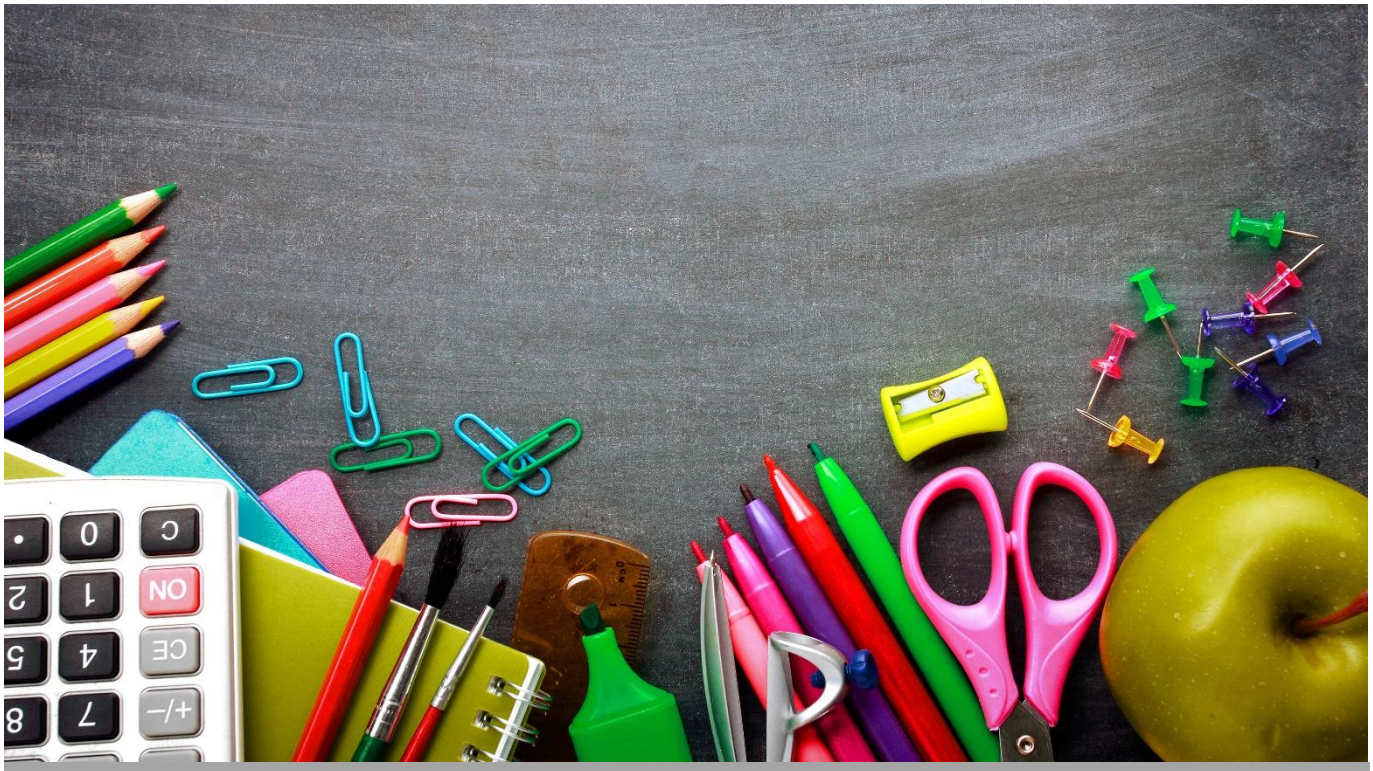
ARLINGTON PUBLIC SCHOOLS
EDUCATE • PREPARE • INSPIRE



November 1, 2017 – October 31, 2018

Employee Benefit Highlights

WEASelect Medical Plans

Arlington Public Schools | http://www.asd.wednet.edu/

Benefit Summary Highlights

Member Service Information

	Group Number	Telephone	Email	Website
Medical Plans				
UnitedHealthcare	APS	1.844.219.3630		www.weaselect.com
Aetna	APS	1.855.878.4101		www.weaselect.com
Kaiser Permanente	1520800	1.206.630.4636 or 1.888.901.4636		www.kp.org/wa
Dental Plans				
Delta Dental	APS	1.800.554.1907		www.deltadentalwa.com
Willamette Dental	APS	1.855.433.6825		www.willamettedental.com
Vision Plan				
NBN Vision		1.800.732.1123		www.nwadmin.com
Additional Lines of Coverage				
AFLAC		1.360.848.1751	lynnr@fidalgo.net	www.aflac.com
American Fidelity		1.800.576.0201		www.americanfidelity.com
Colonial		1.800.438.6423		www.coloniallife.com
LifeMap		1.800.794.5390		www.lifemapco.com
Employee Assistance Plan				
LifeMap		1.866.750.1327		www.myrbh.com Group Code: "LIFEMAP"
Benefit Resource Center				
USI Kibble & Prentice	APS	1.866.468.7272	BRCWest@usi.com	

Welcome to the 2017-2018 Benefits Open Enrollment!

As you may be aware, this Open Enrollment brings about a lot of changes for all of our groups, specifically in regards to our medical plans. Our Benefits Committee has met often during the 16-17 school year and even into the summer, in anticipation of these changes. Along with our broker, this group of volunteers, representing all the bargaining/benefit groups, has reviewed and discussed options, explored new opportunities, and held informational meetings and votes for their respective units.

Each of the Groups voted (according to their group's agreements) and the plans offered for 2017-2018 are a direct result of those votes. We will continue to offer the Kaiser HMO Plans alongside each of the PPO offerings.

This guide will give you an overview of changes and a review of the benefits that are offered through the Arlington School District. It is also helpful for future reference, should you have questions about your plans throughout the school year.

New this year:

We are especially excited to offer in person open enrollment assistance through Colonial Life. They will bring in a team of reps to sit down with employees individually to help understand the plan options and make enrollment changes with employees (including online, as well) and update dependent and beneficiary information.

Colonial Life will also be handling our Section 125 Plan enrollment this year, as well as offering supplemental policies that are voluntary and can be set up as payroll deductions.

I will also be visiting schools, as in past years, during September. With the assistance of Colonial Life, we hope to reach out to even more employees to deliver a better understanding of the changes and benefits offered, and make the 2017-2018 Open Enrollment a smooth process.

This is a great opportunity to really understand your options in a one-on-one session with an expert. Spouses are welcome to attend these sessions! More information will follow separately.

Please review the enclosed information closely. With all the changes to plans this year, it is a great time to really evaluate your insurance needs.

