Walla Walla Public Schools

Benefits Decision Guide

You + Your Benefits

A partnership for good health

Annual required notices are included beginning on page 18.

Walla Walla Public Schools

welcome

Welcome to Open Enrollment. Providing great benefit choices to you and your family is just one of many ways Walla Walla School District supports the health and financial well-being of the people who make our schools successful - you.

Key Dates to Remember

Here is a reminder of key dates and deadlines to remember for the 2019 plan year.

Open Enrollment: September 1 - September 30, 2019

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 state registered domestic partner and your children up to age 26.

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.**

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.

If you are enrolling during open enrollment, any changes you make will begin on November 1, 2019 - December 31st, 2019 for most plans. See page 7 for 2020.

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Benefit Terms to Know

Coinsurance
The percentage you pay of the cost for health care service. The plan pays the majority and you pay the rest.

Copay
A flat fee you pay for a health care service. Some services have a copay instead of co-insurance.

Deductible
The amount you pay for care before the plan begins to pay. Once deductibles are met, the plan will begin to pay for benefits.

Flexible Spending Account (FSA)
A tax-advantaged savings account that lets you contribute money tax-free to pay for eligible health care to participate.

Health Maintenance Organization (HMO)
This type of plan offers lower deductibles and copays than a PPO or PPO HSA plan, but you are required to see doctors in the network, except in case of emergency.

Health Savings Account (HSA)
HSA is a tax-advantaged savings account that lets you contribute money tax-free to pay for eligible health care expenses, but unlike an FSA, the money in your account rolls over year-to-year, and you must be enrolled in a high deductible health plan.

Preferred Provider Organization (PPO)
A PPO plan lets you see any doctor you want, but pays benefits at a higher-level when you see in-network doctors.

Qualified High Deductible Health Plan (QHDHP)
The QHDHP plan uses the same network of doctors as the PPO plans, but has a higher deductible and coinsurance. You are also eligible for an HSA.

Your Enrollment Checklist

- ☐ **Know your options and costs.** Read this guide and review your health care premiums on page 8.
- ☐ **Take action.** Enroll by the deadline: **Open enrollment** - September 1-30, 2019 **New hires** - you must enroll within 30 days from your hire date to receive coverage for the upcoming year. **Already enrolled?** No forms are necessary if you are not making any changes (except HSAs).
- ☐ These changes and plans will run through December 31st, 2019.

  See page 7 for more details on changes for 2020.
- ☐ **Confirm or provide any new dependent and beneficiary information.**

Ready to Enroll?

Once you're ready, you'll need to complete a carrier enrollment form or change form for each benefit you wish to enroll in or change.

choosing a plan

How do you choose the best medical plan that's right 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.

Ashley

Plan usage: Low

Age: 25

Status: Single

Coverage: Employee-only

Overall Health: Healthy. No medical conditions.

What Ashley wants most in a plan: Low premiums

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

Plan Benefits:
•Considerable savings per paycheck •Free preventative care in-network •Financial rewards for staying healthy •HSA helps offset deductible and out-of-pocket expenses

Ashley chooses the: **QHDHP**

Mark

Plan usage: Moderate

Age: 45

Status: Married

Coverage: Employee+Spouse

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

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

Description: Mark goes to the doctor multiple times a year and fills his prescriptions regularly. He likes the flexibilty of choosing providers in and out of the network.

Plan Benefits:
•Provides the best protection against critical illness
•Lower cap on out-of-pocket expenses
•Free preventive care in-network

Mark chooses the: **Premera Plan (3 or 4)**

Donna

Plan usage: High

Age: 60+

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

Coverage: Family

Overall Health: Healthy, but accident prone.

Description: Donna makes frequent visits to the doctor. She does not need to see physicians outside of the network.

What Donna wants most in a plan: Low copays

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

Donna chooses the: **Kaiser HMO Plan 4**

health

Best Plan for You If you anticipate your health care usage for the year is going to be high, the QHDHP may be a good fit because it includes an out-of-pocket maximum that acts as a safety net to help you manage your costs.

