in the Plan. If an employee fails to sign and submit such agreement to the district, he/she will not be permitted to participate in the Plan at any time during the plan year, and any and all excess sick leave shall be forfeited together with all cash conversion rights that pertain to such excess sick leave.

The payment to VEBA Trust is currently non-taxable for social security and federal income tax and is excluded under Internal Revenue Code 419. Disbursements from the trust can only be made for medical expenses for you or your eligible dependents. Funds on deposit earn interest. Meritain Health

administers the VEBA Trust. For information on the Trust, call 1-888-828-4953. The tax-exempt status of VEBA is the responsibility of the Trust.

HomeStreet Bank

Northshore School District partnered with HomeStreet Bank to offer *The Home Town Home Loan Program*, an employer-assisted housing program. The Hometown Home Loan Program offers a wide selection of home loan options whether you are buying your first home or refinancing or remodeling your existing home. In addition, HomeStreet Bank offers Homeownership seminars throughout the school year. You can find out more information on our website or by contacting our HomeStreet Bank representative, Jeff Wood at (206) 264-4262 or (888) 425-6990.

Vendor Discounts

Many vendors have partnered with Northshore School District to offer discounts. The Benefits website has a current list of vendors who are participating in this program. Depending on the vendor, you may be required to provide a Northshore School District proof of employment at the time of purchase. The program is free to all eligible users. The website provides information on how discounts can be obtained. Please contact the vendors directly with questions, concerns, comments, and/or complaints. Neither the Northshore School District nor the Partnerships Office is responsible for precise details of any vendor offer.

Other Benefits

Workers' Compensation Insurance

All employees are covered by workers' compensation. Medical expenses and time loss benefits are paid for injuries incurred on the job. The Northshore School District is a self-insured employer. Eberle Vivian Inc. is the administrator of the plan and processes all claims.

Confidential Counseling - Far West Family Services

Northshore School District offers the services of the Employee Effectiveness Program through Far West Family Services. There are four office locations that provide services. They are located in Seattle, Bellevue, Tukwila, and Lynnwood. Contacts with Far West Family Services are private and not reflected in personnel records of an employee. Far West provides the following:

- Confidential Personal Counseling. The Employee Effectiveness Program provides short-term counseling services and referrals for you and your dependents. Just about any issue can be addressed; i.e., family adjustments, alcohol and drug abuse, marital/relationship issues, changes and transitions, career development, parent/child worries, emotional retirement preparation. You may wish to do a Healthy Family Skills Checkup which looks for satisfaction as well as distress within family interactions. Up to **six** free counseling sessions are available during a Plan Year. The Plan Year runs September 1 through August 31. To arrange for a confidential appointment, call (206) 682-8149 or 1 (800) 398-3440.

- Stressline. 24-hour access for immediate help, telephone counseling and information is provided through Stressline services. Call (206) 682-8149 or toll free at (800) 398-3440, give the name of your employer, Northshore School District, and start talking. You do not need to provide your name.

- Information. The Forecaster, a quarterly newsletter on personal issues, is provided to all employees at their work site. Informational brochures regarding topics on work and life concerns are available upon request or recommendation. A Computerized Resource Bank is available to provide referral information on treatment centers, legal assistance, etc. A 24-hour website is available that provides a resource data bank on self-tests, tip sheets, childcare, eldercare, adoption, schools, colleges, daily living, consumer issues, legal and financial planning, travel and recreation, personal growth, and working wellness. Visit www.farwestfamilyservices.com, click on Work/Life Login, password NSD.

Annual Legal Notices

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply per the benefit summaries outlined in this guide.

NEWBORNS ACT DISCLOSURE – FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Any applicable state law provisions should be outlined in the Summary Plan Description and benefits booklet. For more information, contact person listed at the end of this summary.

WELLNESS PROGRAM DISCLOSURE

Northshore School District offers a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you and your spouse (if covered under the plan) will be asked to complete a voluntary preventive annual health exam by your physician. You are not required to participate in the blood test or preventive annual medical examination.

However, employees who are enrolled on a Regence plan and choose to participate in the wellness program will receive a premium rate incentive for the following plan year. Although you or your spouse are not required to participate in the preventive annual medical examination, only employees and spouses who do so will receive the premium rate incentive.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Northshore School District may use aggregate information it collects to design a program based on identified health risks in the workplace, Regence will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is your physician in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the person listed at the end of this summary.

NOTICE OF PATIENT PROTECTIONS THAT REQUIRE DESIGNATION OF A PCP

Kaiser Permanente generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our 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 Kaiser Permanente at 206-901-4636.