Kim Perry
Human Resources Specialist
360-618-6226
kperry@asd.wednet.edu

HR Benefits Roadshow Schedule:

SCHOOL	DATE	TIME
AHS	Tuesday, 9/12/2017	7:30am – 3:30pm
Pioneer	Wednesday, 9/13/2017	8:15am – 3:30pm
Haller	Thursday, 9/14/2017	7:15am – 3:00pm
Kent Prairie	Monday, 9/18/2017	8:15am – 4:30pm
Post	Tuesday, 9/19/2017	7:30am – 3:30pm
Transportation	Thursday, 9/21/2017	9:00am – 11:30am
Weston		12:00pm – 2:30pm
District Office	Friday, 9/22/2017	7:00am – 3:30pm
Eagle Creek & SVLC (at EC)	Monday, 9/25/2017	8:15am – 4:30pm
Presidents	Tuesday, 9/26/2017	8:15pm – 4:30pm
District Office	Wednesday, 9/27/2017	7:00am – 3:30pm
District Office – LAST CALL	Thursday, 9/28/2017	7:00am – 3:30pm

Annual Benefit Information 2017-2018

Benefit Allocation before pooling: $820.00 (per 1.0 FTE)

MANDATORY BENEFITS

DENTAL (SELECT ONE):	Willamette Dental (family)	$ 82.25
	-- OR --	
	WDS Dental Plan A (family)	$ 114.80
VISION COVERAGE:	Northwest Benefit Network (family)	$ 28.73
LONG TERM DISABILITY:	LifeMap	$ 13.49

Subtract mandatory benefit selections from the benefit allocation.
The amount remaining is available to apply toward a medical plan.

MEDICAL PLAN OPTIONS

Enrolling in a medical plan is optional. Selecting a plan will result in minimum 2% (AEA) or 2.5% (PSE) of the plan premium payroll deduction each month. Depending on the tier and plan you chose, your payroll deduction could be more. There are several medical plans to choose from. Please see the next page for tiers and rates. And review the summary pages in this guide for more details.

Here are some things to consider when selecting a plan:

- The HMO Plan is offered through Kaiser Permanente and utilizes the Core Network.
- If you prefer a traditional PPO plan:
    1. Look at the WEASelect plan designs and choose the one that will best fit your needs. Some things to consider:
        - On-going health conditions
        - Prescription coverages, copays, deductibles
        - Dependents who live out of state
    2. Decide which carrier you will use. Rates and provider networks are different between carriers. The plan designs are the same.
    3. Are your providers in, and can you stay within the "high performance" network?
        - If so, you can save a significant amount on premiums.
        - However, if you go outside the "high performance" networks, then you will be fully responsible for all bills.
        - If you think you might use providers outside of the "high performance" network or simply want the flexibility to go outside, then PPO network will better fit your needs.
    4. Resources:
        - www.ghc.org (Kaiser)
        - www.weaselect.com
        - Arlington School District website

OTHER BENEFITS *

PERSONAL DAYS	SICK LEAVE
EMPLOYEE ASSISTANCE	LIFE and AD&D
RETIREMENT BENEFITS – Deferred Compensation, 403(b)	
VOLUNTARY BENEFITS – Additional Life, Sect. 125, Short Term Disability	

*Please see contract, plan summaries, and employee handbook for full details.

Annual Benefit Information 2017-2018

MEDICAL PLAN OPTIONS *

KAISER PERMANENTE				
	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
HMO (CORE NETWORK)	$ 936.37	$ 1,719.13	$ 1,254.46	$ 2,060.69

1. Choose a PLAN design (below) 2. Choose a CARRIER – make sure your provider is covered 3. Choose a Network (PPO or HP) – make sure your provider is in-network		AETNA		UNITED HEALTHCARE	
		PPO	High Performance	PPO	High Performance
PLAN 5	Employee Only	$1,135.00	$1,089.88	$1,194.42	$1,078.14
	Employee + Spouse	$2,185.31	$2,098.02	$2,300.00	$2,075.03
	Employee + Children	$1,544.89	$1,483.32	$1,625.68	$1,467.01
	Employee + Family	$2,633.37	$2,528.09	$2,771.99	$2,500.62
PLAN 2	Employee Only	$972.29	$933.72	$1,023.14	$923.67
	Employee + Spouse	$1,783.32	$1,712.17	$1,877.25	$1,693.79
	Employee + Children	$1,303.25	$1,251.38	$1,371.77	$1,238.02
	Employee + Family	$2,137.89	$2,052.50	$2,250.17	$2,030.04
PLAN 3	Employee Only	$883.50	$848.49	$929.71	$839.35
	Employee + Spouse	$1,620.77	$1,556.14	$1,706.19	$1,539.39
	Employee + Children	$1,183.91	$1,136.83	$1,245.83	$1,124.35
	Employee + Family	$1,941.52	$1,864.02	$2,043.66	$1,843.65
EZ CHOICE A	Employee Only	$658.33	$632.36	$692.61	$625.61
	Employee + Spouse	$1,199.78	$1,152.07	$1,262.77	$1,139.67
	Employee + Children	$879.09	$844.25	$925.08	$835.20
	Employee + Family	$1,432.16	$1,375.11	$1,507.46	$1,360.28
QHDHP	Employee Only	$505.70	$485.86	$531.95	$480.71
	Employee + Spouse	$926.58	$889.84	$975.19	$880.30
	Employee + Children	$674.14	$647.54	$709.00	$640.33
	Employee + Family	$1,100.05	$1,056.34	$1,158.05	$1,045.15
EZ CHOICE B	Employee Only	$684.23	$657.23	$719.89	$650.20
	Employee + Spouse	$1,250.40	$1,200.66	$1,315.79	$1,187.46
	Employee + Children	$913.85	$877.62	$961.41	$867.95
	Employee + Family	$1,492.46	$1,432.99	$1,571.09	$1,417.64
BASIC PLAN	Employee Only	$551.20	$529.54	$579.82	$523.90
	Employee + Spouse	$1,013.88	$973.63	$1,067.11	$963.22
	Employee + Children	$734.88	$705.83	$772.96	$698.03
	Employee + Family	$1,206.52	$1,158.54	$1,269.64	$1,145.80

**** Selecting a medical will result in at least a minimum payroll deduction of 2% (AEA) or 2.5% (PSE). Depending on the plan and who will be covered, the payroll deduction could be more.***

2017 Benefits at a glance

Medical Insurance

Plan 5 – This medical plan includes a $200 deductible per individual and 90% coverage when using an in-network provider. In addition, you have a $20 copay for a physician office visit.

Plan 2 – This medical plan includes a $300 deductible per individual and 80% coverage when using an in-network provider. In addition, you have a $25 copay for a physician office visit.

Plan 3 – This medical plan includes a $500 deductible per individual and 80% coverage when using an in-network provider. In addition, you have a $30 copay for a physician office visit.

Easy Choice A - This medical plan includes a $1,250 deductible per individual and 80% coverage when using an in-network provider. In addition, you have a $25 copay for a physician office visit.

Easy Choice B – This medical plan includes a $750 deductible per individual and 75% coverage when using an in-network provider. In addition, you have a $30 copay for a physician office visit.

Basic – This medical plan includes a $2,100 deductible per individual and 70% coverage when using an in-network provider. In addition, you have a $35 copay for a physician office visit.

QHDHP & HSA – This medical plan includes a $1,750 deductible per individual and 80% coverage when using an in-network provider. In addition, you are covered at 80% for a physician office visit.

Dental Insurance

Delta Dental – This plan provides rich benefits with the freedom of seeing any dentist (contracted or not); your benefits will be greater when you receive care from a contracted dentist.

