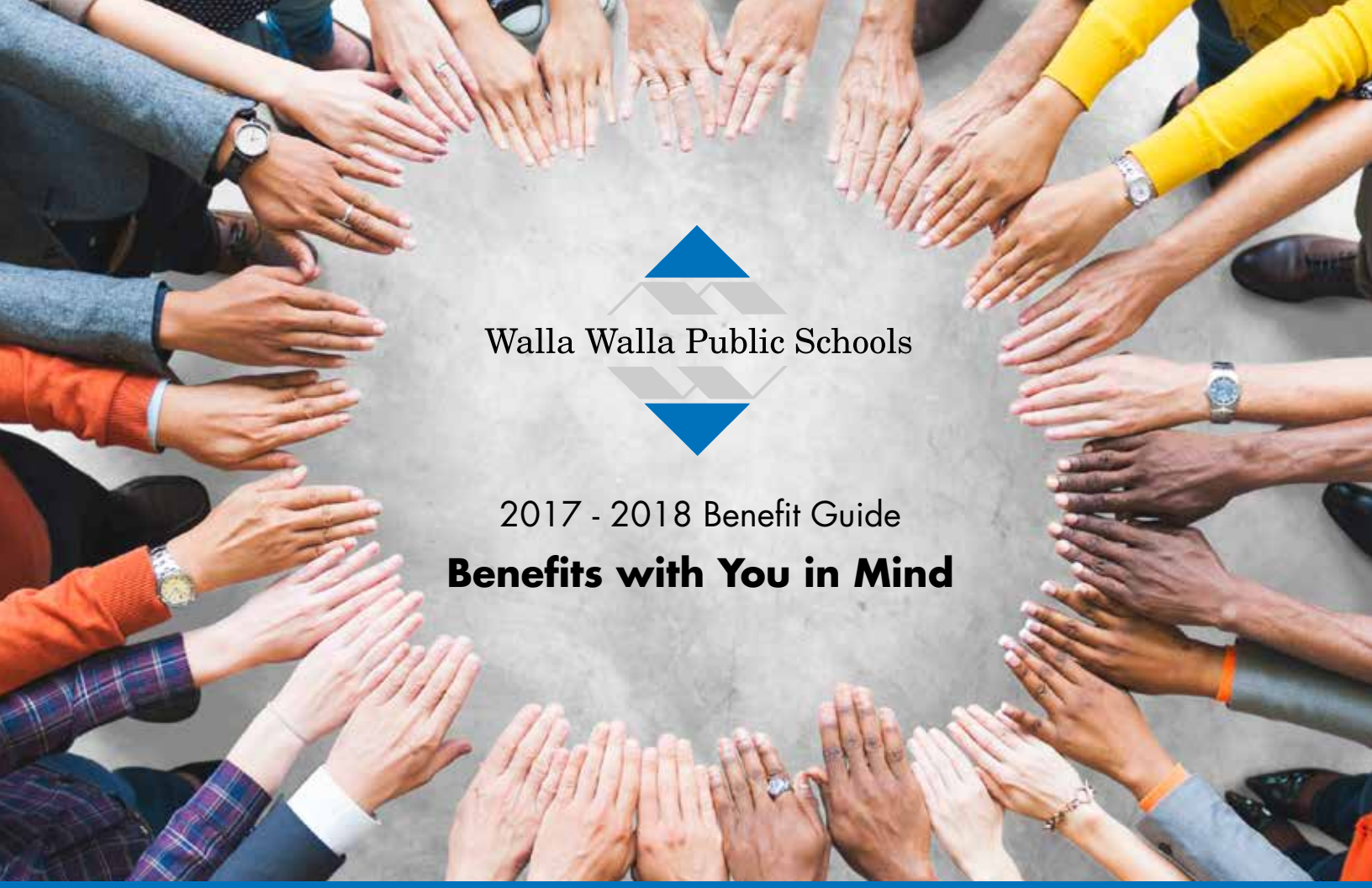

Walla Walla Public Schools

2017 - 2018 Benefit Guide

Benefits with You in Mind

Important Dates to Remember:

September 1 – September 30, 2017	**Open Enrollment**
September 6, 2017, 1 pm - 6 pm	**Benefit Fair – SEA-Tech Skills Center**
September 7, 2017, 8 am - 5 pm	**Individual Plan Consultations - Locations TBD**
September 30, 2017	**Deadline for Flexible Spending Accounts**
September 30, 2017	**Open Enrollment Ends**

INDIVIDUAL MONTHLY BENEFIT CALCULATION

If your contract hours or days are different from the information on the label below, please contact the Business Office.

Annual Required Notices are included beginning on page 16.