Making the Right Choice

Choosing the right medical plan means determining your estimated health care usage for the year and finding what fits you and your budget the best.

Additional Information?

You can get additional information about the available plans from Walla Walla School District at:
District Administration Office
364 S. Park Street

About Your Medical Premiums

You and the District share the costs of your health benefits. Your state allocation pays a generous portion of the total cost and you pay the remainder. The amoount you pay is deducted from your paycheck. Remember, you may have remaining pooled dollars to use toward the purchase of medical bebefits.

Your specific medical premiums are based on your employment status and determined by the plan you choose, the coverage level you select, and your pay level.

Stay Within the Network Remember, an easy way to save money is to stay within your plan's network because network providers have agreed to charge lower costs.

Flexible Spending Accounts (FSAs) are a great way to save money because they allow you to set aside money from your paycheck before taxes.

Advantages of the QHDHP

Walla Walla School District's QHDHP Plan has several advantages over other types of medical plans. Overall, it could reduce your annual costs for health care.

QHDHP Features

1. **Lower-cost coverage** - lower premium than most of all District-offered medical plans, which means you'll keep more of your paycheck each month.
2. **Tax-advantaged savings account** - you can contribute tax-free money directly from your paycheck to an HSA, up to the IRS annual limits. Withdrawls are tax-free when used to pay for eligible health care expenses. The money in the HSA rolls over from year to year and is yours to keep, so you take it with you if you leave Walla Walla or retire.
3. **Free in-network preventive care** - as with all District health plans, preventive care is fully covered - you pay nothing toward your deductible and no copays when you receive care from in-network providers.
4. **Same provider network** - the QHDHP uses the same network of doctors as the other PPO plan options.

2020 HSA Contribution Limits

Coverage Level	Limits
Single	$3,550
Two-party/family	$7,100
Age 55+ (single)	$4,450
Age 55+ (two-party/family)	$7,900

2019 HSA Contribution Limits

Coverage Level	Limits
Single	$3,500
Two-party/family	$7,000
Age 55+ (single)	$4,500
Age 55+ (two-party/family)	$8,000

HSA Eligibility

To establish and contribute to an HSA, you:

- Must be enrolled in the QHDHP, a qualified HDHP
- Cannot also participate in the health care FSA
- Cannot be eligible for Medicare
- Cannot be claimed as a dependent on someone else's tax return

Using Your HSA

You may withdraw available funds from your HSA whenever you have a qualified medical expense by using your debit card, submitting an online request, or mailing a distribution form.

No new enrollment on 11/1/2019:
Employees with FSAs must spend the down by 10/31/2019

2020 SEBB HEALTH BENEFITS OPEN ENROLLMENT

This year, to ensure you have a complete understanding of your benefits and to help make the choices best suited for your needs, Health Care Authority will be providing you with information on how to enroll, as well as a decision support tool to help find the plan that is the right fit for you.

Open enrollment is from Oct 1 to Nov 15 and
is mandatory for all SEBB benefits-eligible new plans and tools will be available soon.
Be sure to check you district email and home mail for details.

CAUTION: If you fail to complete open enrollment by Nov 15, you will automatically be enrolled as an employee only (no dependent coverage) on the Uniform Medical Plan, will be required to pay a $25 monthly tobacco surcharge, and will be unable to make any changes until the next open enrollment period.

URGENT: If you will be enrolling dependents, documented verification will be required – like a birth certificate, marriage license, or tax return.

Save With an HSA A simple way to save on health care costs is to contribute to a Health Savings Account (HSA), available when you enroll in the QHDHP. An HSA helps you pay for medical expenses now - and save for the future. Contributions are made before taxes, which lowers your taxable income and saves you money.

Start now to gather documents!
A full list of acceptable documents is available at hca.wa.gov/sebb-employee

Open Enrollment is your once-a-year opportunity to review your benefits and make any changes to your coverage for the plan year.

Learn more about required health care and your coverage options. Then make smart choices to save on your health care costs.

Your Cost for Health Coverage

As an eligible Walla Walla Public School 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 and choose the plan that's right for you and your family.

