FEDERAL WAY
PUBLIC SCHOOLS

Each Scholar: A voice. A dream. A **BRIGHT** future.

Employee Benefit Handbook (FWEA and FWESP Only) 2018-2019

Benefit Fair

Wednesday, September 19th
2:00-6:00pm

ESC Conference Room 104
33330 - 8th Avenue South
Federal Way, WA 98003

OPEN ENROLLMENT DEADLINE

Enrollment changes must be made by September 28th

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

Dear Colleagues:

We are proud of the people behind the work, vision and passion for bringing out the best in every scholar.

The following pages describe the life, vision, dental, disability, medical and optional benefit coverages offered by the district. They also include information on who to contact, enrollment, pay dates, retirement, FMLA, COBRA and more.

For the benefit year 2018-19 numerous changes continue to occur, some of these are a result of our insurance providers, while others are a part of specific bargaining units and the never ending legislative requirements.

Please take time to review your benefits to ensure they support you and the needs of your family.

Be sure to take into consideration the 3Ps when deciding what medical plan is best for you.

Price (Premium Cost), Product (Benefit Use), Providers (Network of doctors and hospitals)

Important Highlights for the 2018-19 benefit plan year.

- Open Enrollment period August 27, 2018 through September 28, 2018 for November 1, 2018 coverage changes.
- Continued mandatory online enrollment system for all WEA Aetna and United Healthcare plans as well as WEA Delta Dental of Washington and Willamette Dental plans.
- Flex Plan forms for 2018-19 plan year due in to Payroll by October 30, 2018.

Please contact your Union if you have questions or concerns about the medical plans being offered.

Please review the complete hand book for additional information.

We encourage your participation in this year's Benefit Fair.
The Benefit Fair is on Wednesday, September 19, 2018 in the Federal Way District ESC Conference Room 104 from 2:00 to 6:00 pm

Thank you for the service you provide to our district, scholars, families and your fellow FWPS teammates.
Here's to a GREAT 2018-19 school year.

BENEFITS OFFERED BY BARGAINING UNIT

	Mandatory Benefits				Optional Benefits		
Bargaining Unit	Basic Term Life/AD&D	Vision	Dental (15 hrs wk)	Long Term Disability (17.5 hrs wk)	Medical (.5 FTE or 20 hrs wk)	Supplemental Term Life (15 hrs wk)	Voluntary Short-Term Disability (18.75 hrs wk)
FWEA Teachers	SunLife $25,000	Vision Service Plan	Delta Dental or Willamette Dental	Standard Insurance	Aetna, United Healthcare or Kaiser Permanente	SunLife $2.40 per $10,000 increments	Mutual of Omaha
FWESP Secretary	SunLife $10,000	Vision Service Plan	Delta Dental or Willamette Dental	Standard Insurance	Aetna, United Healthcare or Kaiser Permanente	SunLife $2.40 per $10,000 increments	Mutual of Omaha

IMPORTANT INFORMATION FOR 2018-19

Open Enrollment begins August 27, 2018 and ends September 28, 2018. This is your opportunity to make changes to your dental, medical, voluntary disability insurance and flexible spending plans for the 2018-19 plan year. There will be NO opportunity to make changes to your plan after these dates unless you have a qualifying event (see page 7). This is important if you wish to add a dependent who is not currently enrolled on your plan or if you want to move to a different plan for the 2018-19 plan year.

WEA Plans which include Aetna, United Healthcare, Delta Dental of Washington and Willamette Dental **requires employees to enroll and / or make online changes.** These changes have to be completed by September 28, 2018 for November 1st coverage change. It is **requested that you also email payroll** at 'Benefits' (in district) or Benefits@fwps.org if you change medical plans or dental carriers to ensure your payroll deductions are accurate.

Delta Dental of Washington and Willamette are family plans but ALL Dependents must be entered into the online enrollment system to ensure that dependents receive coverage.

Set up your online account at http://digital.alight.com/wea to view your current medical and Delta Dental of Washington or Willamette dental enrollment and to make changes (see page 7 for additional information).

Additional information will be available at the Benefit Fair on Wednesday, September 19, 2018 in the FWPS - ESC Conference Room 104 from 2:00 to 6:00 pm.

You may also contact the Payroll Department or our benefit broker, OneDigital, Jessica Carr at jcarr@onedigital.com or Jill Krueger at jkrueger@onedigital.com or call 253-858-5115.

School Employees Benefits Board (SEBB) Program

At the end of June 2017, the Washington State Legislature passed EHB 2242. This bill directs the Health Care Authority (HCA) to administer health care and other benefits (such as life insurance) for all Washington State school employees through the School Employees Benefits Board (SEBB) Program.

Starting January 1, 2020, all school districts and educational service districts will be required to participate in the SEBB Program. The SEBB Program will obtain health care and other benefits for eligible school employees statewide, and the benefits structure may change at that time.

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. The SEB Board is separate and independent from the Public Employees Benefits Board (PEB Board).

Information will be available well before open enrollment in fall 2019. You can visit www.hca.wa.gov/sebb to see the latest announcements and find updates on benefit plan offerings.

In anticipation of SEBB on 1/1/2020 the current PLAN YEAR for FWPS insurance benefits will be extended through 12/31/2019, NO lapse in coverage will occur.

CONTENTS

2018-19 PREMIUM CHANGES

Medical (Kaiser Permanente)	7.19% increase
Medical (AETNA & United Healthcare)	2.4% increase to a 2.2% decrease depending upon plan and network selection
Vision (VSP)	No rate change
Delta Dental of Washington	1.3% rate decrease
Willamette Dental	5.5% increase
Long Term Disability (Standard)	2.7% increase
Life Insurance (SunLife)	No rate change
Voluntary Life Insurance (SunLife)	No rate change
Voluntary Short Term Disability (Mutual of Omaha)	8.0% increase

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

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

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

Each carrier retains discretionary authority to administer their program according to the terms of their Master Group Contract. You must exhaust all claim appeal remedies outlined in the carrier's Master Group Contract before pursuing further/other legal action.

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

YOUR 2018-19 BENEFITS

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

*****Open Enrollment*****

Open enrollment is your opportunity you to make changes to your dental, medical and optional plans for the 2018-19 plan year. There will be NO opportunity to make changes to your plan after these dates unless you have a qualifying event (see page 7). This is important if you wish to add a dependent who is not currently enrolled on your plan or if you want to move to a different plan for the 2018-19 plan year.

Online Access: Your Benefits Resources at http://digital.alight.com /wea (or call 1-855-668-5039) to complete enrollment for medical, Delta Dental of Washington and Willamette dental plans.

KAISER PERMANENTE

- No changes to the plan for 2018-19
- You may now receive care through an online visit – for more information, see www.kp.org/wa/onlinevisit

WEA MEDICAL PLANS

- There are two medical carriers to choose from: AETNA and United Healthcare.
- Once you've selected a medical carrier, you must choose between the larger PPO network or a limited High Performance network with each carrier. It is important to note that not all providers are covered under these networks. There is no out-of-network service (except for emergencies) under the United Healthcare High Performance network. It is recommended that you confirm that your providers are contracted with the network you are choosing.
- Deductibles and out-of-pocket maximums run on a contract year rather than a calendar year and will reset November 1st each year.
- Telemedicine is available through Teladoc at no cost (with the exception of the High Deductible Health Plan). You will have access to care without having to visit a doctor's office via computer, smartphone or tablet.
- Out-of-network benefits differ between Aetna and United Healthcare and between the PPO and the High Performance networks. Additional coverage information available online at WEAselect.com or the call center for each carrier, Aetna (855) 878-4101 or United Health Care (844) 219-3630.