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

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care 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 health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at 206-901-4636.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days (31 days under Kaiser Permanente)** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days (31 days under Kaiser Permanente)** after the marriage, and **60 days** after birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within **60 days** from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

COBRA
(CONSOLIDATED OMNIBUS RECONCILIATION ACT OF 1985)

You and/or each of your covered dependents may qualify to continue your group health care coverage that would otherwise end due to any of the following qualifying events:

- Termination of employment or through retirement for any reason other than your Gross Misconduct
- A loss of benefits due to a reduction in your work hours; or
- For your surviving spouse (and/or children) if coverage would otherwise end due to your death; or
- For your former spouse (and any children) if coverage would otherwise end due to divorce or legal separation; or
- For your spouse and/or children, if coverage would otherwise end due to your reduction in hours
- For your spouse and/or children if coverage would otherwise end due to your Medicare entitlement
- For your child if coverage would otherwise end because the child ceased to be a dependent

COBRA for employees, their spouse, or children must be paid through Automated Clearing House (ACH). The monthly premium is deducted from your personal checking account on the last day of the month proceeding the month of coverage. A voided check is required for set up.

Please note that Domestic Partners or non-qualified dependents do not qualify for COBRA coverage.

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 losing eligibility for coverage as a dependent child), you must give written notice to the Plan Administrator, Audrey Martin, in the Benefits Office within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Benefits Office 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 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. You must make sure that the Plan Administrator is notified, in person, of the determination within 14 days of receiving the Social Security Administration determination letter and before the end of the 18-month period of COBRA continuation coverage. The premium during the 11-month disability extension may increase to 150% of the regular COBRA premium. If the qualified

beneficiary is determined by Social Security Administration to no longer be disabled, you must notify the Northshore School District Human Resources Plan Administrator of that fact, in writing, within 30 days after Social Security Administration's determination.

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 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 Administrator. This extension is available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies or gets divorced or legally separated. You must make sure that the Plan Administrator is notified of the second qualifying event, in person, within 60 days of the second qualifying event. The notice must be made in writing to:

Audrey Martin
Human Resources Benefits Office
Northshore School District
3330 Monte Villa Parkway
Bothell, WA 98021-8972
(425) 408-7612

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified above. 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 Changes

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.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a participant in the Northshore School District Plan (the "Plan"), you are eligible for certain health care benefits. In the course of providing these benefits to you, the Plan may receive and maintain some of your medical information. Federal law requires that the Plan protect the privacy of, generally, medical information that identifies you and relates to your past, present or future health or condition, the provision

of health care to you, or the payment for health care received by you (“protected health information” or “PHI”). The Plan may hire other companies (“Business Associates”) to help provide health care benefits to you. These Business Associates may also receive and maintain your medical information.

The Plan is required to abide by the terms of the Notice currently in effect.

The Plan may change its privacy practices and the terms of this Notice at any time. Changes will be effective for all of your medical information received or created by the Plan. If the Plan changes its policies regarding the protection of your medical information, the Plan will mail you a new notice of privacy practices that incorporates any changes within 60 days. The Plan will also post a new notice on its internet website.

How The Plan May Use And Disclose Your Medical Information

The Plan may use and disclose your medical information without your written permission for the following purposes:

For treatment. While the Plan does not directly participate in decisions regarding your health treatment, the Plan may disclose medical information it has created or received for treatment purposes. For example, the Plan may disclose your medical information to your doctor, at the doctor's request, for his or her treatment of you.

For payment. The Plan or one of its Business Associates may use or disclose your medical information to pay claims for medical services provided to you or to provide eligibility information to your doctor when you receive medical treatment.

For health care operations. The Plan may provide your medical information to our accountants, attorneys, consultants, and others in order to make sure we are complying with federal law. Also, your medical information may be used or disclosed to assess the quality of health care that you receive or to assist the Plan in the management of its performance of administrative activities.

To you, your personal representative, or others involved in your healthcare. The Plan may provide your medical information to you and your legal representative. The Plan may also provide medical information to a person, including family members, other relatives, friends or others identified by you and acting on your behalf, so long as you do not object and the information is directly relevant to such person's involvement in your health care. For this purpose, a person acts on your behalf by being involved in the provision and/or payment of your health care.

As required by law. For example, the Plan may disclose your medical information to comply with workers' compensation laws or other similar laws.

To Business Associates. The Plan may disclose your medical information to its Business Associates so that they may perform the services that the Plan has asked them to perform. The Plan requires that these entities appropriately safeguard your medical information.

For health-related benefits. The Plan or one of its Business Associates may contact you about treatment alternatives or other health benefits or services that may be of interest to you.