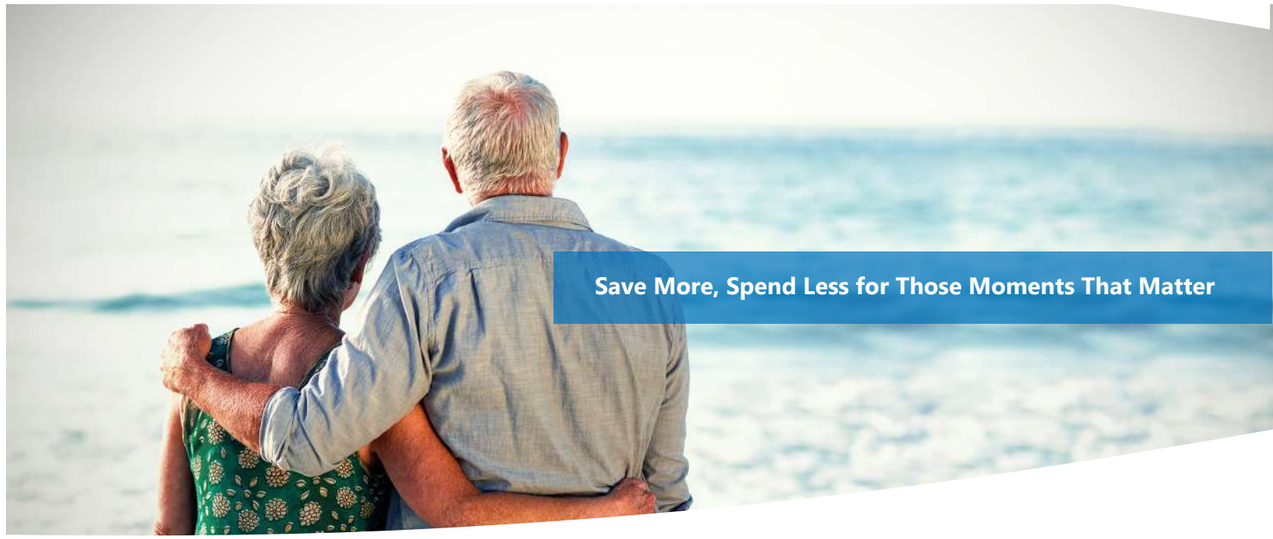
Monthly Rates - the monthly rates for medical, dental, vision, and basic life coverage are shown in the table below.

Benefit Plan	Employee only	Employee+ spouse	Employee+ child(ren)	Employee+ 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	$769.01	$1,384.36	$999.80	$1,692.03
Premera PPO Plan 4	$680.61	$1,225.16	$884.82	$1,497.51
Premera QHDHP	$583.66	$1,050.69	$758.80	$1,284.23
Premera Alternative Plan	$577.46	$1,039.49	$750.72	$1,270.53
Dental				
United Concordia	$122.93			
Vision				
MetLife/VSP	$25.36			

Live Well, Spend Less

A healthy lifestyle means spending less on health care.

- Take advantage of wellness perks to reach your wellness goals.
- Always check that you're getting the lowest-cost prescription. Use mail order and get a 90-day supply of medication for the cost of a 60-day supply (excluding the QHDHP).
- Visit the emergency room for true emergencies only - opt for an urgent care facility or your physician's office for non-life-threatening conditions.



Required Health Care Coverage

The health care reform law, also known as the Affordable Care Act (ACA), requires almost all U.S. citizens and and legal residents to have health insurance. If you enroll in a medical plan offered through the District, you'll meet this requirement. If you choose to waive coverage, you must complete a district medical waiver form. Other options for meeting coverage requirements may include enrolling in one of the following:

- Medical plan through another employer such as your spouse's or domestic partner's employer
- Medical plan through your parent's employer if you're younger than 26
- Government plan such as Medicare or Medicaid (if eligible)
- Private health care insurance plan
- Public health care insurance marketplace

Understanding ACA Requirements

To learn more about coverage requirements and the health care reform law, visit **www.healthcare.gov**.