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Welcome to Your 2017-2018 Benefits!

At Walla Walla Public Schools, we are committed to providing you with a competitive, comprehensive benefits program with the care you and your family need to lead healthy, productive lives. Please review this guide carefully for the highlights of our benefits and discuss these options with your family.

What's New?

Read on to discover what's new or changing for the 2017-18 plan year.

- After an in-depth review by our Benefits Committee, a decision was made to replace the UnitedHealthcare plans with comparable plans offered through Premera Blue Cross. Kaiser Permanente PPO plans will no longer be offered as a result of this change. No changes were made to the benefits under the Kaiser HMO plans.
- Premiums increased on the medical and dental plans.

Eligibility

You are eligible for Walla Walla Public Schools benefits on the first of the month following 10 days of employment if you are scheduled to work 15 hours or more per week.

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse or domestic partner and your children up to age 26.

Note: To enroll your domestic partner, you must complete an Affidavit of Domestic Partnership.

If you are enrolling during open enrollment, any changes you make will begin on November 1.

When to Enroll

You can enroll for coverage within 30 days of your eligibility date or during the annual open enrollment period.

If you don't enroll for coverage within 30 days of your eligibility date, you won't receive health coverage during the plan year unless you have a qualified change in family status (see Making Changes for details).

How to Enroll

Enroll in coverage for yourself and your dependents by submitting enrollment forms to the Business Office. Enrollment forms for Medical, Dental and Vision can be found here: www.wwps.org/departments/business-office.

Making Changes

The choices you make when you are first eligible are in effect for the remainder of the plan year which ends on October 31. Once you enroll, you must wait until the next open enrollment period to change your benefits or add or remove coverage for dependents unless you have a qualifying life event as defined by the IRS.

The following are examples of a qualifying life event:

- Marriage, divorce, legal separation, annulment or death of spouse
- Birth, adoption or placement for adoption
- Change in your residence or workplace (if your benefit options change)
- Loss of other health coverage
- Change in your dependent's eligibility status because of age, student status or any similar circumstance

You have 30 days to make changes to your coverage. **Keep in mind:** Any change you make to your coverage must be consistent with the qualifying life event.

Medical Coverage – Spelled Out

As an eligible Walla Walla Public Schools' employee, you have access to six medical plan options for convenience and flexibility. It is important to consider how the plans work and the total cost of coverage. This includes what you pay in premiums and what you pay out-of-pocket to providers. Review your options below and choose the plan that's right for you and your family.

- **Kaiser HMO Plans 3 & 4** – These plans provide coverage for in-network care. Out-of-network care is only available in an emergency.
- **Premera PPO Plans 3 & 4** – These plans provide coverage for in and out-of-network care.
- **Premera QHDHP Plan** – This plan is a Qualified High-Deductible Health Plan (QHDHP) with coverage for in- and out-of-network care. It offers lower premiums, a higher deductible, and a tax-advantaged Health Savings Account (HSA).
- **NEW Premera Alternative Plan** – This plan provides coverage for in- and out-of-network care. It offers lower premiums and a higher deductible with office visits and prescriptions covered by copays.

Your Cost for Health Coverage

The monthly rates for medical, dental, and vision coverage are shown in the table below:

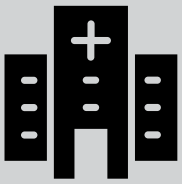
Benefit Plan	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Medical				
Kaiser HMO Plan 3	$825.88	$1,602.20	$1,156.24	$1,932.55
Kaiser HMO Plan 4	$582.41	$1,129.87	$815.37	$1,362.84
Premera PPO Plan 3	$738.25	$1,328.85	$959.75	$1,624.15
Premera PPO Plan 4	$653.40	$1,176.05	$849.40	$1,437.45
Premera QHDHP	$560.35	$1,008.60	$728.45	$1,232.75
Premera Alternative Plan	$554.40	$997.85	$720.70	$1,219.60
Dental (mandatory for all employees)				
United Concordia	$118.36			
Vision (mandatory for all employees)				
MetLife/VSP	$19.97			

Benefit Dollars and Pooling

The state allocation for 2017-18 is $820 per month per full-time equivalent employee. You must first use this money for dental and vision coverage, then you may spend the balance on medical benefits. Any money remaining is "pooled" within bargaining units and divided among employees to use toward medical premiums. No portion of the state allocation, or pooling dollars, can be applied to the purchase of other voluntary insurance programs. 2017-2018 pooling dollars will be determined in October.

Know Where to Go!

When you're sick or need medical care, it's important to know where to go for treatment, so you and your loved ones get the care you need. Get to know your options now so you can feel prepared.