Willamette Dental – This plan requires that you see a Willamette Dental Group Provider at a Willamette Dental Clinic in order to receive benefits.

Vision Insurance

NBN – This plan provides coverage for eye exams and vision hardware (lenses and frames) subject to plan limitations.

Disability Insurance

Long Term Disability - the LifeMap Assurance Company plan covers 60% of your earnings up to $5,000 per month, after a 60 day waiting period.

Voluntary Short Term Disability – LifeMap covers 66.67% of your earnings up to $1,385 per week, after a 0 day injury / 3 day sickness waiting period. Colonial offers a guarantee issue of 60% of your earnings up to $4,000 per month, after a 0 day injury / 7 day sickness waiting period.

Life and AD&D Insurance

Basic Life and AD&D – This plan provides you with $50,000 of basic life and AD&D insurance through LifeMap Assurance Company.

Voluntary Life and AD&D - You may purchase additional group term life insurance through LifeMap Assurance Company in $10,000 up to 5 X salary to $500,000.

Health Savings Account (HSA)

If you are enrolled in the qualified high deductible health plan (QHDHP), you may elect to participate in the HSA plan offered by Heritage Bank. This is administered via payroll deduction to help you pay for qualified health care expenses.

Flexible Spending Plans

Health Care FSA – You may set aside $2,500 pre- tax per year to pay for eligible health, dental and vision care expenses.

Dependent Care FSA – You may pay dependent care expenses of up to $5,000 per year on a pre-tax basis.

Employee Assistance Program (EAP)

You and your family members have access to confidential, professional assistance through the LifeMap Assurance Company; The EAP is a professional counseling service dedicated to assisting employees and their family.

Eligibility & Enrollment

Eligibility Rules

Employees working 17.5 hours/week are eligible to participate in the Arlington Public Schools Employee Benefits Program. For most of our benefit plans your coverage will become effective on the first of the month following your date of hire, provided you are paid for at least 10 days in your first month of employment. You may also enroll your eligible dependents in the Arlington Public Schools Benefit Plans. Your eligible dependents include your spouse, your domestic partner, as well as your dependent children, whether natural, adopted, stepchildren, foster, or those for whom you have legal custody by court decree. When enrolling in medical, dental or vision coverage, you may enroll any dependent child up to age 26.

Enrollment Is Simple

You have two options:

1. ***Personal enrollment assistance:***
Colonial Life will have specialists in your building to walk you through the open enrollment process, including the WEASelect online system, updating dependent and beneficiary information, and discussing voluntary policies and Section 125 Plans.

2. ***Do it yourself enrollment:***
Dental: See WEASelect Quick Start Guide
Medical: See WEASelect Quick Start Guide or complete the Kaiser Enrollment form.
Vision: Complete the NBN Enrollment form.
All completed paper forms must be turned in to the HR Department by 9/29/17.

When Can You Enroll?

You can sign up for Benefits at any of the following times:

- After completing initial eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified family-status change

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

Making Changes

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your Employer and another change is permitted under the plan terms.

Examples of these change in status events may include:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you have a family status change, you must timely notify your Personnel Manager and complete the necessary forms. For more information refer to your benefits booklet.

Cost of Coverage: *How You Pay for Health Care Costs*

You share the cost of health care services with Arlington Public Schools and the medical plan you select. As you review the medical plan options you should consider the following types of costs:

Premium: A premium is the total cost for your medical insurance. You and Arlington Public Schools share this cost. You pay your portion through pre-tax payroll deductions.

Deductible: A deductible is the amount you must pay before the medical plan begins sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits.

Copay: A copay is a set payment you make for a specific service. For example, in the plan you will make a $25 copay, then 80% (Visits 1-4 PCY: $25 copay/100% DW) for visits to your primary care physician.

Coinsurance: When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, in the plan, after you satisfy your deductible, you will pay 80% for most medical care that you receive from preferred providers.

Out-of-Pocket Maximum: The out-of-pocket maximum protects you from major medical expenses. This is the most you would pay and includes your medical deductible, copays and coinsurance, for eligible expenses during a plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of the usual, customary and reasonable charges for the balance of the year.

Your Total Costs Remember, the total cost you pay for health care services in a plan year is the combination of your out-of-pocket costs when you access medical care and the premium payments you are required to make for coverage.

Premiums + Out-of-Pocket Costs **= *Total Cost of Health Care***

Depending on your personal situation, the plan with the lowest deductibles and copays may not be the best plan for you—it is important to also take into account the premium you will pay for coverage when deciding which plan is best for you and your family. If you are in generally good health, it may make more sense to enroll in the High Deductible plan. This plan offers the lowest premium cost and the chance to save money in an HSA.

Types of Plans: *How You Select Your Medical Insurance Plan*

Not everyone needs the same automobile or number of bedrooms in their home or apartment. In the same regard, not everyone needs the same type of health insurance plan or drug coverage. Our lives and our needs are diverse. Some are young; some are old. Some of us have families to consider, others don't. Some have major ongoing health issues; others see a doctor once a year just for a physical. All of these variables and many more influence the decisions we make as individuals.

Preferred Provider Organization (PPO): A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers

- You pay less if you use providers that belong to the plan's network
- You can use doctors, hospitals and providers outside of the network for an additional cost
- You do not have to choose a primary care physician

High Performance Network: This is similar to a PPO in structure and operation, with the main difference being that services are covered only if you go to doctors, specialists or hospitals in the plan's network, although there are exceptions for emergencies.

Health Maintenance Organization (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the plan

- Small copayment due for office visits and hospital stays
- Generally will not cover out-of-network care except for emergencies
- May require you to live and work within the service area
- Requires you to select a primary care physician who will provide all your basic health service, and must give a referral for you to see a specialist

Arlington Public Schools offers many different options of health insurance for you to choose from. You will have the same eight options that you have had in the past. Both the plan names and the benefit details (including deductibles, out of-pocket maximums and coinsurance) remain the same. However, the PPO plans 2, 3, 5, EasyChoice A and B, the Basic plan and the Qualified High Deductible Health Plan are now offered through the Aetna and UnitedHealthcare. The HMO plan is offered through Kaiser Permanente. Selecting the right coverage involves sorting through a lot of information. Each of the plans we offer has different levels of copays, deductibles and out-of-pocket maximums. To make the right choice, you need a basic understanding of the different types of plans that we offer. Keep reading for a brief description of each plan.

Please note: This benefit summary has been prepared to help you review the key factors that are associated with our benefit plans and is designed to help you make informed benefit choices and enroll in coverage. This summary does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. Use this guide, in conjunction with the plan documents, to make an informed plan decision.