It is requested that you also email 'Benefits' (in district) or 'Benefits@fwps.org' if you change medical plans or dental carriers.

BENEFIT DOLLARS AND POOLING

STATE ALLOCATIONS FOR 2018-19

FWEA	$831.89* per mo / FTE
FWESP	$812.48* per mo / FTE

*Based on 2017-18 Bargaining Agreements

Amounts are pro-rates depending on individual benefit FTD which is calculated based on hours worked per week.

The state allocation is used first to pay for negotiated mandatory benefits such as life insurance, long term disability, dental and vision coverage. The balance of the allocation dollars are then pooled within bargaining units for employees to spend toward the purchase of medical benefits.

Employer Paid Guarantee for Medical Premium for full time FTE.

Premium Amount minus Employer Paid = Maximum Employee Cost

Group	w/ Delta Dental	w/ Willamette Dental
FWEA	$677.41*	$704.49*
FWESP	$660.40*	$687.48*

Additional money may be available through pooling. Pooling dollars are subject to change.

CUSTOMER SERVICE DIRECTORY

If you have questions a representative at the numbers below may be able to help. You can also refer to the enclosed Medical and Dental Comparisons for information.

Medical Coverage	AETNA – 855-878-4101 or www.weaselect.aetna.com (Group # 285730) United Healthcare – 844-219-3630 or wea.welcometouhc.com (Group # 911302) Kaiser Permanente – (888) 901-4636 or www.kp.org (Group # 0069600) Kaiser Permanente Consulting Nurse Service – (800) 297-6877		
Dental Coverage	Delta Dental of Washington – (800) 554-1907 or www.deltadentalwa.com/wea (Group # 00186-03320) Willamette Dental – (855) 433-6825 or www.willamettedental.com (Group # W210/WA299)		
Vision Coverage	Vision Service Plan (VSP) – (800) 877-7195 or www.vsp.com (Group # 07103510)		
Life & Accident Coverage • Group term life insurance • Accidental death and dismemberment • Additional group term life insurance	SunLife at (800) 733-7879 or www.SunLife.com (Group # 4005773)		
Income Replacement • Long term disability insurance • Short term disability insurance	Standard Insurance Co. (mandatory long term disability) (800) 368-1135 (Group # 629653) Mutual of Omaha (voluntary short term disability) (800) 877-5176		
Flexible Spending Accounts	Navia (425) 452-3500 or (800) 669-3539 or www.naviabenefits.com (Company code FSD)		
Employee Assistance Program	Health Venture (253) 572-5552 Morneau Shepell, BDA at (888) 293-6948 www.workhealthlife.com/Standard3 (Standard LTD eligible employees only)		
Eligibility & Enrollment	Benefits Specialist – (253) 945-2060 or Benefits@fwps.org		
Department of Retirement Systems • TRS, SERS & PERS	WA State Department of Retirement – (800) 547-6657 or www.drs.wa.gov. FWPS Retirement Specialist, Connie Gard (253) 945-2064 or retirement@fwps.org		
Benefits Advisor/Consultant	OneDigital – (888) 858-5115 or Jessica Carr jcarr@onedigital.com or Jill Krueger jkrueger@onedigital.com		
Payroll Department			
Patty McDugle	benefits@fwps.org	ext. 2060	Payroll Benefits Specialist
Connie Gard	cgard@fwps.org	ext. 2064	Payroll Retirement Specialist
Lynette Pearl	lpearl@fwps.org	ext. 2079	Payroll Compensation Specialist - Timesheets
Laveda Nichols	lnichols@fwps.org	ext. 2062	Payroll Compensation Specialist – Absence Sheets/Worker's Comp
Pam Jacobson	pjacobso@fwps.org	ext. 2061	Payroll Manager
Human Resources			
Susan Partain	spartain@fwps.org	ext. 2025	HR Specialist\FMLA and Leave Requests
Kelly Wittman	kwittman@fwps.org	ext. 2024	Compensation Specialist – Contract & Stipend Pay
Alicia Larsen	alarsen@fwps.org	ext. 2190	Compensation Specialist – Contract & Stipend Pay

ENROLLMENT INFORMATION

BENEFIT ELIGIBILITY

New Hires, Terminating Employees, and Employees on an Authorized Unpaid Leave: An employee must have a minimum of ten (10) earned work and/or paid leave time days per month to qualify for health benefits. If you have been granted a Family Medical Leave by Human Resources, please consult with Payroll regarding your benefit eligibility.

New hires become eligible for coverage on the first day of the month following the first payroll deduction of required premiums (if any). In most cases this means benefits start on the first day of the month following the date of hire.

(Note: Employees must have worked a minimum of two weeks in the month).

Open Enrollment Begins August 27, 2018 and Ends September 28, 2018. Open enrollment is your opportunity you to make changes to your medical, and dental plans for the 2018-19 plan year. During open enrollment you may choose the benefit plans for yourself and eligible dependents. Benefit or enrollment changes made by September 28, 2018 are effective November 1, 2018. Changes received after September 28, 2018 will not be processed.

OPEN ENROLLMENT DEADLINE FOR CHANGES

August 27, 2018 - September 28, 2018
(November 1, 2018 Coverage)

REQUIRED ACTIONS PRIOR TO THE ENROLLMENT DEADLINES:

If you wish to change medical or dental plans, add or delete dependents, or change coverages:

1. For Medical, Delta Dental of Washington and Willamette dental plans you must access Your Benefits Resources at http://digital.alight.com/wea (or call 1-855-668-5039). When electing medical - you must choose between Aetna and United Healthcare. Once you've selected a medical carrier, you must choose between the full PPO network or a limited High Performance network. It is important to note that not all providers are covered under these networks. There is no out-of-network service (except for emergencies) under the United Healthcare High Performance network. It is recommended that you confirm that your providers are contracted with the network you are choosing. Kaiser Permanente enrollment and / or changes still require you to complete paperwork available in Payroll.
2. Complete all enrollment changes by September 28, 2018 for November 1, 2018 coverage. If you do not complete enrollment by the deadlines, your current benefit elections will continue throughout the 2018-19 benefit year.
3. Contact the Payroll Department for questions and sign up regarding all other plans.

CHANGING YOUR ELECTIONS AFTER OPEN ENROLLMENT

Once open enrollment is over, you cannot change your elections unless you have a legally defined change in family status, such as:

- You get married, obtain domestic partnership, or divorce;
- You add a dependent child to your family through birth or adoption;
- An enrolled family member dies;
- You or your spouse go on an unpaid leave of absence;
- You or your spouse have a change in employment status (for example, you go from part-time to full-time or vice versa). Hours with FWPS increase to at least a .5 FTE or 20.00 per week;
- You waived medical coverage for yourself or your family members because of other health care coverage and you lose that other coverage for certain reasons.
- If you declined coverage when you were eligible to enroll in the group plan you may subsequently apply for coverage in the event that the Department of Social and Health Services (DSHS) has determined that it is cost-effective to enroll you or your eligible dependents in this health plan. Applications must be submitted within 60 days following the determination by DSHS.