Care Center	Reasons to go	Type of Care	Cost/Time Considerations
Doctor's Office 	• Your primary doctor knows you and your health history and can access your medical records • Provide preventive and routine care • Manage medications • Refer you to a specialist	• Routine checkups • Preventive services • Flu shots and other immunizations • General health	• Often requires a copay and/or coinsurance • Normally requires an appointment • Little wait time with scheduled appointment
Convenience Care Clinic 	• Convenient walk-in clinics located in retail stores, supermarkets and pharmacies • Staffed by a nurse practitioner or physician assistant and treat uncomplicated minor illnesses and provide preventive health care services	• Common infections, such as strep throat • Minor skin conditions, such as poison ivy • Flu shots • Minor cuts • Earaches	• Often requires a copay and/or coinsurance similar to an office visit • Walk in patients welcome with no appointments necessary, but wait times can vary
Urgent Care Center 	• If your primary care physician is not available and you need medical attention for non-life-threatening issues, visit an urgent care center • Urgent care provides comprehensive quality care on a walk-in basis with extended hours	• Sprains • Strains • Minor broken bones, such as a finger • Minor infections • Minor burns	• Often requires a copy and/or coinsurance typically higher than an office visit • Walk in patients welcome, but wait times can vary as patients with more urgent needs will be treated first
Emergency Room 	• Emergency rooms offer inpatient care, trauma services and more • If a situation is life threatening, call 911 or your local emergency number right away	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Major burns • Spinal injuries • Severe head injury • Difficulty breathing • Major broken bones	• Often requires a much higher copay and/or coinsurance • Open 24/7. Waiting periods vary because patients with life-threatening emergencies will be treated first

Medical Plan Comparison (Modified)

Plan Features	Premera PPO Plan 3		Premera PPO Plan 4	
	In-Network	**Out-of- Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible Individual/Family	$500/$1,500		$1,000/$3,000	$2,000/$6,000
Coinsurance	20%	40%	20%	50%
Out-of-Pocket Maximum Individual/Family	$3,000/$6,000		$5,000/$12,700	$10,000/$30,000
Preventive Care	Covered in full	20% after deductible	Covered in full	Not covered
Office Visits	$30 copay	$40 copay	$15 copay	50% after deductible
Outpatient Hospital Services	20% after deductible	40% after deductible	20% after deductible	50% after deductible
Inpatient Hospital Services	$300 copay per admit, then 20% after deductible	40% after deductible	20% after deductible	50% after deductible
Emergency Services (Copay waived if admitted)	$150 copay		$150 copay	
Urgent Care	$30 copay	$40 copay	$15 copay	50% after deductible
Outpatient Mental Health and Substance Abuse	$30 copay	$40 copay	$15 copay	50% after deductible
Inpatient Mental Health and Substance Abuse	$300 copay per admit, then 20% after deductible	40% after deductible	20% after deductible	50% after deductible
Rehab Outpatient Physical, Occupational, Speech and Massage	$30 copay (45 visits PCY)	$40 copay (45 visits PCY)	$15 copay (30 visits PCY)	50% after deductible (30 visits PCY)
Acupuncture	$30 copay (15 visits PCY)	$40 copay (15 visits PCY)	$15 copay (15 visits PCY)	50% after deductible (15 visits PCY)
Chiropractic	$30 copay (20 visits PCY)	$40 copay (20 visits PCY)	$15 copay (20 visits PCY)	50% after deductible (20 visits PCY)
Prescription Drug: Retail (Up to 30-day supply)				
Generic	$15 copay		$15 copay	
Preferred Brand	$25 copay		$25 copay	
Non-Preferred Brand	$40 copay		$40 copay	
Prescription Drug: Mail Order (Up to 90-day supply)				
Generic	$15 copay		$15 copay	
Preferred Brand	$25 copay		$25 copay	
Non-Preferred Brand	$40 copay		$40 copay	