Medical Plan Comparison (Modified)

Plan Features	Premera PPO Plan 3		Premera PPO Plan 4		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	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Calendar Year Deductible Individual/Family	$500/$1,500		$1,000/$3,000	$2,000/$6,000	$1,500/$3,000	$3,000/$6,000	$2,500/$5,000	$5,000/$10,000	$250/$500	$750/$1,500
Coinsurance	20%	40%	20%	50%	20%	50%	20%	50%	20%	20%
Out-of-Pocket Maximum Individual/Family	$3,000/$6,000		$5,000/$12,700	$10,000/$30,000	$4,000/$6,850	$8,000/$16,000	$6,000/$12,000	$12,000/$24,000	$2,000/$4,000	$6,000/$12,000
Preventive Care	Covered in full	20% after deductible	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Covered in full
Office Visits	$30 copay	$40 copay	$15 copay	50% after deductible	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
Outpatient Hospital Services	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	$20 copay, then 20% after deductible
Inpatient Hospital Services	$300 copay per admit, then 20% after deductible	40% after deductible	20% after deductible	50% 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
Emergency Services (Copay waived if admitted)	$150 copay		$150 copay		20% after deductible		$150 copay		$150 copay, then 20% after deductible	$150 copay, then 20% after deductible
Urgent Care	$30 copay	$40 copay	$15 copay	50% after deductible	20% after deductible	50% after deductible	$25 copay	50% after deductible	$20 copay, then 20%	$20 copay, then 20% after deductible
Outpatient Mental Health and Substance Abuse	$30 copay	$40 copay	$15 copay	50% after deductible	20% after deductible	50% after deductible	$25 copay	50% after deductible	$20 copay, then 20%	$20 copay, then 20% 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	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
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)	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)
Acupuncture	$30 copay (15 visits PCY)	$40 copay (15 visits PCY)	$15 copay (15 visits PCY)	50% after deductible (15 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)
Chiropractic	$30 copay (20 visits PCY)	$40 copay (20 visits PCY)	$15 copay (20 visits PCY)	50% after deductible (20 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)
Prescription Drug: Retail (Up to 30-day supply)										
Generic	$15 copay		$15 copay		20% after deductible		$15 copay		$15 copay	$20 copay
Preferred Brand	$25 copay		$25 copay				$25 copay		$30 copay	$40 copay
Non-Preferred Brand	$40 copay		$40 copay				$40 copay		$50 copay	$60 copay
Prescription Drug: Mail Order (Up to 90-day supply)										
Generic	$15 copay		$15 copay		20% after deductible		$15 copay		$30 copay	$40 copay
Preferred Brand	$25 copay		$25 copay				$25 copay		$60 copay	$80 copay
Non-Preferred Brand	$40 copay		$40 copay				$40 copay		$100 copay	$120 copay

Have Money Available When You Need It If you enroll in the QHDHP, put your savings from lower paycheck deductions into your tax-free HSA to have money available when you need to pay out-of-pocket costs.

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 your optometrist 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.

	MetLife VSP Vision	
Plan Features	**In-Network You pay:**	**Out-of-Network 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:	$200 allowance	Up to $105
Medically Necessary:	Maximum $60 copay	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

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 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!

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 (AFLAC)

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 AD&D 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

important notices

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).

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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, 2019. 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

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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/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov 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: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/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: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

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VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, 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)

your benefits contacts Questions?

Benefit	Contact	Phone	Website
General Information	Walla Walla Business Office	509-526-6768	www.wwps.org
Medical & Prescriptions	Kaiser	800-464-4000	www.kp.org
	Premera	800-722-1471	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)	Navia Benefits Soultions	800-669-3539	www.naviabenefits.com
Life, AD&D, and Disability	Sun Life	800-247-6875	www.sunlife.com
Employee Assistance Program (EAP)	ComPsych	844-862-0898	www.guideancesources.com
	First Choice Health	800-777-4114	www.firstchoiceap.com
Tax Sheltered Annuity Porgram (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
AFLAC Voluntary Benefits	Trisha Jennings	509-540-4925	www.aflac.com