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

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

BASIC LIFE INSURANCE (Enrollment form is your Beneficiary form)

Group Life/Accidental Death and Dismemberment (AD&D) insurance is provided by SunLife Employee Benefit.

This benefit is mandatory for all contracted employees. The benefit amount is dependent on your bargaining unit.

	Benefit Amount Basic Life	AD&D	Cost per Month
FWESP	$10,000	$10,000	$1.60
FWEA	$25,000	$25,000	$4.00

ADDITIONAL FEATURES

Accelerated Benefit: If you have a medical condition which is diagnosed by a doctor as life threatening and which results in an expected life span of 12 months or less, you may elect to receive up to 50% of your life insurance benefit immediately.

Higher Education Benefit: Unmarried children who are less than 25 years of age and who are already enrolled on a full-time basis in an accredited school at your death or enroll in an accredited school within one year of your death will receive $3,000 at the beginning of each school year for a maximum of 4 consecutive years.

Accidental Dismemberment Definition: If, due to an accident, a member loses 1 hand, 1 foot or the sight in 1 eye, the member will receive half of the AD&D benefit. If the member loses any 2 or more of the above, the full benefit will be received.

SUPPLEMENTAL TERM LIFE INSURANCE (EMPLOYEE PAID)
(Enrollment form is required if electing)
Supplemental Life is an optional benefit for employees working 15 or more hours per week and is only available in increments of $10,000. Spouse coverage is equal to half of employee supplemental coverage.

New employees may purchase up to $100,000 of coverage. If employees participate for themselves, they may also purchase up to $50,000 for a spouse and up to $25,000 for their children without answering health questions.

Benefit Amount

Employee Supplemental Life	$2.40 per each $10,000 of coverage ($200,000 maximum, not to exceed 5 times your basic annual earnings)
Spouse Supplemental Life	$1.20 per each $5,000 of coverage ($100,000 maximum)
Children (under 6 months old)	$0.90 per month for $500 of coverage
Children (to age 26)	$0.90 per each $5,000 of coverage ($25,000 maximum)

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

VISION BENEFITS

(No Enrollment form is required)
This is a family benefit and is mandatory for all bargaining units. The group number for the Vision Service Plan is 07103510. No benefit card will be issued. Your identification number is the last 4 digits of the Employee's SSN for you and your dependents.

BENEFIT FREQUENCIES

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

	VSP DOCTOR	NON-VSP DOCTOR
Rate (covers employee and all dependents)	$18.50 per month	
Examination	Paid in full	$45 allowance
$10 COPAY APPLIES TO ALL VISION HARDWARE / MATERIALS		
Lenses		
Single Vision Lenses	Paid in full	$45 allowance
Lined Bifocal Lenses	Paid in full	$65 allowance
Lined Trifocal Lenses	Paid in full	$85 allowance
Frames	Selection of frames from which to choose are paid in full up to $160 allowance. (An additional $20 allowance is available for some Name Brand frames)	$45 allowance
Contact Lenses Elective (in lieu of lenses and a frame)	No copay applies. $130 allowance	$105 allowance
	Contact lens exam and fitting fee is a separate charge included in the cost of the lenses. If you see a VSP provider you will pay no more than a $60 copay.	
Additional Pairs of Glasses	30% discount if purchased on the same day as exam by the same provider	Not included

Dependents are covered to age 26, regardless of student status.

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

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

VSP Claims
PO Box 385018
Birmingham, AL 35238-5018

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

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

HEARING AID DISCOUNT PROGRAM

TruHearing Membership is provided to all VSP members and their covered dependents. (Up to four extended family members including parents, grandparents and siblings are eligible).
The program includes:

- You can save up to $2,400 on a pair of hearing aids with TruHearing pricing.).
- 3 visits with hearing professional after purchase of hearing aids.
- 3-year repair warranty
- 48 batteries per purchased hearing aid.

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

DENTAL BENEFITS

(WEA Online Enrollment)
This is a family benefit and is mandatory for all bargaining units for employees working 15 or more hours per week.
ALL: Dependents must be entered into the online enrollment system or they may not receive any dental benefits.
Access Your Benefits Resources at http://digital.alight.com/wea (or call 1-855-668-5039) to modify your dependent information

	Delta Dental of Washington Select Dental Plan A (Group #00186-03320)	Willamette Dental Plan I (Group # W210/WA299)
Rate (including eligible dependents)	$ 114.48	$ 87.40
Provider Network	Use any licensed dentist. Use of Delta Dental member dentists provides better benefits. Delta Dental PPO dentists provide the best benefits.	Use a Willamette Dental Group office.
Annual Individual Benefit Maximum (Plan year runs 11/1-10/31)	$1,750 ($2,000 if Delta Dental PPO provider is used)	No maximum benefit, except TMJ
Annual Deductible	None	None
Diagnostic and Preventive Care – Exams, x-rays, cleanings, sealants, fluoride application	70% year 1, 80% year 2, 90% year 3, 100% year 4	100% after $15 copay
Routine Care – Fillings, oral surgery, root canals, periodontics, endodontics, extractions	70% year 1, 80% year 2, 90% year 3, 100% year 4	100% after $15 copay
Crowns	70% year 1, 80% year 2, 90% year 3, 100% year 4	100% after $50 copay
Dentures, Bridges, Partials	50%	100% after $50 copay
Implants	50%	Not covered (Members receive 20% off of the Willamette Dental provider's usual, customary and reasonable fee-for-service price of implant services.)
Emergency Treatment	70% year 1, 80% year 2, 90% year 3, 100% year 4	Covered after $15 copay
Orthodontia	50% to $1,000 lifetime benefit maximum	Treatment paid in full after a copay of $2,000 and $15 office visit copays
TMJ	50% up to $1,000 per year, $5,000 lifetime maximum	$1,000 annual maximum, $5,000 lifetime maximum
Dependents covered to age	26 regardless of student status	26 regardless of student status

DELTA DENTAL OF WASHINGTON

* Delta Dental requires each member to see the dentist at least once per year in order to move up to the next percentage. If you do not visit the dentist at least once in the year, your benefit percentages will drop by 10% below the last level of payment, but never below the original 70%. You can find a participating dentist in your area by visiting the Delta Dental website at www.DeltaDentalWA.com/findadentist. Be sure to select the appropriate plan – Delta Dental PPO or Delta Dental Premier – and follow the prompts.

WILLAMETTE DENTAL:

Willamette Dental is an exclusive provider network. Benefits are covered under a Willamette Dental group provider. To find a provider in your area, please visit their website at www.willamettedental.com or call 1.855.433.6825 to speak to a member services representative.

DISABILITY INSURANCE

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

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

	Mandatory Long Term: Standard Insurance (District Paid) (No enrollment form required)	Voluntary Short Term: Mutual of Omaha (Employee Paid) (Enrollment form required if electing)
Monthly Rate	$18.00	Varies per employee
Eligibility	17.5 hrs per week minimum	18.75 hours per week minimum
Minimum Benefit	$100 per month	$25 per week
Maximum Benefit	$10,000 per month	$1,400 weekly benefit
Covered Earnings	60% of pre-disability earnings; or 70% of pre-disability earnings reduced by deductible income	Not to exceed 66 2/3% of regular monthly earnings
Waiting Period	90 Days	7th day accident; 7th day illness
Benefit Period	To Social Security Retirement age	13 weeks

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

MEDICAL BENEFIT MONTHLY RATES

During open enrollment, you may choose between Kaiser Permanente, AETNA, or United Healthcare (UHC). If you select AETNA or UHC, you must choose between the full PPO network and the limited High Performance network. It is important to note that not all providers are covered under these networks. There is no out-of-network service (except for emergencies) under the United Healthcare High Performance network. It is recommended that you confirm that your providers are contracted with the network you are choosing.