PCY = Per calendar year

Premera QHDHP		Premera Alternative Plan		Kaiser HMO Plan 3	Kaiser HMO Plan 4
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
$1,500/$3,000	$3,000/$6,000	$2,500/$5,000	$5,000/$10,000	$250/$500	$750/$1,500
20%	50%	20%	50%	20%	20%
$4,000/$6,850	$8,000/$16,000	$6,000/$12,000	$12,000/$24,000	$2,000/$4,000	$6,000/$12,000
Covered in full	Not covered	Covered in full	Not covered	Covered in full	Covered in full
20% after deductible	50% after deductible	$25 copay	50% after deductible	$20 copay, then 20%	$20 copay (first 4 visits PCY), then 20% after deductible
20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	$20 copay, then 20% after deductible
20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	$200 copay/day (up to 5 days per admit), then 20% after deductible
20% after deductible		$150 copay		$150 copay, then 20% after deductible	$150 copay, then 20% after deductible
20% after deductible	50% after deductible	$25 copay	50% after deductible	$20 copay, then 20%	$20 copay, then 20% after deductible
20% after deductible	50% after deductible	$25 copay	50% after deductible	$20 copay, then 20%	$20 copay, then 20% after deductible
20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	$200 copay/day (up to 5 days per admit), then 20% after deductible
20% after deductible (20 visits PCY)	50% after deductible (20 visits PCY)	$25 copay (30 visits PCY)	50% after deductible (30 visits PCY)	$20 copay, then 20% (45 visits PCY)	$20 copay, then 20% after deductible (45 visits PCY)
20% after deductible (15 visits PCY)	50% after deductible (15 visits PCY)	$25 copay (15 visits PCY)	50% after deductible (15 visits PCY)	$20 copay, then 20% (12 visits PCY)	$20 copay, then 20% after deductible (12 visits PCY)
20% after deductible (20 visits PCY)	50% after deductible (20 visits PCY)	$25 copay (20 visits PCY)	50% after deductible (20 visits PCY)	$20 copay, then 20% (unlimited visits PCY)	$20 copay, then 20% after deductible (unlimited visits PCY)
20% after deductible		$15 copay		$15 copay	$20 copay
		$25 copay		$30 copay	$40 copay
		$40 copay		$50 copay	$60 copay
20% after deductible		$15 copay		$30 copay	$40 copay
		$25 copay		$60 copay	$80 copay
		$40 copay		$100 copay	$120 copay

This is only a brief summary of the plans. For more details, including limitations and exclusions, please contact the Business Office for a Summary Plan Description.

Getting Started with Teladoc

Call: 855-332-4059

Web: www.teladoc.com/premera and click "My Medical History"

App: www.teladoc.com/mobile

Premera Value Added Resources

ComPsych EAP

The Employee Assistance Program (EAP) through ComPsych is available to you and your household family members 24 hours a day, 7 days a week at **844-862-0898** or online at www.guidanceresources.com (web ID premerawellness). All calls are completely confidential and there is no cost to you for using the service.

The professionals at the EAP will help by assessing, advising, and recommending options to help you or your family members deal with problems. In addition to unlimited phone counseling, you're eligible for three face-to-face counseling sessions per incident per year.

Your Compsych EAP can help with many issues including conflicts at work, financial or legal problems, depression, grief, stress, or anxiety, marital or family concerns, eldercare, drug and alcohol dependency and more!

Nurse line

If you're not feeling well, it's sometimes difficult to know what to do. Should you see a doctor? Rush to the emergency room? Just wait it out? The nurse line is a 24/7 hotline that can help answer these questions and provide immediate support for everyday health issues that might otherwise lead to unnecessary doctor or emergency room visits. It can also be a valuable resource in helping identify minor health issues before they become more serious.

Call 800-841-8343 to speak with a registered nurse 24 hours a day, 7 days a week, 365 days a year. Your call is free and confidential.

Virtual Care

Teladoc provides 24/7/365 access to a national network of U.S. board-certified physicians who can resolve many medical issues via phone or online video consultations. You simply request a virtual doctor visit and describe your symptoms. Teladoc will pair you with a doctor licensed in your state and after your virtual doctor visit, if medically necessary, a prescription can be sent to the pharmacy of your choice.

The cost of your virtual care visit with Teladoc or your doctor is based on your standard in-network office visit cost shares (copay or deductible and coinsurance).

Health Savings Account (HSA) – A Better Way to Save

When you enroll in the Qualified High-Deductible Health Plan (QHDHP) and meet the HSA eligibility requirements, you're eligible to contribute to a Health Savings Account to pay for eligible health care expenses with pre-tax dollars.

HSA Quick Facts

- You decide how much you want to contribute each year (up to IRS limits). Contributions are deducted from your paychecks in equal installments throughout the year.
- Paying for eligible health care expenses is easy. Simply swipe your HSA debit/credit card or submit carrier forms for reimbursement.
- HSAs give you triple tax advantages: your contributions are tax-free, payment of qualified expenses is tax-free, and interest accrues tax-free.
- Unused funds roll over year to year and can be used to pay for next year's medical care.
- The HSA is your bank account—if you leave the company, the account goes with you.
- Remember to keep your receipts. You don't have to provide receipts to access your HSA funds, but you'll need to prove you used your HSA for qualified medical expenses if the IRS ever asks.

Did You Know?