Benefit Description	WEASelect Plan 5	WEASelect Plan 2	WEASelect Plan 3
Plan Year Deductible *(per member / family)* (begins Nov. 1)	$200 / $600	$300 / $900	$500 / $1,500
Plan Year Out-of-Pocket Maximum *(per member / family)* (begins Nov. 1)	$1,000 / $3,000	$2,000 / $6,000	$3,000 / $9,000
Primary Care Physician Office Visit	$20 copay	$25 copay	$30 copay
Specialist office visit	$30 copay	$35 copay	$40 copay
Preventive, wellness, prenatal and virtual care	100%	100%	100%
Inpatient hospital care	$150 copay per day, then 90% per admit	$150 copay per day, then 80% per admit	$300 copay per day, then 80% per admit
Emergency room services (copay waived if admitted)	$50 copay, then 90%	$75 copay, then 80%	$100 copay, then 80%
Rx Deductible *(per member / family)*	$0 / $0	$0 / $0	$0 / $0
Rx Out-of-Pocket Maximum *(per member / family)*	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000
Retail Prescription Drugs	**30 Day Supply Limit** Most Generics: $10 copay Preferred: $15 copay Non-Preferred: $30 copay	**34 Day Supply Limit** Most Generics: $10 copay Preferred: $20 copay Non-Preferred: $35 copay	**34 Day Supply Limit** Most Generics: $15 copay Preferred: $25 copay Non-Preferred: $40 copay
Mail Order Prescriptions	**90 Day Supply Limit** Most Generics: $20 copay Preferred: $30 copay Non-Preferred: $60 copay	**100 Day Supply Limit** Most Generics: $20 copay Preferred: $40 copay Non-Preferred: $65 copay	**100 Day Supply Limit** Most Generics: $30 copay Preferred: $50 copay Non-Preferred: $70 copay
Specialty Prescriptions	**30 Day Supply Limit** $50 copay	**30 Day Supply Limit** $50 copay	**30 Day Supply Limit** $60 copay
PPO Network Monthly Premium			
Employee *Aetna* *UnitedHealthcare*	 $1,135.00 $1,194.42	 $972.29 $1,023.14	 $883.50 $929.71
Employee & Spouse/DP* *Aetna* *UnitedHealthcare*	 $2,185.31 $2,300.00	 $1,783.32 $1,877.25	 $1,620.77 $1,706.19
Employee & Child(ren) *Aetna* *UnitedHealthcare*	 $1,544.89 $1,625.68	 $1,303.25 $1,371.77	 $1,183.91 $1,245.83
Employee & Family *Aetna* *UnitedHealthcare*	 $2,633.37 $2,771.99	 $2,137.89 $2,250.17	 $1,941.52 $2,043.66
High Performance Network Monthly Premium			
Employee *Aetna* *UnitedHealthcare*	 $1,089.88 $1,078.14	 $933.72 $923.67	 $848.49 $839.35
Employee & Spouse/DP* *Aetna* *UnitedHealthcare*	 $2,098.02 $2,075.03	 $1,712.17 $1,693.79	 $1,556.14 $1,539.39
Employee & Child(ren) *Aetna* *UnitedHealthcare*	 $1,483.32 $1,467.01	 $1,251.38 $1,238.02	 $1,136.83 $1,124.35
Employee & Family *Aetna* *UnitedHealthcare*	 $2,528.09 $2,500.62	 $2,052.50 $2,030.04	 $1,864.02 $1,843.65

Benefit Description	WEASelect EasyChoice B	WEASelect EasyChoice A	WEASelect Basic
Plan Year Deductible *(per member / family)* (begins Nov. 1)	$750 / $2,250	$1,250 / $3,750	$2,100 / $4,200
Plan Year Out-of-Pocket Maximum *(per member / family)* (begins Nov. 1)	$3,500 / $7,000	$4,000 / $8,000	$6,600 / $13,200
Primary Care Physician Office Visit	$30 copay	$25 copay	$35 copay
Specialist office visit	$40 copay	$35 copay	$50 copay
Preventive, wellness, prenatal and virtual care	100%	100%	100%
Inpatient hospital care	75%	80%	70%
Emergency room services	$150 copay, then 75%	$100 copay, then 80%	$200 copay, then 80%
Rx Deductible *(per member / family)*	$250 / n/a waived for Generics	$500 / n/a waived for Generics	$750 / $1,500
Rx Out-of-Pocket Maximum *(per member / family)*	$2,500 / $5,000	$2,500 / $5,000	Shared with medical out-of-pocket max.
Retail Prescription Drugs	**30 Day Supply Limit** Most Generics: $5 copay Preferred: $30 copay Non-Preferred: $45 copay	**30 Day Supply Limit** Most Generics: $10 copay Preferred: 30% Non-Preferred: 30%	**30 Day Supply Limit** Most Generics: $15 copay Preferred: $30 copay Non-Preferred: $50 copay
Mail Order Prescriptions	**90 Day Supply Limit** Most Generics: $10 copay Preferred: $75 copay Non-Preferred: $112 copay	**90 Day Supply Limit** Most Generics: $20 copay Preferred: 30% Non-Preferred: 30%	**90 Day Supply Limit** Most Generics: $30 copay Preferred: $60 copay Non-Preferred: $100 copay
Specialty Prescriptions	**30 Day Supply Limit** 30%	**30 Day Supply Limit** 30%	**30 Day Supply Limit** 30%
PPO Network Monthly Premium			
Employee *Aetna* *UnitedHealthcare*	 $684.23 $719.89	 $658.33 $692.61	 $551.20 $579.82
Employee & Spouse/DP* *Aetna* *UnitedHealthcare*	 $1250.40 $1315.79	 $1,199.78 $1,262.77	 $1,013.88 $1,067.11
Employee & Child(ren) *Aetna* *UnitedHealthcare*	 $913.85 $961.41	 $879.09 $925.08	 $734.88 $772.96
Employee & Family *Aetna* *UnitedHealthcare*	 $1,492.46 $1,571.09	 $1,432.16 $1,507.46	 $1,206.52 $1,269.64
High Performance Network Monthly Premium			
Employee *Aetna* *UnitedHealthcare*	 $657.23 $650.20	 $632.36 $625.61	 $529.54 $523.90
Employee & Spouse/DP* *Aetna* *UnitedHealthcare*	 $1,200.66 $1,187.46	 $1,152.07 $1,139.67	 $973.63 $963.22
Employee & Child(ren) *Aetna* *UnitedHealthcare*	 $877.62 $867.95	 $844.25 $835.20	 $705.83 $698.03
Employee & Family *Aetna* *UnitedHealthcare*	 $1,432.99 $1,417.64	 $1,375.11 $1,360.28	 $1,158.54 $1,145.80