	AETNA or UNITED HEALTHCARE	AETNA OPEN ACCESS PPO	AETNA WHOLE HEALTH IN PUGET SOUND HIGH PERFORMANCE	UNITED HEALTHCARE CHOICE PLUS PPO	UNITED HEALTHCARE NAVIGATE BALANCED HIGH PERFORMANCE
PLAN 2	Employee only	$ 972.38	$ 883.7	$1,014.95	$909.72
	Employee & Spouse	$1,788.84	$1,625.04	$1,867.46	$1,673.10
	Employee, Spouse & Child(ren)	$2,143.57	$1,947.14	$2,237.85	$2,004.77
	Employee & Child(ren)	$1,306.87	$1,187.42	$1,364.20	$1,222.46
PLAN 3	Employee only	$ 890.22	$ 809.10	$ 925.56	$835.82
	Employee & Spouse	$1,638.86	$1,488.86	$1,704.20	$1,538.27
	Employee, Spouse & Child(ren)	$1,961.59	$1,781.90	$2,039.87	$1,841.10
	Employee & Child(ren)	$1,196.20	$1,086.93	$1,243.80	$1,122.93
PLAN 5	Employee only	$1,135.56	$1,031.86	$1,178.58	$1,056.80
	Employee & Spouse	$2,192.79	$1,991.83	$2,276.17	$2,040.16
	Employee, Spouse & Child(ren)	$2,634.62	$2,393.01	$2,734.86	$2,451.12
	Employee & Child(ren)	$1,550.34	$1,408.48	$1,609.19	$1,442.60
QHDHP	Employee only	$ 511.69	$ 465.40	$ 528.54	$477.35
	Employee & Spouse	$ 941.98	$ 856.09	$ 973.23	$878.26
	Employee, Spouse & Child(ren)	$1,119.63	$1,017.40	$1,156.82	$1,043.79
	Employee & Child(ren)	$ 684.81	$ 622.59	$ 707.46	$638.65
EasyChoice A	Employee only	$ 670.86	$ 609.92	$ 680.35	$610.24
	Employee & Spouse	$1,227.30	$1,115.17	$1,244.75	$1,115.75
	Employee, Spouse & Child(ren)	$1,467.10	$1,332.90	$1,487.99	$1,333.60
	Employee & Child(ren)	$ 898.74	$ 816.83	$ 911.49	$817.26
EasyChoice B	Employee only	$ 699.59	$ 636.00	$ 712.39	$638.85
	Employee & Spouse	$1,283.60	$1,166.29	$1,307.23	$1,171.55
	Employee, Spouse & Child(ren)	$1,533.80	$1,393.47	$1,562.06	$1,399.76
	Employee & Child(ren)	$ 937.34	$ 851.88	$ 954.44	$855.71
BASIC PLAN	Employee only	$ 554.72	$ 504.46	$ 575.01	$518.25
	Employee & Spouse	$1,025.07	$ 931.54	$1,062.82	$957.20
	Employee, Spouse & Child(ren)	$1,218.45	$1,107.13	$1,263.38	$1,137.68
	Employee & Child(ren)	$ 742.09	$ 674.60	$ 769.34	$693.12

HMO	KAISER PERMANENTE OF WA	
	Employee only	$ 877.30
	Employee & Spouse	$1,700.98
	Employee, Spouse & Child(ren)	$2,049.60
	Employee & Child(ren)	$1,225.94

MEDICAL BENEFIT COMPARISON

	Kaiser Permanente Managed Care	WEA Select Plan 2
BENEFITS AT A GLANCE		
Annual Deductible	No deductible	$300 per individual / $600 per family per year
Office Calls and Urgent Care	$30 copay	$25 copay, $35 specialist copay
Out-of-Pocket Maximum	$1,000 per individual / $2,000 per family	$3,000 per individual / $7,500 per family. (Includes medical copay, deductible, coinsurance and Rx.)
Out-of-Network Benefits (Note: Out-of-network benefits differ between Aetna and United Healthcare and between the PPO and the High Performance networks. Additional coverage information available online at WEAselect.com or the call center for each carrier, Aetna (855) 878-4101 or United Healthcare (844) 219-3630.)	Not covered	$30 office visit copay, $40 specialist. Services generally covered at 60% of allowed amount after deductible to separate $3,400 individual / $10,200 family out-of-pocket maximum (Separate $800 individual / $2,400 family deductible and no out-of-pocket maximum Aetna High Performance Network) <u>No out-of-network coverage under United Healthcare High Performance network.</u>
Prescription Drugs Generic Preferred Brand Name Non-Preferred Brand Name Specialty Days Supply	$10 copay Generic, $20 copay Brand Name, must be prescribed by KP provider, filled at KP pharmacy and in KP formulary 30-day supply (Mail order 90-day supply for 2 copays)	Retail / Mail Order $10 / $20 $20 / $40 $35 / $65 $50 copay 30-day supply 34 / 100
Spinal Manipulations (Chiropractic)	$30 copay, 10 visit limit	$25 copay, 52 visit limit
Diagnostic X-Ray / Lab	Covered in full, high end radiology requires prior authorization	80% after deductible
PREVENTIVE CARE		
Well Child Care	Covered in full	Covered in full
Routine Physicals	Covered in full	Covered in full

Medical coverage is an optional benefit and you must work at least a .5 FTE or 20.00 hours per week to be eligible. Actual dollars available to each employee will depend on pooling amounts which will vary for each bargaining unit (see Page 4).

MEDICAL BENEFIT COMPARISON

WEA Select Plan 3	WEA Select Plan 5	WEA Qualified High Deductible Health Plan
$500 per individual / $1,000 per family per year	$200 per individual / $400 per family per year	$1,750 if enrolled as employee only / $3,500 if enrolled as employee and dependent
$30 copay, $40 specialist copay	$20 copay, $30 specialist copay	80% after deductible
$3,750 per individual / $9,375 per family. (Includes medical copay, deductible, coinsurance and Rx.)	$2,000 per individual / $5,000 per family. (Includes medical copay, deductible, coinsurance, and Rx.)	$5,000 if enrolled as employee only / $10,000 if enrolled as employee and dependent.
$40 office visit copay, $50 specialist. Services generally covered at 60% of allowed amount to separate $5,900 individual / $17,700 family out-of-pocket maximum. (Separate $1,000 individual / $3,000 family deductible and no out-of-pocket maximum on Aetna High Performance Network) No out-of-network coverage under United Healthcare High Performance network.	Generally covered at 70% (60% Aetna High Performance network) of allowed amount after separate $350 deductible per member. No out-of-pocket maximum applies. Preventive and Well Child Care not covered out-of-network. (Separate $700 individual / $2,100 family deductible and no out-of-pocket maximum on Aetna High Performance Network) No out-of-network coverage under United Healthcare High Performance network.	Generally covered at 50% after separate $3,000 individual / $6,000 family deductible. No out-of-pocket maximum applies. Preventive and Well Child Care not covered out-of-network. Preventive screenings covered at 50%. (Separate $2,250 individual / $4,500 family deductible and no out-of-pocket maximum on Aetna High Performance Network) No out-of-network coverage under United Healthcare High Performance network.
Retail / Mail Order $15 / $30 $25 / $50 $40 / $70 $60 copay 30-day supply 34 / 100	Retail / Mail Order $10 / $20 $15 / $30 $30 / $60 $50 copay 30-day supply 30 / 90	80% after deductible Retail – 30-day supply Mail Order – 90-day supply
$30 copay, 52 visit limit	$20 copay, 52 visit limit	80% after deductible, 12 visit limit
80% after deductible	90% after deductible	80% after deductible
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full

MEDICAL BENEFIT COMPARISON – cont.