To help you cover out-of-pocket health care costs, a Health Savings Account (HSA) will be opened for you when you elect the QHDHP + HSA. The HSA is a **tax-favored account** you use to pay for medical expenses—both now and in the future.

You contribute pre-tax dollars to the account—this lowers your taxable income and gives you more take home pay.

Account balances accrue interest tax-free.

You withdraw funds tax-free when you pay for qualified medical expenses.

HSAs are a great way to save for health care expenses in retirement!

Coverage Type	2017 IRS Limits	2018 IRS Limits
Individual Coverage	$3,400	$3,450
Family Coverage	$6,750	$6,900
Age 55+ (individual)	$4,400	$4,450
Age 55+ (family)	$7,750	$7,900

Please note, combined employee and company contributions cannot exceed the IRS maximums. If you are age 55 or older, you may contribute an additional $1,000 above annual IRS limits.

What's in the fine print?

HSA Eligibility Requirements:

- You must be enrolled in a qualified high-deductible health plan to be eligible for an HSA.
- You cannot be covered under another health plan, including your spouse's Health Care Flexible Spending Account.
- If you are covered under your spouse's Flexible Spending Account (FSA), you can still participate in the HSA by changing your spouse's FSA to a limited-purpose FSA that can cover vision and dental expenses.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

Choosing the Best Medical Plan for You

The ideal medical plan should cover most of your health care needs at the most reasonable cost. Let's look at three fictional employees as they explore their medical plan usage and decide which plan is best for them.

Kristi

Plan Usage: Low

Overall Health: Healthy. No medical conditions.

Age: 25

Status: Single

Coverage: Employee-only

Description: Kristi is healthy and active and does not visit the doctor often (outside of regular preventive visits).

What Kristi wants most in a plan: Low premiums

Plan Selection: Kristi chooses the QHDHP. Here's why

- Considerable savings per paycheck
- Free preventive care in-network
- Financial rewards for staying healthy
- HSA helps offset deductible and out-of-pocket costs
- Annual out-of-pocket maximum — provides built-in safety net in case major medical attention is needed

Chad

Plan Usage: Moderate

Overall Health: Somewhat healthy. Chad has high blood pressure and his wife has high cholesterol.

Age: 45

Status: Married

Coverage: Employee + Spouse

Description: Chad goes to the doctor multiple times a year and fills his prescriptions regularly. He likes the flexibility of choosing providers inside and outside of the network.

What Chad wants most in a plan: The best coverage level

Plan Selection: Chad chooses the Premera Plan (3 or 4). Here's why:

- Provides the best protection against critical illnesses
- Lower cap on out-of-pocket expenses
- Free preventive care in-network

Wendy

Plan Usage: High

Overall Health: Healthy with two accident-prone children.

Age: 35

Status: Married w/ children; Husband is self-employed

Coverage: Family

Description: Wendy is a parent of two young children who make frequent visits to the doctor. She does not need to see physicians outside of the network.

What Wendy wants most in a plan: Low copays

Plan Selection: Wendy chooses the Kaiser HMO Plan 4. Here's why:

- Affordable monthly premiums with up-front office visit copays
- Predictable month-to-month budget and lower total annual costs
- Free preventive care in-network

Dental Coverage – Reasons to Smile

Good dental care is an important part of your overall health and well-being. The United Concordia dental plan is designed to help you maintain a healthy smile. Visit an in-network provider for preferred provider rates.

	United Concordia Flex PPO
Plan Features	**In-Network**
Calendar Year Deductible	None
Calendar Year Maximum	$2,250
Diagnostic and Preventive Services (e.g., cleanings, sealants, exams)	Covered in full
Basic and Restorative Services (e.g., fillings, extractions, root canals)	90%
Major Services (e.g., dentures, crowns, bridges)	60%
Orthodontia (child and adult)	50%
Orthodontia Lifetime Maximum	$1,750 per member

Note: If you visit an out-of-network provider, you are responsible for charges above usual, customary, and reasonable (UCR) limits.

Vision Coverage – Seeing the Future, Even Brighter!

Keep your vision clear and eyes healthy with regular visits to youroptometrist. The MetLife VSP plan offers comprehensive coverage for exams, frames, lenses or contacts. You may visit a doctor within the VSP network and take advantage of higher benefits coverage, or visit an out-of-network provider of your choice for a reduced benefit.