Benefit Description	WEASelect QHDHP	Kaiser HMO (Core Network)
Plan Year Deductible *(per member / family)*	$1,750 / $3,500 Begins Nov. 1	$200 / $400 Begins Jan.1
Plan Year Out-of-Pocket Maximum *(per member / family)* (begins Nov. 1)	$5,000 / $10,000	$2,000 / $4,000
Primary Care Physician Office Visit	No copay, 80%	$15 copay
Specialist office visit	No copay, 80%	$15 copay
Preventive and wellness	100%	100%
Inpatient hospital care	80%	$200 copay per day for up to 3 days per admit, then 100%
Emergency room services	80%	$100 copay, then 100%
Rx Deductible *(per member / family)*	Shared with Medical	$0 / $0
Rx Out-of-Pocket Maximum *(per member / family)*	Shared with medical out-of-pocket max.	Shared with medical out-of-pocket max.
Retail Prescription Drugs	**30 Day Supply Limit** 80%	**30 Day Supply Limit** Generic: $15 copay Preferred: $30 copay Non-Preferred: Not Covered
Mail Order Prescriptions	**90 Day Supply Limit** 80%	**90 Day Supply Limit** Generic: $30 copay Preferred: $60 copay Non-Preferred: Not Covered
Specialty Prescriptions	**30 Day Supply Limit** 80%	**30 Day Supply Limit** Applicable tier copay applies
PPO Network Monthly Premium		**HMO Network Monthly Premiums**
Employee *Aetna* *UnitedHealthcare*	$505.70 $531.95	**Kaiser Permanente** $936.37
Employee & Spouse/DP* *Aetna* *UnitedHealthcare*	$926.58 $975.19	**Kaiser Permanente** $1,719.13
Employee & Child(ren) *Aetna* *UnitedHealthcare*	$674.14 $709.00	**Kaiser Permanente** $1,254.46
Employee & Family *Aetna* *UnitedHealthcare*	$1,100.05 $1,158.05	**Kaiser Permanente** $2,060.69
High Performance Network Monthly Premium		
Employee *Aetna* *UnitedHealthcare*	$485.86 $480.71	
Employee & Spouse/DP* *Aetna* *UnitedHealthcare*	$889.84 $880.30	
Employee & Child(ren) *Aetna* *UnitedHealthcare*	$647.54 $640.33	
Employee & Family *Aetna* *UnitedHealthcare*	$1,056.34 $1,045.15	

Health Savings Account (HSA): For those enrolled on the High Deductible Health Plan (QHDHP)

The Health Savings Account is only available to employees who choose the High Deductible Health Plan. It allows you to set aside pre-tax dollars each paycheck for the reimbursement of eligible medical, dental and vision expenses. You own the funds in the HSA account and unspent balances remain in your account earning interest that can be rolled over from year–to-year. The funds are portable and can be taken with you so the money remains available to you when you need it. To be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under an HDHP on the first day of the month
- The HDHP must be your only medical plan, otherwise, you will not qualify for the HSA
- You are not enrolled in Medicare
- You are not claimed as a dependent on someone else's tax return
- Not covered by a Spouse's FSA Plan

The calendar year maximum contribution amounts are set by the US Treasury and IRS. For 2017 the maximum is **$3,400** for an individual or **$6,750** for a family.

Catch-up contributions: This is available to HSA-eligible individuals who have attained age 55 by the end of the taxable year. If you are age 55 or older at the end of the tax year (and not enrolled in Medicare), you are eligible to make a $1,000 catch-up contribution. Thus, the above amounts increase to $4,400 for an individual with single HDHP coverage or $7,750 for employees with family HDHP coverage. If both you and your spouse are eligible for and want to make catch-up contributions, you must each have a separate HSA.

Eligible Health Expenses:

A complete listing (including over-the-counter expenses and expenses requiring a prescription) is provided in Code Section 213(d) of the IRS Ruling for Flexible Spending Accounts and Health Savings Accounts. Below are a few examples of allowed vs. not allowed expenses.

Allowed	Not Allowed
• Acupuncture	• Airborne
• Chiropractic Care	• Books
• Deductibles & Coinsurance	• Club Memberships
• Dental & Orthodontia	• Face Lifts & Liposuction
• Frames & Contact Lenses	• Marriage Counseling
• Prescriptions	• Teeth Bleaching
• Physical Therapy	• Vitamins

To establish your HSA Account, please contact Colonial Life.

Vision Insurance

Are you really seeing your best? Or are you simply used to the view? With good vision, your experiences are clearer, sharper and brighter. Vision examinations not only determine the need for corrective eye wear but also may help detect other general health problems such as glaucoma, cataracts, and diabetes. Plus, eye exams for children can help detect problems that can impact learning and development.

Dollar for dollar, you get the best value from your vision care plan when you visit a Northwest Benefit Network (NBN) panel provider. Going to a panel provider assures that you will receive quality, professional eye care and eyewear at a controlled cost. If you decide not to see a panel provider, the plan will reimburse you up to a stated amount. The choice is yours—either way, your vision benefits are a tremendous part of your overall benefits package.

Please note: Spouse and dependent coverage are included at no additional cost if enrolled.

NBN Vision: Panel Provider

When you elect to use the services of a panel provider of NBN Vision Plan, the following benefits will be provided in full unless otherwise noted:

1. Vision Examination – A complete analysis of the eyes and related structure to determine the presence of vision problems will be covered in full.
2. Lenses – The Plan provides high quality lenses necessary to improve your visual acuity. Basic prescription lenses will be covered in full; however, cosmetic features are not covered by the Plan (see Limitations)
3. Frames - The Plan offers a selection of frames that will be covered in full; however, if you select a frame which costs more than the amount allowed by your Plan, there will be an additional charge. Please ask your panel provider to show you the frames that are covered in full by your Plan and those which will cost more than the Plan maximum.
4. Contact Lenses – The Plan covers both elective and medically necessary contacts. When patients choose elective contact lenses, NBN will make an allowance of $250.00 toward the cost of the lenses and fitting/evaluation/dispensing in lieu of all other hardware for that year. To receive this allowance, the patient must select a provider from the NBN Vision Plan list and be eligible for the lenses (glasses) at the time services for contact lenses begin. The $250.00 elective contacts benefit allowance can be used only once per benefit period. Once any claim for contact lenses has been paid by the plan in a benefit period, any additional contact lenses that are purchased by the same patient during the benefit period will NOT be covered in the benefit period. To maximize your plan benefits, you should avoid multiple purchases of small quantities of contact lenses in the same benefit period.

Note: To be eligible for your contact lens benefit you must be eligible for your lens (glasses) benefit at the time you begin contact lens benefit services (Fitting/Evaluation/Contacts). Contact lenses must be obtained by the patient in order to use the contact lens benefit. A contact lens fitting fee submitted without contact lenses is not an eligible expense under the contact lens benefit.

The Plan also covers the full cost of medically necessary contact lenses (subnormal vision aid) only after cataract surgery. Prior Authorization is required.

NBN Vision: Non-Panel Provider

When you use the services of a licensed non-panel provider, you will be reimbursed for covered services up to the maximum shown in the following schedule:

1. **Vision Examination** $50.00
2. **Lenses and Frames (only if needed)**
   - Single vision prescription (per pair).....$55.00
   - Bifocal prescription (per pair).....$75.00
   - Trifocal prescription (per pair) $95.00
   - Progressive lenses (per pair) $75.00
   - Lenticular (per pair).....$120.00
   - Contacts (per pair, including fitting; in lieu of all other hardware for the year).....$110.00
   - Contacts as subnormal vision aid (per pair, including exam) $200.00
   - Frames $45.00

Frequency of Benefits

Vision Exam:

Once every calendar year **Lenses; Glasses:** Once every calendar year

Frames:

Once every calendar year **Contacts (in lieu of all other services):** Once every calendar year

Important: Selecting a provider from the NBN list assures that you will receive the full benefits of your Plan with direct payment to the provider by NBN and a guarantee of quality and cost control. If you seek the services of a provider who is not an NBN panel participant, you should pay the provider's full fee. You will be reimbursed by NBN in accordance with this reimbursement schedule. In most cases, the non-panel schedule will not be sufficient to pay the full cost of examination and glasses and you will likely incur out-of-pocket expense. Claims must be submitted within 365 days from the date of service..