	Kaiser Permanente Managed Care	WEA Select Plan 2
HOSPITAL		
Inpatient Care	Covered in full	80% after deductible and $150 per admission copay
Emergency Care	$100 copay	Aetna 80% after deductible and $125 copay; UHC Flat $300 copay
OTHER BENEFITS		
Acupuncture	$30 copay, 8 visits per medical diagnosis per calendar year	$25 copay, 12 visits per year
Ambulance Services	80%	80% after deductible
Chemical Dependency	Inpatient: Covered in full Outpatient: $30 copay per visit.	Inpatient: 80% after deductible and $150 inpatient copay per day ($450 maximum copays collected per year) Outpatient: $25 copay
Maternity	$30 copay per visit, delivery covered in full	80% after deductible; $150 copay per day ($450 maximum copays collected per year)
Mental Health	Inpatient - covered in full Outpatient - $30 copay	Inpatient – 80% after deductible and $150 copay per day ($450 maximum copays collected per year) Outpatient - $25 copay
Naturopathic	$30 copay, 3 visits per medical diagnosis per calendar year	$25 copay
Outpatient Surgery	$30 copay	$100 copay and 80% after deductible
Rehabilitation (includes Physical Therapy)	$30 copay; 60 visit limit per calendar year	Inpatient: 80% after deductible and $150 inpatient copay per day ($450 maximum copays collected per year), 120 maximum days Outpatient: $35 copay, 45 visit limit (includes physical therapy)
Dependents covered to age	26 regardless of student or marital status	26 regardless of student or marital status
Organ Transplant Waiting Period	None	None
Life Insurance	None	$12,500 (to age 65)

MEDICAL BENEFIT COMPARISON – cont.

WEA Select Plan 3	WEA Select Plan 5	WEA Qualified High Deductible Health Plan
80% after deductible and $300 per admission copay	90% after deductible and $150 per admission copay	80% after deductible
Aetna:80% after deductible and $150 copay; UHC Flat $300 copay	Aetna 90% after deductible and $100 copay; UHC Flat $300 copay	80% after deductible
$30 copay, 12 visits per year	$20 copay, unlimited	80% after deductible, 12 visits per year
80% after deductible	90% after deductible and $50 copay	80% after deductible
Inpatient: 80% after deductible and $300 inpatient copay per day ($900 maximum copays collected per year) Outpatient: $30 copay	Inpatient: 90% after deductible and $150 per day copay ($450 maximum copays collected per year) Outpatient: $20 copay	80% after deductible
80% after deductible and $300 copay per day ($900 maximum copays collected per year)	90% after deductible and $150 per day copay ($450 maximum copays collected per year)	80% after deductible
Inpatient – 80% after deductible and $300 copay per day ($900 maximum copays collected per year) Outpatient - $30 copay	Inpatient – 90% after deductible and $150 per day copay ($450 maximum copays collected per year) Outpatient – $20 copay	80% after deductible
$30 copay	$20 copay	80% after deductible
$150 copay and 80% after deductible	90% after deductible	80% after deductible
Inpatient: 80% after deductible and $300 inpatient copay per day ($900 maximum copays collected per year), 30 maximum days Outpatient: $40 copay, 45 visit limit (includes physical therapy)	Inpatient: 90% after deductible and $150 per day copay ($450 maximum copays collected per year) 30 maximum days Outpatient: $30 copay, 45 visit limit; (includes physical therapy)	Inpatient: 80% after deductible, 30 maximum days Outpatient: 80% after deductible, 15 visit limit
26 regardless of student or marital status	26 regardless of student or marital status	26 regardless of student or marital status
None	None	None
$12,500 (to age 65)	$12,500 (to age 65)	$12,500 (to age 65)

MEDICAL BENEFIT COMPARISON –WEA EASYCHOICE

	WEA Select Plan EasyChoice A
BENEFITS AT A GLANCE	
Annual Deductible	$1,250 per person/$2,500 per family
Office Calls and Urgent Care	$25 copay, $35 specialist copay
Out-of-pocket Maximum	$5,000 per person/$10,000 per family. (Includes medical copay, deductible, coinsurance, and Rx.)
Out-of-Network Benefits (Note: Out-of-network benefits differ between Aetna and United Healthcare and between the PPO and the High Performance networks. Additional coverage information available online at WEAselect.com or the call center for each carrier, Aetna (855) 878-4101 or United Healthcare (844) 219-3630.)	Services generally covered at 50% of allowed amount (60% Aetna High Performance network) after separate $2,000 per person / $6,000 per family deductible (Separate $1,750 individual / $5,250 family deductible Aetna High Performance network) No out-of-pocket maximum No out-of-network coverage under United Healthcare High Performance network.
Prescription Drugs	
Deductible	$500 per person
Retail	
Generic	$10 (deductible waived)
Preferred Brand Name	Member share is 30% after deductible up to $150 per prescription
Non-Preferred Brand Name	Member share is 30% after deductible up to $300 per prescription
Specialty Drugs	Member share is 30% after deductible up to $200 per prescription
Days Supply	30 day supply
Mail Order	
Generic	$20 (deductible waived)
Preferred Brand Name	Member share is 30% after deductible up to $350 per prescription
Non-Preferred Brand Name	Member share is 30% after deductible up to $450 per prescription
Days Supply	90 day supply
Spinal Manipulations (Chiropractic)	$25 copay, 12 visit limit
Diagnostic X-Ray / Lab	First $250 deductible waived, then 80% after deductible
PREVENTIVE CARE	
Well Child Care	Covered in full
Routine Physicals	Covered in full

MEDICAL BENEFIT COMPARISON –WEA EASYCHOICE & BASIC

WEA Select Plan EasyChoice B	WEA Basic Plan
$750 per person/$1,500 per family	$2,100 per person/$4,200 per family
$30 copay, $40 specialist copay	$35 copay, $50 specialist copay
$4,500 per person / $9,000 per family. (Includes medical copay, deductible, coinsurance, and Rx.)	$6,600 per person / $13,200 per family(Includes deductible and coinsurance)
Services generally covered at 50% of allowed amount (60% Aetna High Performance network) after separate $1,500 per person / $4,500 per family deductible (Separate $1,250 individual / $3,750 family deductible Aetna High Performance network) No out-of-pocket maximum No out-of-network coverage under United Healthcare High Performance network.	Services generally covered at 50% of allowed amount (60% Aetna High Performance network) after separate $2,500 per person / $5,000 per family deductible (Separate $1,750 individual / $5,250 family deductible Aetna High Performance network) No out-of-pocket maximum No out-of-network coverage under United Healthcare High Performance network.
$250 per person $5 (deductible waived) $30 copay after deductible $45 copay after deductible Member share is 30% after deductible up to $200 per Rx 30 day supply $10 (deductible waived) $75 copay after deductible $112 copay after deductible 90 day supply	$750 individual / $1,500 family $15 copay after deductible $30 copay after deductible $50 copay after deductible Member share is 30% after deductible 30 day supply $30 copay after deductible $60 copay after deductible $100 copay after deductible 90 day supply
$30 copay, 12 visit limit	$35 copay, 12 visit limit
75% after deductible	70% after deductible
Covered in full	Covered in full
Covered in full	Covered in full

MEDICAL BENEFIT COMPARISON –WEA EASYCHOICE & BASIC – cont.