Plan Features	**MetLife VSP Vision**	
	In-Network	**Out-of-Network**
	You pay:	**Plan reimburses you:**
Exam every 12 months	$5 copay	Up to $45
Frames every 24 months	$10 copay $200 retail allowance $110 Costco allowance	Up to $70
Lenses every 12 months Single Vision: Bifocal: Trifocal: Lenticular:	$10 copay	 Up to $30 Up to $50 Up to $65 Up to $100
Contact Lenses (in lieu of lenses and frames) every 12 months		
Elective: Medically Necessary:	$200 allowance Maximum $60 copay	Up to $105 Up to $210

Tints, Adult Polycarbonate and Photochromic lenses are available with "not to exceed" copay schedule listed below:

Lens Options	**Single Vision**	**Multifocal**
Solid tints and dyes – Pink I and II	$0	$0
Solid plastic dye – Expect Pink I and II	$15	$17
Plastic gradient dye	$17	$17
Polycarbonate lenses (Polycarbonate lenses are covered in full for dependent children)	$31	$31
Photochromic lenses – plastic	$70	$82

Flexible Spending Accounts (FSA) – Pay the Expenses, Save on Taxes

The Flexible Spending Accounts (FSAs), administered by Navia Benefit Solutions, are a tax-saving way to pay for health care and dependent care expenses you'd typically pay for with after-tax dollars. Expenses such as deductibles and copays can add up quickly, and dependent care or elder care expenses can be even more expensive. FSAs let you pay for these expenses with **pre-tax** dollars. This means the money you set aside is not taxed, so you save money!

Each year you participate, you must elect the amount you want to contribute to either or both FSAs. Contributions are deducted from your paychecks in equal installments throughout the year and deposited into your account(s).

You may contribute up to $2,600 to the Health Care FSA and up to $5,000 ($2,500 if you are married and file your taxes separately) to the Dependent Care FSA. Both accounts function separately.

Eligible Expenses for Your FSAs

Eligible Health Care FSA expenses include medical, dental, and vision expenses not covered under your health care plans.

Eligible Dependent Care FSA expenses are those which allow you and your spouse (if you are married) to work or attend school full time. These services include day care, babysitters, day camps, and caregivers for disabled dependents.

Reimbursement from Your FSAs

You will receive a Navia Benefit Solutions debit/credit card to pay for eligible expenses. You can also be reimbursed for expenses by completing required forms for reimbursement from your account.

Rules to Keep in Mind

FSAs offer huge tax advantages, but are subject to strict IRS regulations:

- If you don't use the full amount in your FSAs by the end of the plan year, you forfeit any unused funds. You have 90 days from the plan year end date to submit claims incurred between November 1, 2017 and October 31, 2018.
- Once you enroll in the FSAs, you can't change your contribution amount during the year unless you experience a qualifying life event, such as marriage or birth of a child.
- You cannot transfer funds from one FSA to another.
- Keep your receipts! You may be required to submit receipts to show claims eligibility.

If you are unable to estimate your health care and dependent care costs accurately, it's better to be conservative and underestimate rather than overestimate your expenses. For a detailed list of eligible expenses, visit www.irs.gov/publications and search for *Publications 502 (Medical and Dental Expenses)* and *503 (Child and Dependent Care Expenses)*.

How Much Can You Save With an FSA?

Maria and her husband are contributing the maximum amount to a Dependent Care FSA this year. See how much they'll save:

$5,000 before-tax = $6,400 after-tax

SAVED $1,400 (28% tax rate)

Important!

Make sure your beneficiary information is up-to-date as situations may change. Payroll can assist you if you need to make changes.

Employee Assistance Program (EAP)

We recognize you may experience issues that affect the quality of life at home or at work, which is why we offer two Employee Assistance Program options so you can select the plan that works best for you and your family.

First Choice Health EAP

Your First Choice Health EAP is a free, easy to access resource available to you, your spouse or domestic partner, and your children up to the age of 26. Your EAP benefit can be utilized at no charge whenever you or your dependents are experiencing a work-related, personal, family, or emotional concern, and the EAP provides for up to 3 face-to-face sessions with a licensed counselor who is trained in the area of your concern. In addition, the EAP provides assistance with legal consultations and referrals, financial planning consultations, eldercare and childcare resources, identity theft resolution, and with the process of buying, selling, or refinancing a home. Your EAP can be accessed 24/7 by calling 800-777-4114, or by visiting their website at www.firstchoiceeap.com.

Voluntary Benefits

Voluntary benefits pay for medical costs your health plan doesn't cover. You can enroll in the following plans through Aflac:

- Cancer
- Intensive care protection
- Personal recovery plus
- Personal sickness indemnity plan
- Hospital protection plan
- Accidental indemnity advantage plan

To learn more about the Aflac benefits or to enroll, call 509-540-4925.

Peace of Mind with Voluntary Life and Disability Coverage

Voluntary Life and AD&D Insurance

You have the opportunity to buy Life and AD&D insurance for yourself and your dependents at group rates. Consider the cost of funeral expenses, legal expenses, and general living expenses for your surviving family members when choosing an appropriate amount of coverage.