Pediatric Vision Care

To comply with Health Care Reform, for children under age 19 the following are provided every calendar year in full:

- Exam, lenses, and select frames or contacts in lieu of glasses
- Scratch coating and polycarbonate
- Year's supply of disposable contacts and evaluation, fitting and follow-up care relating to contacts
- Medically necessary contacts

Coordination of Benefits

If you are entitled to benefits for the same expenses from both the Arlington SD Plan and some other group plan, the benefits under this Plan will be coordinated so that the total benefits from all plans will not exceed the covered expenses actually incurred by the Arlington SD participant. Married employees of the Arlington SD may coordinate coverage between each other's NBN plans. If, after benefits have been paid under the primary plan, outstanding balances exist for eligible expenses, the spouse's NBN plan may be used to cover these expenses (not to exceed the total charge of the allowable expense) or a second set of benefits may be obtained under the spouse's plan.

Procedure to Obtain Vision Care

Step 1: Log on to www.nwadmin.com or NWA's mobile app and use the NBN Vision Provider Locator feature to find an NBN eye care professional. It's also a good idea to verify your eligibility status online prior to receiving services.

Step 2: Present your NBN Vision ID card when you arrive for your appointment. Failure to tell your NBN eye care professional that you have NBN Vision eye care coverage could result in significant out of pocket expenses. Need additional ID cards? You can print extras online at www.nwadmin.com.
Complete any paperwork your eye care provider may require.

Step 3: After your services are complete, pay your NBN Vision provider any co-payments (if your plan requires them) and/or charges for any uncovered items you elected to receive. NBN will pay the panel provider directly for professional services and eyewear covered under your NBN Vision Plan.

Step 4: If you decide to use the services of a vision care provider not in the NBN network, simply pay for your vision services and/or materials and send the itemized bill to NBN with a completed NBN Vision claim form. Claim forms are available online at www.nwadmin.com. You will be reimbursed according to the out-of-network schedule of benefits (see your plan booklet for details). Payment for your claim will typically be made within 10 – 14 business days from receipt of your claim.

Dental Insurance

Strong teeth and healthy gums are an important part of good health, which is why we offer you and your eligible dependents dental coverage. Arlington Public Schools offers a choice between a Dental PPO plan through Delta Dental of Washington and a DHMO plan through Willamette Dental. Review the chart below for a summary of your dental plan features:

Please note:
Spouse and dependent coverage are included at no additional cost if enrolled and verified through the WEA Benefits Center.

In-Network Benefits	Delta Dental Plan A (Certificated & Classified only)	Willamette Plan 1
Provider Network		
In Network	DDW Network Providers	Willamette Dental Group Providers
Out of Network	Non-network licensed providers	Not covered
Annual Deductible		
Individual & Family	None	None
Services		
Diagnostic & Preventive Care Exams, x-rays, cleanings, sealants, fluoride	70% – 100% (Coverage varies by incentive level)*	100% after $15 copay/office visit
Routine Care: Fillings, oral surgery, root canals, periodontics, endodontics		100% after $15 copay/office visit
Gold Inlays, Onlays, Crowns		100% after $50 copay and $15 copay for office visit
Dentures, Bridges, Partials	Constant 50%	100% after $50 copay and $15 copay for office visit
Annual Benefit Maximum		
Per Individual	Delta Dental PPO: $2,000 Delta Dental Premier: $1,750 Non-participating: $1,750	None
Orthodontia Coverage		
Eligibility	Dependent children to age 26	Dependent children to age 26
Benefit Amount	50%	100% after $2,000 copay and $15 copay /office visit
Individual Lifetime Maximum	$2,000	None

*Your level of coverage depends on your incentive level (70%, 80%, 90%, or 100%). When you use your benefits in the current benefit period, your benefits will increase by 10% in the next benefit period, up to a maximum of 100%. If you don't use your benefits during any benefit period, the benefit level will decrease by 10% in the next benefit period, but will not drop below 70%.

EXCLUDED GROUP: Your Delta Dental Plan is **Plan C**, with the same Orthodontia coverage. Please see the supplemental form for plan details.

Delta Dental of Washington

With DDW, you can choose from two networks: Delta Dental PPO or Delta Dental Premier. Visit www.DeltaDentalWA.com/WEA and use the "Find a Dentist" tool to find in-network dentists. Utilizing these two networks will provide you with treatments at discounted rates and all the claim paperwork will be filed for you. You will experience the greatest out-of-pocket saving if you choose a dentist from the Delta Dental PPO network. If you choose a non-participating dentist you will be responsible for ensuring the dentist completes your claim forms and that the claims are sent to DDW. Claim payments will be based on actual charges or the maximum allowable fees for non-participating dentists, whichever is less. You are then responsible for any balance remaining after DDW pays.

Please note: It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation. Review carrier descriptions below for carrier specific information.

Willamette Dental

With Willamette, you must see a Willamette Dental Group Provider at a Willamette Dental Clinic in order to receive benefits. To find a clinic location near you, visit https://www.willamettedental.com/locations.htm.

Life Insurance

Basic Life and AD&D

Although we don't like to think about it, should death occur, the survivors left behind could face serious financial hardships. Your family might need an alternative source of income to pay off your bills and meet their ongoing financial responsibilities. That is the purpose of life insurance–to provide funds for those left behind.

It is also possible that an accident could cause serious injury–the loss of limbs or eyesight, for example. There is special insurance coverage which pays benefits if an accident causes loss of life, limb or sight–it is called accidental death and dismemberment (AD&D) insurance. AD&D pays an amount equal to your life insurance benefit in the event of your accidental death. It also provides benefits for certain accidental injuries. As an eligible employee of Arlington Public Schools, you are provided with life and AD&D insurance coverage through LifeMap Assurance Company equal to $250,000 at no cost to you.

Voluntary Life and AD&D

In addition to the basic life insurance plan, you are eligible to purchase additional amounts of individual term life insurance through LifeMap Assurance Company for yourself, your spouse and your children. Employees may purchase amounts of life insurance coverage in increments of $10,000, not to exceed 5 X salary to $500,000. Dependent spouse life insurance can be purchased in increments of $5,000, not to exceed 50% of EE Amt up to $100,000. Dependent child life insurance is available in increments of $2,000 up to a maximum of 50% of EE Amt to $10,000. You may also purchase additional amounts of AD&D insurance through LifeMap Assurance Company for you and your dependents.

There are three points to consider when deciding how much life insurance coverage you might need:

- If you have dependents that rely on you, how much will they need to pay off your current debts such as your mortgage, car loans, or credit card balances?
- What will it cost your beneficiaries to maintain their current standard of living?
- What kind of future would you like to provide for your spouse or dependent children or others who rely on you for financial support?