	WEA Select Plan EasyChoice A
HOSPITAL	
Inpatient Care	80% after deductible
Emergency Care	Aenta 80% after deductible and $150 copay; UHC Flat $300 copay
OTHER BENEFITS	
Acupuncture	$25 copay, 12 visit limit
Ambulance Services	80% after deductible
Chemical Dependency	Inpatient: 80% after deductible Outpatient: $25 copay
Maternity	80% after deductible
Mental Health	Inpatient: 80% after deductible Outpatient: $25 copay
Naturopathic	$25 copay
Outpatient Surgery	80% after deductible
Rehabilitation (includes Physical Therapy)	Inpatient: 80% after deductible, 30 day limit Outpatient: $35 copay, 30 visit limit
Dependents covered to age	26 regardless of student or marital status
Organ Transplant waiting period	None
Life Insurance	$12,500 (to age 65)

Glossary of Terms

- Allowable Charge – The maximum amount the carrier will pay for a covered service or supply.
- Calendar Year – a 12-month period, running from January 1 through December 31, when medical expenses are incurred that count toward specific annual benefit maximums, limitations, deductibles and out-of-pocket maximums for the Kaiser Permanente plan.
- Coinsurance – The percentage of a covered service you pay after your deductible is met and continue to pay until your –out-of-pocket maximum is met.
- Copay – The fixed dollar amount you pay each time you use certain services until your out-of-pocket maximum is met.
- Deductible – The amount you pay each plan year before your plan starts to pay benefits toward certain services.

MEDICAL BENEFIT COMPARISON –WEA EASYCHOICE & BASIC – cont.

WEA Select Plan EasyChoice B	WEA Basic Plan
75% after deductible	70% after deductible
Aetna 75% after deductible and $200 copay; UCH Flat $300 copay	Aetna 70% after deductible and $250 copay; UHC Flat $300 copay
$30 copay, 12 visit limit	$35 copay, 12 visit limit
75% after deductible	70% after deductible
Inpatient: 75% after deductible Outpatient: $30 copay	Inpatient: 70% after deductible Outpatient: $35 copay
75% after deductible	70% after deductible
Inpatient: 75% after deductible Outpatient: $30 copay	Inpatient: 70% after deductible Outpatient: $35 copay
$30 copay	$35 copay
75% after deductible	70% after deductible
Inpatient: 75% after deductible, 45 day limit Outpatient: $40 copay, 45 visit limit	Inpatient: 70% after deductible, 30 day limit Outpatient: $50 copay, 30 visit limit
26 regardless of student or marital status	26 regardless of student or marital status
None	None
$12,500 (to age 65)	$12,500 (to age 65)

- Network – Your plan's contracted provider network determines which doctors, hospitals, and other healthcare providers are covered at your plan's in-network benefit level.
- Out-of-pocket maximum – The maximum amount you pay out of your own pocket for medical and/or prescription drug costs, deductible and coinsurance in a plan year.
- Plan year – The 12-month period in which benefits and rates are contracted, running from November 1 through October 31. With a possible 2-month extension due to the anticipated SEBB implementation on January 1, 2020.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) AND HEALTH SAVINGS ACCOUNT(HSA) INFORMATION

During open enrollment you may enroll on the either the Aetna or United Healthcare HDHP medical plan and participate in the Navia Health Savings Account (HSA) tax-advantaged bank savings account. When looking at this option the following are some important things to know:

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

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

Important Items to Note:

1. If you enroll with any dependents covered on the plan, the individual deductible does not apply. Only the family deductible applies (even if only one person enrolled accesses care).
2. You will receive a medical ID card for the HDHP medical plan which you will give to the provider at the time of service. You will also have a debit card for the HSA bank account which you can use to pay any out-of-pocket expenses. You must give the healthcare provider your medical ID card first so that expenses will be applied towards your deductible for the year.
3. The IRS sets limits for how much you can contribute to the HSA bank account in a calendar year. For 2018 the limits are $3,450 Individual (self-only) and $6,900 Family. For 2019 the limits increase to $3,500 for Individual (self only) and $7,000 for Family. (There is a tax penalty if you over-contribute to the HSA). If you are over 55 you can contribute an additional $1,000 as a catch-up contribution. (As long as you are enrolled on the plan as of December 1, 2018, you may contribute up to the full annual limit for 2018, however you must remain on the HDHP through December 1, 2019.)
4. Distributions from your HSA account must be for IRS 213(d) medical expenses (see eligible expenses on page 21).
5. An administrative fee of $2.00 per month will automatically be deducted from the HSA account. When you enroll in the HSA plan you can also participate in the Flexible Spending Plan (FSA) but on a limited basis. The FSA plan can be used only for dependent care expenses and expenses related to Orthodontia, Dental, Vision and Preventive care for you, your spouse or dependents.
6. Investment opportunities are available once the balance in the HSA account reaches $2,000.

Eligible Expenses for Health Savings Accounts and Flexible Spending Accounts

(Refer to IRS Publication 969 for a complete listing)

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

<u>Over-the-Counter Medicines and Drugs Requiring a Prescription:</u>

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

FLEXIBLE SPENDING ACCOUNTS

This is a contract year election and enrollment forms will be sent out the first of September to eligible employees (Certificated employees at .5 FTE or above and Classified employees of 20 hour per week of above) and are due back in to Payroll no later than October 31st.

The Flex Plan year runs November 1, 2018 through October 31, 2019. Forms due in to Payroll by October 31, 2018. If your information is received prior to October 10, 2018, your funds will be available without delay..

PREMIUM CONVERSION PLAN

Federal Way Public School's premium conversion plan allows employees to avoid Social Security and federal income tax on monthly amounts that are deducted for group insurance premiums (medical, dental, vision and life). Payroll will automatically adjust your monthly contribution for qualifying insurance premiums from an "after-tax" to a "pre-tax" basis. There are no forms to fill out. Participation in the program is automatic unless you request in writing not to participate in the premium conversion plan (contact the Payroll Department for form).

HEALTHCARE FLEXIBLE SPENDING ARRANGEMENT

This program allows the enrollee to pre-pay taxes on many medical, dental and other health care expenses that are not covered by medical insurance. The program lets you use pre-tax dollars to pay for healthcare expenses. Your contribution will be deducted from your paycheck on a pre-tax basis in equal amounts for the plan year. You may set aside up to $2,650 ($300 minimum) for the November 1, 2018 – October 31, 2019 plan year in your Healthcare Flexible Spending Arrangement through automatic payroll deductions.

There is also a carryover feature added to the plan where up to $500 of unused funds can be used for the following plan year.