Employee: Choose an amount in increments of $10,000 to a maximum of 5x your annual earnings, or up to $50,000 guaranteed. For new employees, the guaranteed issue amount is 5x your annual earnings or up to $150,000.

If you enroll in additional coverage for yourself, you may elect coverage for your spouse and/or your child(ren) in the following amounts:

Spouse: Choose an amount in increments of $5,000 to a maximum of $250,000, not to exceed 100% of employee elected amount. The guaranteed issue amount for spouses is $50,000.

Child(ren): $500 for children ages 14 days to six months, $10,000 for children ages six months to 19 years (age 26 if full-time student).

Please note: Evidence of Insurability (EOI) may be required prior to approval for amounts above guaranteed issue limits.

Plan Features	Age Bands	Rates per $1,000 per Pay Period
Employee and Spouse Life You pay the rate based on employee's age for your coverage. Some amounts may require Evidence of Insurability (EOI)	<25	$0.06
	25-29	$0.06
	30-34	$0.07
	35-39	$0.08
	40-44	$0.11
	45-49	$0.17
	50-54	$0.25
	55-59	$0.43
	60-64	$0.64
	65-69	$1.00
	70-74	$1.77
	75+	$2.08
Child Life	**Amount of Coverage**	**Rates per $1,000 per Pay Period**
	$10,000	$1.90

Voluntary Disability Insurance

Loss of income due to an illness or injury can cause serious financial hardship for families. Disability insurance replaces a portion of your income to help you continue paying your bills. If you want to purchase Short-Term Disability coverage, you must also purchase Long-Term Disability insurance. You may choose to elect Long-Term Disability as a stand-alone product.

You have two benefit options:

1. Coverage beginning after 15 days (Short-Term and Long-Term Disability)
2. Coverage beginning after 90 days (Long-Term Disability)

Your disability coverage replaces 66 2/3% of your base salary. Short-Term Disability pays up to $1,500 per week and Long-Term Disability pays up to $6,000 per month while you are disabled.

SUN LIFE Disability Rates

Salary	Monthly Benefit	Weekly Benefit	LTD Premium	STD + LTD Premium
$1,800	$100	$30	$1.24	$3.43
$3,600	$200	$50	$2.47	$6.12
$5,400	$300	$70	$3.71	$8.82
$7,200	$400	$100	$4.95	$12.25
$9,000	$500	$120	$6.19	$14.95
$10,800	$600	$140	$7.42	$17.64
$12,600	$700	$170	$8.66	$21.07
$14,400	$800	$190	$9.90	$23.77
$16,200	$900	$210	$11.14	$26.47
$18,000	$1,000	$240	$12.37	$29.89
$19,800	$1,100	$260	$13.61	$32.59
$21,600	$1,200	$280	$14.85	$35.29
$23,400	$1,300	$300	$16.09	$37.99
$25,200	$1,400	$330	$17.32	$41.41
$27,000	$1,500	$350	$18.56	$44.11
$28,800	$1,600	$370	$19.80	$46.81
$30,600	$1,700	$400	$21.04	$50.24
$32,400	$1,800	$420	$22.27	$52.93
$34,200	$1,900	$440	$23.51	$55.63
$36,000	$2,000	$470	$24.75	$59.06
$37,800	$2,100	$490	$25.99	$61.76
$39,600	$2,200	$510	$27.22	$64.45
$41,400	$2,300	$540	$28.46	$67.88
$43,200	$2,400	$560	$29.70	$70.58
$45,000	$2,500	$580	$30.94	$73.28
$46,800	$2,600	$600	$32.17	$75.97
$48,600	$2,700	$630	$33.41	$79.40
$50,400	$2,800	$650	$34.65	$82.10
$52,200	$2,900	$670	$35.89	$84.80
$54,000	$3,000	$700	$37.12	$88.22
$55,800	$3,100	$720	$38.36	$90.92
$57,600	$3,200	$740	$39.60	$93.62
$59,400	$3,300	$770	$40.84	$97.05
$61,200	$3,400	$790	$42.07	$99.74
$63,000	$3,500	$810	$43.31	$102.44
$64,800	$3,600	$840	$44.55	$105.87
$66,600	$3,700	$860	$45.79	$108.57
$68,400	$3,800	$880	$47.02	$111.26
$70,200	$3,900	$900	$48.26	$113.96
$72,000	$4,000	$930	$49.50	$117.39
$73,800	$4,100	$950	$50.74	$120.09
$75,600	$4,200	$970	$51.97	$122.78
$77,400	$4,300	$1,000	$53.21	$126.21
$79,200	$4,400	$1,020	$54.45	$128.91
$81,000	$4,500	$1,040	$55.69	$131.61
$82,800	$4,600	$1,070	$56.92	$135.03
$84,600	$4,700	$1,090	$58.16	$137.73
$86,400	$4,800	$1,110	$59.40	$140.43
$88,200	$4,900	$1,140	$60.64	$143.86
$90,000	$5,000	$1,160	$61.87	$146.55
$91,800	$5,100	$1,180	$63.11	$149.25
$93,600	$5,200	$1,200	$64.35	$151.95
$95,400	$5,300	$1,230	$65.59	$155.38
$97,200	$5,400	$1,250	$66.82	$158.07
$99,000	$5,500	$1,270	$68.06	$160.77
$100,800	$5,600	$1,300	$69.30	$164.20
$102,600	$5,700	$1,320	$70.54	$166.90
$104,400	$5,800	$1,340	$71.77	$169.59
$106,200	$5,900	$1,370	$73.01	$173.02
$108,000	$6,000	$1,390	$74.25	$175.72