Voluntary life benefits are non-taxable when funded with post-tax dollars. The price you pay for voluntary group term life insurance is a function of your age and your coverage amount. The following table shows the price for voluntary life insurance.

	LifeMap
Basic Life and AD&D (applies to Classified and Certificated staff only)	
Employee Life and AD&D Plan Benefit	$50,000
Accelerated Benefit	Members who are diagnosed terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary
AD&D	If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available
Benefit Reduction Schedule	Your benefits reduce to 65% at age 65, to 45% at age 70, to 30% at age 75, to 20% at age 80, to 15% at age 85 and to 10% at age 90
Voluntary Life and AD&D (to enroll in spouse or dependent child(ren) coverage, employee needs to enroll in voluntary coverage)	
Employee Life and AD&D Plan Benefit	Up to 5x your annual earnings up to $500,000 (in $10,000 increments)
Spouse Life and AD&D Plan Benefit	Up to $100,000 (in $5,000 increments)
Dependent Child(ren) Life and AD&D Plan Benefit	Up to $10,000 (in $2,000 increments)
Benefit Reduction Schedule	Your benefits reduce to 65% at age 65, to 45% at age 70, to 30% at age 75, to 20% at age 80, to 15% at age 85 and to 10% at age 90
Contact Kim Perry, HR Specialist, at 360-618-6226 for additional details on these plans.	

Naming Your Beneficiary

You may name anyone you wish as your beneficiary who will receive your life and AD&D benefits in case of your death. To designate your beneficiary, please contact your Human Resources team for the preferred method of communication.

Disability Insurance

Arlington Public Schools provides a company–sponsored long-term disability (LTD) insurance plan through LifeMap. In addition, Arlington Public Schools employees have the opportunity to purchase Short-Term Disability (STD) insurance through Colonial's salary contribution program.

Long Term Disability (LTD)

The greatest threat to your earning power is illness or injury. If you are disabled for 60 day or longer due to a non-occupational illness or injury, Arlington provides you with LTD benefits. The LTD plan is designed to provide you with a reasonable level of income replacement in case you can no longer work due to a disability. Highlights of the LTD plan are shown below.

Voluntary Short Term Disability (STD)

For added protection, Arlington Public Schools employees have the opportunity to purchase Short-Term Disability (STD) insurance through LifeMap or Colonial's Short Term Disability program.

	LifeMap	Colonial
Mandatory LTD Coverage		
Benefits Begin	After 60 days of disability	N/A
Monthly Benefit	60% of pre-disability earnings up to $5,000 per month	N/A
Benefit Duration	If you become disabled, as defined by the policy prior to age 60, benefits are payable to your normal retirement age as currently defined by Social Security	N/A
Voluntary STD Coverage		
Benefits Begin	Accident: 1st day of disability Illness: 4th day of disability	Accident: 1st day of disability Illness: 8th day of disability
Weekly Benefit	66.67% of pre-disability earnings up to $1,385 per week	60% of pre-disability earnings up to $4,000 per week
Benefit Duration	9 weeks	3 months

Contact Kim Perry, HR Specialist, at 360-618-6226 for additional details on these plans.

Flexible Spending Accounts (FSA)

What Is A Flexible Spending Account (FSA)?

An FSA is a type of cafeteria plan authorized under Section 125 of the Internal Revenue Code. When you participate in an FSA plan via salary reduction, you reduce your federal FICA taxes and increase your take-home pay. You have the opportunity to enroll in two Flexible Spending Account (FSA) options depending on you and your family's needs; a Health Care FSA and/or a Dependent Care FSA.

The FSA plans run from October 1, 2017 through September 30, 2018 and are provided through American Fidelity.

The Health Care FSA – "General Purpose FSA"

This type of account allows you to aside up to $2,500 each year on a pre-tax basis to pay expenses you know you're going to have, such as medical and dental plan deductibles, copayments, vision care expenses, and other out–of–pocket health and dental care expenses. The IRS has ruled that you can set aside pre–tax dollars to pay for LASIK eye surgery and over–the–counter medications, such as aspirin, that you obtain with a physician's prescription. The dollars you contribute to your Health Care FSA are deducted from your paycheck pre-tax and are available to pay for most medically necessary health care services that are not covered by insurance. Examples of eligible expenses for reimbursement from your Health Care FSA include:

- Deductibles & coinsurance amounts not covered by health, dental and vision plans
- Over–the–counter medications obtained with a doctor's prescription used to treat a medical problem (e.g.; aspirin)
- Copayments for birth control pills and other prescribed drugs
- Smoking cessation programs
- Immunizations
- Surgery to improve vision (LASIK)
- In vitro fertilization
- Orthodontic care
- Psychological and psychiatric care
- Chiropractic expenses
- Psychological and psychiatric care
- Routine physicals & other preventive medical care services
- Chiropractic expenses
- Hearing exams and hearing aids
- Prescription vitamins

A complete list of eligible expenses may be found in IRS Publication 502. Changes to the new plan year's Health FSA election amount will be allowable as long as the participant completes a new or revised election form prior to September 30, 2016. Changes to the current year election may not be made.

$500 Carryover Provision: If you do not spend your entire balance by the end of the plan year, you can rollover amounts in excess of $5.00 and up to $500 into the next plan year. Rollover funds will not affect your next year's maximum election. Note that funds over $500 are subject to "use-it or lose-it" and amounts will be forfeited. This provision may impact contribution elections, planning for medical expenses, and health and welfare benefit plan choices. For example, a participant with a $500 carryover amount will not be eligible to contribute to a Health Savings Account even if the participant did not elect to make additional contributions to the Health FSA for the new plan year.

Note: If you are enrolling on the QHDHP and you open an HSA, you are not eligible to participate in the General Purpose Health Care FSA and will have to make elections under the Limited Purpose FSA that will only reimburse your dental and vision expenses. Medical expenses cannot be reimbursed under a limited purpose FSA.

The Dependent Care FSA

With the Dependent Care FSA you can set aside up to $5,000 each year to pay for dependent care expenses you incur in order to work (if you're married but filing separately, federal regulations limit the use of a Dependent Care FSA to $5,000 each year). As with your Health Care FSA, you can save 25% or more on your dependent care expenses, depending on your personal tax rate. You should consult your tax advisor to determine whether the Dependent Care FSA or the dependent care deduction on IRS Form 1040 would be more advantageous for you. In order to qualify for a Dependent Care FSA, the IRS has established two regulations. The first is that an eligible dependent is any child under the age of 13 or an eligible dependent who is physically or mentally incapable of caring for his or her own needs, such as an invalid parent. The second is that if you claim the dependent care credit on your tax return or collect compensation through your Dependent Care FSA, you must report the name, address, and taxpayer identification number of each dependent care provider. If you do not comply, you will either lose the credit or pay taxes on the income placed in your Dependent Care FSA.

How to Enroll

A representative from Colonial Life will come out to the school district during Open Enrollment to meet with individuals (see school visitation schedule on the District website). If you wish to enroll in the Flexible Spending Accounts, you must meet with a representative at one of these opportunities. If you cannot attend an Open Enrollment session or if you are hired mid-year, contact by calling or go to www.coloniallife.com.