Eligible Expenses

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

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

Ineligible Expenses

- Medicine purchased over-the-counter without a doctor's prescription. Over-the-counter medicines and drugs include items such as Advil, Tylenol, allergy medicine, antacid, etc.
- Expenses reimbursed through any insurance policy or plan
- Expenses incurred before you enroll in the plan
- Expenses you claim as a deduction or credit for income tax purposes
- Expenses incurred by a domestic partner

Flexi-Card Users

Current users keep your card so it can be reloaded. Forms turned in by October 10, 2018 will be active for November 1, 2018. New Flexi-Card user forms received by October 10, 2018 will be ready for November 1, 2018 use. Forms received after these dates will have a delay in getting the Flexi-Card activated.

DEPENDENT CARE FLEXIBLE SPENDING ARRANGEMENT

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

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

You may set aside up to $5,000 in your Dependent Care Spending Account through automatic payroll deductions or $2,500 if you are married filing a separate return. ($300 minimum) for the November 1, 2018-October 31, 2019 plan year.

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

For many employees, the Dependent Care Spending Account is a better method than taking the dependent care tax credit on the income tax return. Generally, the tax credit is more beneficial if your adjusted gross income is less than $24,000. Use the tax savings calculator at www.naviabenefits.com to determine which option is best for you.

FLEXIBLE SPENDING ACCOUNTS

EXAMPLE OF TAX SAVINGS WITH FLEXIBLE REIMBURSEMENT ACCOUNTS

Without Flexible Reimbursement Account		*With* Flexible Reimbursement Account	
Gross Monthly Salary	$2,600	Gross Monthly Salary	$2,600
Income Tax @ 15% plus		Qualifying Insurance Premiums	- 100
FICA @ 7.65%	- 589	Qualifying Health Care Expenses	- 100
		Qualifying Dependent Care Expenses	- 350
Net Income (after taxes)	$2,011	Gross Taxable Income	$2,000
Qualifying Insurance Premiums	-100	Income Tax @ 15% plus	
Qualifying Health Care Expenses	-100	FICA @ 7.65%	-464
Qualifying Dependent Care Expenses	-350		
Net Spendable Income	$1,461	Net Spendable Income	$1,586

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

FLEXI-CARD

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

The Flexible Spending Account is electronically debited whenever you use the card. IRS regulations still require you to send documentation to verify the eligibility of the expense. You'll receive notification for the transactions that need to be substantiated. You can obtain additional information from the Payroll Department.

PLAN RULES

The IRS requires that you use all the money you contribute to your account or forfeit the remainder at the end of the plan year. Federal tax law says that any money left in your account at the end of the plan year must be forfeited. Also known as the "Use it or lose it" provision. However, if you have funds remaining in your account at the end of the plan year, up to $500 will be moved into the subsequent plan year.

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

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

Making Changes

Your selection will be effective beginning November 1, 2018. The plan will run on a 12 month election year ending October 31, 2019.

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

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

Making Claims

When you incur an eligible expense during the year, file a request for reimbursement form (available from the Payroll Department or online at www.naviabenefits.com). Enclose documentation from your provider that indicates what type of service, dates of service, and cost incurred.

The last day to file a claim is 90-days after the end of the plan year (January 31, 2020).

OTHER MEDICAL INSURANCE OPTIONS

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

INDIVIDUAL MEDICAL COVERAGE OPTIONS

In some instances, you may be able to insure your dependent spouse and/or dependent children for medical coverage less expensively by applying for an individual medical policy. The Washington Healthplanfinder "The Marketplace" is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 15, 2018 for coverage starting January 1, 2019. Depending upon income, some people may receive paid-in-full insurance coverage through the Department of Social and Health Services (DSHS). Applications must be submitted within 60 days following the determination by DSHS.

To talk with someone about individual medical plans, or if you or your spouse is 65 to review Medicare plans you can contact Thea Feltzs at Red Quote 253-341-4382. When calling, mention that you are a FWPS employee.

APPLE HEALTH FOR KIDS PROGRAM

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

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

The Family's Income is:	Up to 200% of "federal poverty level"*	250% of "federal poverty level"*	300% of "federal poverty level"*
Examples of Qualifying Income Levels	For a family of 2 people, 200% of federal poverty level is $2,881 monthly. For a family of 4, 200% is $4,393 monthly.	For a family of 2 people, 250% of federal poverty level is $3,567 monthly. For a family of 4, 250% is $5,439 monthly.	For a family of 2 people, 300% of federal poverty level is $4,281 monthly. For a family of 4, 250% is $6,527 monthly.
Monthly Cost to the Family	Free	$20 per child per month ($40 per month maximum).	$30 per child per month ($60 per month maximum).

Notes:

- Income is figured on gross monthly wages minus $90 per person working. Monthly childcare expenses (and child support payments for a child not living in the home) may also be deducted from monthly income when determining eligibility.
- A pregnant woman counts as a family size of two. Other programs with different eligibility requirements are available for families and pregnant women. Call toll-free 1-877-543-7669 to find out more.

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

CHIPRA NOTIFICATION

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

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

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

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

WASHINGTON – Medicaid

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

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

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

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

OTHER BENEFITS

EMPLOYEE ASSISTANCE PROGRAM (EAP)
The EAP program provides professional assessment and referral services for you and your family for almost any personal difficulty – such as treatment for alcoholism and drug abuse, individual and marriage counseling, family therapy, financial difficulties, etc. For information, call Health Venture toll free at (253) 572-5552. The EAP is provided at no cost to district employees and their dependents.

An EAP is also available through Morneau Shepell, BDA for employees enrolled on the Standard LTD plan. Call toll free at (888) 293-6948 or visit their website at workhealthlife.com/Standard3. (Standard LTD eligible employees only) Includes up to three face-to-face counseling sessions and unlimited telephone and online support.

EMPLOYEE DISCOUNTS
Membership discounts are available to FWPS employees at the following locations.

- Verizon Wireless – 17% discount on plans, 25% discount on accessories, phone discounts vary by model and current promotion. Current Verizon customers and new customers can receive the discounts by going to the following website: www.verizonwireless.com/discount
- TMobile – 15% off monthly charges and no activation fees. Existing users call (800) 937-8997, new users call (866) 464-8662. Use discount code 19424MOFAV

INSPIRUS CREDIT UNION (Formerly School Employees Credit Union)
The Inspirus Credit Union offers free checking and low-interest Visa accounts to FWPS employees and their families. For information, call (888) 628-4010 or visit their website at www.inspiruscu.org.

AFLAC
Additional voluntary benefits are available through AFLAC. Open enrollment information will be sent out in November. For information, contact Don Ruzicka, ALFAC Agent at (360) 703-4967 or email at don_ruzicka@us.aflac.com.

ENHANCED BENEFIT GROUP
Receive discounted real estate, mortgage, escrow, moving, carpet cleaning, maid services and home inspection services. For information, call toll free at (866) 505-3244 or visit their website at www.ebgi.org.

2018-19 PAY DAYS / DIRECT DEPOSIT

Contract pay (hired into a permanent positon) is spread evenly over the fiscal year. Time sheet pay and absences are posted in the following month's payroll and are due in to Payroll by the 5th of each month (i.e., September time and absence is due October 5th and posted with October 31st payroll).

ALL Pay Checks are put into the US Mail the day before Pay Day and can only be reissued after they have been returned or 10 postal delivery days have passed.

Direct Deposit pay stubs are mailed out by special request only.