Retirement Plans – Plan Now for a Secure Future

Tax Sheltered Annuity (403b) Program

Walla Walla School District's Tax Sheltered Annuity (403b) Program is administered by Carruth Compliance Consulting. Visit their site at www.ncompliance.com/guest_employees.aspx?EmployerID=63. Online, you'll find information about vendors and forms. Contact the Business Office for more information.

Deferred Compensation (457) Program

To help you save for the future, Walla Walla Public Schools participates in a Deferred Compensation Plan through the Washington State Department of Retirement Systems to assist you in building up your retirement funds. Visit www.drs.wa.gov/DCP for more information.

Important Notices

Women's Health and Cancer Rights Act

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

Coverage must include:

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

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

Special Enrollment Rights

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

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

HIPAA Notice of Privacy Practices Reminder

HIPAA requires Walla Walla School District to notify its employees that a privacy notice is available from the Human Resources Department. To request a copy of Walla Walla School District's Privacy Notice or for additional information, please contact the Business Office at 509-526-6768, 509-526-6721, or 509-526-6736.

Healthcare Reform & Your Benefits

The Affordable Care Act requires most Americans to have health insurance (unless you meet certain exceptions). If you do not have health insurance you may pay a tax penalty. Walla Walla School District offers a medical plan option that provide valuable comprehensive coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. Also note, it's unlikely that you are eligible for financial help from the government to help you pay for insurance purchased through a Marketplace because you have access to an employer plan that complies with the affordability standard.

Patient Protection Disclosure Notice

Premera Blue Cross and Kaiser Permanente generally allow 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 the Premera Blue Cross and/or Kaiser Permanente listed under "Your Benefits Contacts" in the back of this Guide.

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

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

Preventive Care

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed under "Your Benefits Contacts" in the back of this Guide.

COBRA

Federal COBRA is a U.S. law that applies to employers who employ 20 or more individuals and sponsor a group health plan. Under Federal COBRA you may be eligible to continue your same group health insurance for up to 18 months if your job ends or your hours are reduced. You are responsible for COBRA premium payments.

Certificate of Creditable Prescription Drug Coverage

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Walla Walla School District 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 company has determined that the prescription drug coverage offered by the Premera Blue Cross and Kaiser Permanente are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current company coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company benefit plan.

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the company 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 your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

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

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 August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Questions? Your Benefits Contacts

Benefit	Contact	Phone	Website
General Information	Walla Walla Business Office	509-526-6768 509-526-6721 509-526-6736	www.wwps.org
Medical & Prescriptions	Kaiser Premera	800-464-4000 800-722-1471	www.kp.org www.premera.com
Dental	United Concordia	800-332-0366	www.unitedconcordia.com
Vision	MetLife	855-638-3931	www.metlife.com/mybenefits
Health Savings Account (HSA) and Flexible Spending Accounts (FSAs)	Navia Benefit Solutions	800-669-3539	www.naviabenefits.com
Life, AD&D, and Disability	Sun Life	800-247-6875	www.sunlife.com
Employee Assistance Program (EAP)	ComPsych First Choice Health	844-862-0898 800-777-4114	www.guideanceresources.com www.firstchoiceeap.com
Tax Sheltered Annuity Program (403b)	Carruth Compliance Consulting	877-222-3090	www.ncompliance.com/contact.aspx
Deferred Compensation Plan (457)	Washington State Department of Retirement Systems	888-327-5596	www.drs.wa.gov/DCP
Voluntary Benefits	AFLAC	509-540-4925	www.aflac.com

Walla Walla Public Schools