<u>For other uses and disclosures permitted by law such as:</u>

- To public health authorities for public health purposes (e.g. the reporting of communicable diseases);
- To state agencies handling cases of abuse, neglect, or domestic violence;
- To a government agency authorized to oversee the health care system or government programs (e.g. determining eligibility for public benefits);
- To law enforcement officials for limited law enforcement purposes (e.g. to locate a missing person or suspect);
- To a coroner, medical examiner, or funeral director about a deceased person (e.g. to identify a person);
- To an organ procurement organization under limited circumstances;
- For research purposes in limited circumstances (e.g. if identifying information is removed or a research board has approved the use of the information);
- To avert a serious threat to your health or safety or the health or safety of others;
- To military authorities if you are a member of the armed forces or a veteran of the armed forces;
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes;
- To an executor or administrator of your estate; and
- To any other persons and/or entities authorized under law to receive medical information.

For any other use or disclosure of your medical information, the Plan must have your written authorization. You may cancel your written authorization for the use and disclosure of any or all of your medical information, unless the Plan has taken action in reliance on your permission.

Some uses and disclosures that require your authorization are those with respect to:

- Psychotherapy notes, except:
  - to carry out the following treatment, payment, or health care operations:
    - use by the originator of the psychotherapy notes for treatment;
    - use or disclosure by the provider for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or
    - use or disclosure by the Plan to defend itself in a legal action or other proceeding brought by the individual; or
  - with respect to a use or disclosure that is:
    - required by the Secretary to investigate or determine the Plan's compliance;
    - permitted to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law and in accordance with HIPAA;
    - to a health oversight agency for oversight activities authorized by law with respect to the oversight of the originator of the psychotherapy notes;
    - to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; or
    - as necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- Marketing except if the communication is in the form of:

    - a face-to-face communication made by a Plan to an individual; or
    - a promotional gift of nominal value provided by the Plan.

  If the marketing involves financial remuneration, to the Plan from a third party, the authorization must state that such remuneration is involved.
- Sale of PHI.

The Plan is prohibited from using or disclosing PHI that is genetic information of an individual for underwriting purposes.

The Plan is required by law to maintain the privacy of PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information received or created by the Plan and/or the Plan's Business Associates:

- The right to request restrictions on certain uses and disclosures of medical information; however, the Plan is not required to agree to such request unless:
    - the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
    - the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the Plan in full.
- The right to receive confidential communications of medical information by alternative means or at alternative locations.
- The right to inspect and copy medical information.
- The right to amend medical information.
- The right to receive an accounting of disclosures of medical information.
- The right, even if you have agreed to receive this notice electronically, to obtain a paper copy of this from the Plan upon request.

Although the Plan will utilize its best efforts to comply with your request, the Plan may legally deny your request under certain circumstances. The Plan will notify you of the reason for the denial and you will get a chance to respond. The Plan may not deny a request to communicate with you in confidence by a different means or location if the current means or location used by the Plan endangers you. The Plan may, however, request payment for any additional expenses it incurs to comply with your request. Your request to communicate by a different means or location must be in writing, include a statement that disclosure of all or part of the medical information by the current means could endanger you, specifically state the different means or location by which you would like the Plan to communicate with you, and continue to allow the Plan to pay claims.

Complaints

If you feel as if your privacy rights have been violated, you may file a written complaint with:

Lisa McLean
Human Resources Benefits Office

Northshore School District
3330 Monte Villa Parkway
Bothell, WA 98021-8972
(425) 408-7611

You may also send a written or electronic complaint to the Secretary of the Department of Health and Human Services. The complaint must state the name of the entity that is the subject of the complaint and describe the act or omissions believed to be in violation of law. A complaint must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred. The Plan may not retaliate against you if you file a complaint.

More information

If you would like more information about this Notice, please contact Lisa McLean at (425) 408-7611.

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 call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. 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.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
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: http://www.nyhealth.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: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	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/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**

Website: http://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/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://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://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: 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 July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor | U.S. Department of Health and Human Services

Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2018)

Preparing for 2020

Introducing

School Employees Benefits Board (SEBB)

https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program

Starting January 1, 2020

for

K-12 School Districts, Educational Services, and Charter schools

Starting January 1, 2020, all school districts, educational service districts, and charter schools will be required to participate in the SEBB Program. (RCW 28A.400.350(6))

The School Employees Benefits Board (SEB Board) will design and approve insurance benefit plans for school employees, and establish eligibility criteria for participation in these plans.

More information is available from the SEBB website above.

Your Benefits office will help guide you through the transition.