View up to 24 months of pay stubs using Employee Online. You can also view prior year W2, update your federal withholding status, do a change of address, view leave balances and a lot more.

To access Employee Online (EO) direct website https://employeeonline.fwps.org or www.fwps.org then choose Staff then Employee Online and it will take you to your log in.

First time users: User name is your EE ID#, Password is your full social security number without the dashes.

Make sure your personal email is on file so you can use the forgotten password even if you leave the district.

Please contact the Business Applications Manager, ext. 2041, if you are having problems resetting your password.

PAY DAYS	
September 28, 2018	
October 31, 2018	
November 30, 2018	
December 31, 2018	Winter Break
January 31, 2019	
February 28, 2019	
March 29, 2019	
April 30, 2019	
May 31, 2019	
June 28, 2019	Summer Break
July 31, 2019	Summer Break
August 30, 2019	Summer Break

CHANGE IN STATUS REMINDER

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

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

403(b) INVESTMENT OPPORTUNITIES

As a benefit to its employees, Federal Way Public Schools sponsors a supplemental, tax-advantaged, retirement savings program authorized by Section 403(b) of the Internal Revenue Code. Such plans are often called 403(b) Plans or Tax Sheltered Annuity Plans or simply TSA Plans.

Individual accounts in a 403(b) plan can be any of the following types.

- An annuity contract, which is a contract provided through an insurance company, or
- A custodial account, which is an account invested in mutual funds.

Generally, an employee's contributions to their 403(b) and the earnings are not taxed to the employee until they are distributed from the vendor, usually at retirement.

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

To start an investment plan, you must have an established account or open an account with one of the approved companies. A list of approved representatives is on file in the Payroll Department for your convenience. Once the account is established, the employee and the vendor representative must sign a FWPS Salary Reduction Agreement Form to submit to Payroll.

Carruth Compliance Consulting (CCC) is the district's third party administrator due to the complexity of IRS code [403(b)] changes. Payroll handles the actual payroll deductions but transfers and loans are processed through CCC. Specific information is available through CCC's website at www.ncompliance.com.

DEFERRED COMPENSATION

The Deferred Compensation Program (DCP) is an IRC Section 457 program designed to help you save for retirement on a pre-tax basis. This is a tax-deferred investment to add to your retirement and Social Security benefits. To enroll, review the Washington State Department of Retirement System's Deferred Compensation Program booklet and complete the Participant Agreement, selecting the investment funds you wish to invest in. For additional information, call the DCP Information Line toll free at (888) 327-5596 or visit their website at www.drs.wa.gov/dcp.

GET PROGRAM

The GET (Guaranteed Education Tuition) Program is Washington's 529 prepaid college tuition plan. You prepay for future college tuition in unit increments and the value of your account is guaranteed by the state to keep pace with rising college tuition. For additional information visit the GET Program website at www.get.wa.gov. (Payroll deductions are not available for this program.)

WASHINGTON STATE DEPARTMENT OF RETIREMENT SYSTEMS (DRS)

RETIREMENT PLANNING "TO DO" LIST

- If you are within 5 years of retiring, plan to attend a retirement planning seminar. See the DRS website at www.drs.wa.gov for calendar and registration information.
- Review your member handbook (available online) at the DRS website under "Publications".
- If you have ever withdrawn your contributions, check with DRS to see if you can restore the contributions, and if so, what the benefit would be to you (this must be done in writing).
- Use online account access at www.drs.wa.gov to review service credit, beneficiary information and to create a benefit estimate.
- Two years prior to retiring, make sure your birth evidence, your spouse's birth evidence, and (if appropriate) your marriage evidence is in order.
- One year before retirement, contact the Social Security Administration (www.ssa.gov) to determine your eligibility date and request an estimate of benefits, if applicable. You can also contact them by calling 800-772-1213.
- During the year before your retirement, visit DRS and consult with a retirement benefits specialist to make sure your file is in order. Call to make an appointment.
- The last year before your retirement, check on your medical insurance options as a retiree. Enrollment information for the Washington State Health Care Authority program is available from the Public Employees Benefits Board at www.pebb.hca.wa.gov or by calling (800) 200-1004.

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

FAMILY AND MEDICAL LEAVE ACT

NOTIFICATION

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

FMLA applies to all employees who have:

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

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

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

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

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

A SERIOUS HEALTH CONDITION IS DEFINED AS

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

EMPLOYEE RESPONSIBILITIES

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

IT IS IMPORTANT TO REMEMBER

- With employer's approval, leave may be taken intermittently or by working a reduced week. However, an exception exists for an employee or family member's serious health condition whereby leave is taken whenever medically necessary.
- An employer is allowed to substitute an employee's accrued paid leave for any portion of the 12-week period.
- The employee is responsible for their portion of the medical premium even if they enter an unpaid status. Arrangements for repayment will be made upon their return.
- The employer is allowed to recover the total cost of health benefits paid during the leave if the employee does not return to work.
- During the leave, the employee is ineligible for unemployment compensation.

COBRA

WHAT IS COBRA?

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring most employers sponsoring group health plans to offer employees and their families the opportunity to continue to be enrolled on the health plan even after termination of employment (and other scenarios). This coverage is simply an extension of the employer's current plan. In most instances the former employee is required to pay the full cost of the coverage.

COBRA QUALIFYING EVENTS

COBRA continuation coverage is continuation of Plan coverage (medical, dental and/or vision) when coverage would otherwise end because of a "qualifying event." Common qualifying events are:

1. Termination of employment
2. A reduction in your hours of employment that would cause a loss of coverage

If you are the spouse or dependent child of an employee enrolled in a group medical, dental, and vision plans, you have the right to choose continuation of coverage for yourself if you lose group coverage for any of the following reasons:

1. Termination of your spouse's employment
2. Death of your spouse
3. Divorce or legal separation from your spouse
4. Your spouse becomes eligible for Medicare (resulting in the loss of dependent coverage)
5. Your retired spouse’s employer files for Chapter 11 reorganization
6. Your child ceases to be a dependent or attains the maximum age allowed
7. Your spouse's hours of employment are reduced to a level that would cause a loss of coverage

LENGTH OF COVERAGE

In most instances, the law requires you be offered the opportunity to maintain continuation of coverage for up to 18 months, in some instances you can maintain coverage for 29 or 36 months. The law also provides your continuation coverage may be terminated for any of the following reasons:

1. Your employer ceases to provide group health coverage to any of its employees
2. The premium for your continuation coverage is not paid in a timely fashion
3. You become covered under another group health plan which does not contain a pre-existing conditions limitation; or
4. You become entitled (covered) under Medicare after COBRA has been elected

You do not have to show you are insurable to choose continuation coverage. However, you will pay the entire premium for your continuation. These rates are subject to change whenever the corresponding rates for the plan are increased.

Look for additional information from your employer that details your COBRA rights. It is your responsibility to make sure your employer has your correct address, as all COBRA notifications will be sent to your last known address.

WOMEN'S HEALTH & CANCER RIGHTS

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

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

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

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

OTHER NOTICES

LIFETIME LIMIT NO LONGER APPLIES AND ENROLLMENT OPPORTUNITY

The lifetime limit on the dollar value of benefits under the Group Medical Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Payroll

HIPAA SPECIAL ENROLLMENT RIGHTS

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

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

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage…

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

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

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


ONEDIGITAL
HEALTH AND BENEFITS