Please note: IRS regulations require that Flexible Spending Account elections be made each year. Your elections from last year will not rollover to this year. All employees are eligible to participate in the FSA.

Employee Assistance Program (EAP)

Most of us manage our lives successfully. There are times, however, when situations may prove too tough to get through by ourselves and our personal concerns may interfere with relationships, job performance, and physical health. Everyone can benefit from help when these difficulties arise. Because Arlington Public Schools is concerned about your well- being on and off the job, you and your family members are able to access confidential, professional assistance through the Employee Assistance Program (EAP). The EAP plan is a professional counseling service dedicated to assisting Arlington Public Schools employees and their family members through a period of personal difficulty.

The Arlington Public Schools EAP plan is provided by LifeMap Assurance Company. They offer confidential, professional counseling assistance and a 24-hour hotline seven days a week to assist in times of personal crisis. Additionally, you are eligible for face-to-face visits to assist with counseling, legal services and financial planning. Services include:

- 24-hour Crisis Help
- In-person Counseling (4 face-to-face visits)
- Online Consultations (www.MyRBH.com)
- Childcare Services
- Adult and Eldercare Services
- Pet Concierge
- Legal Services (free, half hour then 25% discount)
- Will Preparation
- Mediation Services
- Financial Services
- Home Ownership Program
- Identity Theft Services

Call 866-750-1327 or visit www.myRBH.com for more information.
Group code: LifeMap

Benefit Resource Center (BRC)

What Is The Benefit Resource Center (BRC)?

The Benefit Resource Center is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and assist with elevated claims, unresolved eligibility problems, and any other benefit questions you might have. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Mountain, Pacific and Alaska Standard Time via phone 866-468-7272 or via e-mail BRCWest@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Phone: (866) 4ourBRC (468-7272)

Email: 4ourBRC@usi.com

Model General Notice Of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Kim Perry, Human Resources Specialist, located in the Human Resources Department. Payment must be received by the District by the 15th day of the month for the next month's coverage. Coverage must be maintained on a continuous basis. Once coverage is terminated it may not be reinstated.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

Attention: Kim Perry, Human Resources Specialist
Arlington Public Schools, Human Resources Department
315 N. French
Arlington, WA 98223

Important Legal Notices Affecting Your Health Plan Coverage

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).

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 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 after the marriage, 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.

PATIENT PROTECTION MODEL DISCLOSURE

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.

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.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Arlington Public Schools, Human Resources Department
315 N. French
Arlington, WA 98223
360-618-6226

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

This memorandum has been prepared to help you review the annual legal notices associated with our benefit plans. This memorandum does not provide all of the required provisions associated with our policies and should be considered only as a summary of information. Refer to the SPDs for more information. If any differences exist between this summary and the official contracts, the contracts prevail.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of 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	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	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
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

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
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2017)

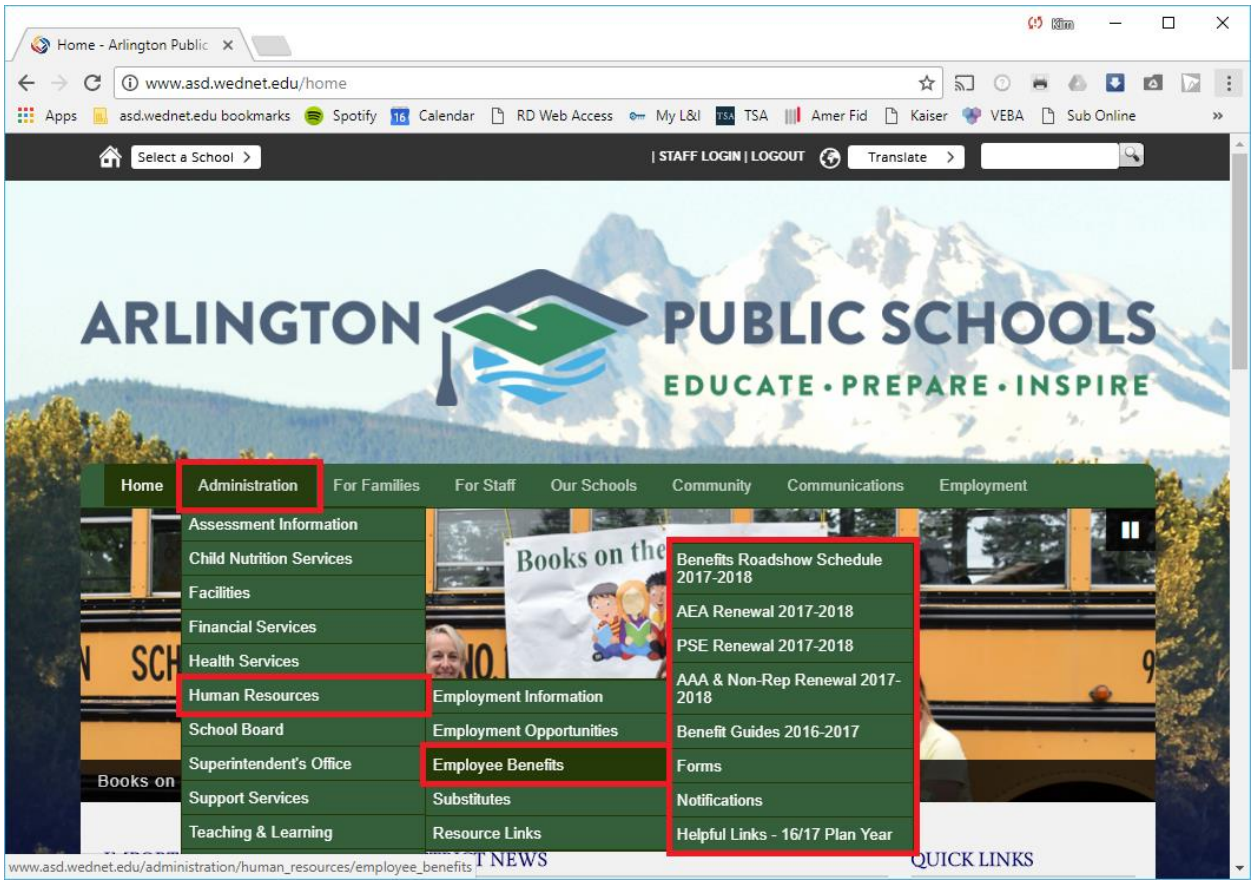
District Website Benefits Information

Keep yourself informed about Benefit Updates!

We keep the District website updated with important benefit information and reference materials, including

- Benefit Guides
- upcoming presentation dates
- frequently used insurance forms
- and more!

If you have questions about benefits, this is a great place to start looking for answers.



You can also contact your HR Benefits Specialist:

Kim Perry
kperry@asd.wednet.edu
360-618-6226

ARLINGTON PUBLIC SCHOOLS
EDUCATE • PREPARE • INSPIRE

Notes:

Questions?
Kim Perry, HR Benefits Specialist
360-618-6226
kperry@asd.wednet.edu
http://www.asd.wednet.edu/administration/human_resources/employee_benefits/