Your Benefits

Effective November 1, 2019

FRANKLIN PIERCE SCHOOL DISTRICT

OPEN ENROLLMENT
DENTAL & VISION (WEA PLANS): 9/10/19-9/19/19
KAISER, PREMERA, VOLUNTARY PLANS: 9/2/19-9/19/19

WELCOME TO YOUR BENEFITS!

Franklin Pierce School District is proud to offer a comprehensive benefits package to our employees and their families. This package is designed to provide choice, flexibility, and value.

This Benefits Guide will help you learn more about your benefits, review highlights of the available plans and make selections that best fit your lifestyle and budget. In addition, you can contact the Payroll Office or call a Gallagher Benefit Advocate for help understanding your benefits and completing your paperwork or online enrollment. The phone numbers are listed on the last page of this Guide under "Your Benefits Contacts." After enrollment, you will also have access to insurance plan booklets that provide more detailed information on each of the programs you select.

To help you make decisions regarding your healthcare coverage, a Summary of Benefits and Coverage (SBC) is available for your medical plan. The SBC summarizes important information about any health coverage options in a standard format as required by Healthcare Reform regulations. The SBCs are available on the web at: www.GBSwa.com/BenefitManager, password: fpps. A paper copy is also available, free of charge. Please contact our FPSD payroll office.

IMPORTANT:
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 22 for more details.

Teamsters: You will only be making medical elections. Your dental and vision coverage is through Northwest Administrators.

WHAT'S INSIDE

OPEN ENROLLMENT OVERVIEW

For employees already enrolled. ***Teamsters you will only make medical elections.***

Open Enrollment is September 2 through 19 and September 10 through September 19 for the Dental and Vision (WEA) plans. You are able to change your elections during the Open Enrollment period. You may only make election changes outside of Open Enrollment under certain circumstances, which are referred to as qualified changes in status. Unless you experience a qualified change in status, you will not be able to change your enrollment election until the next Open Enrollment period. A qualified change in status can include:

- Birth or adoption of a child
- You, your spouse, or a dependent loses coverage under another group plan
- Change in marital status
- Relocation out of the service area
- You, your spouse, or dependent become eligible for or lose other group coverage including loss of eligibility for Medicaid, including becoming eligible for Medicaid, or a child reaches age 26.
- Open Enrollment through your spouse's employer

IMPORTANT

Enrollment timeline may vary in certain situations. See "Special Enrollment Rights" on page 14.

THE BENEFIT PLANS OFFERED ARE:

- Choice of seven medical plans including a prescription drug benefit:
  - Premera Blue Cross Plan 2 PPO
  - Premera Blue Cross Plan 3 PPO
  - Premera Blue Cross Plan QHDHP PPO
  - Premera Blue Cross EasyChoice A PPO
  - Premera Blue Cross EasyChoice B PPO
  - Premera Blue Cross Basic PPO
  - Kaiser Permanente HMO
- Choice of two dental plans:
  - Delta Dental of Washington PPO
  - Willamette Dental of Washington, Inc. EPO
- Vision plan through Vision Service Plan (VSP)
- Life/AD&D insurance if enrolled in a Premera Blue Cross medical plan
- Employee Assistance Program
- Voluntary insurance options, including Flexible Spending Accounts for tax savings on health and daycare expenses

QUESTIONS

Contact a Benefit Advocate (a service provided by Gallagher). You can reach a Benefit Advocate at: bac.franklinpiercesd@ajg.com or by phone: 425.201.9056, toll free: 800.542.3737, 6:00 a.m. - 6:00 p.m. PT, Monday - Friday

IMPORTANT

Employees who would like to make a change must call the WEA Select Benefits Center at 855.668.5039. Participants will not be able to make changes using UPoint for these plans:

- DDWA
- Willamette Dental
- VSP
- American Fidelity

Unless you are making Open Enrollment changes (i.e. changing from one medical plan to another, adding/removing a spouse/domestic partner or child), there is no need to complete an enrollment form or enroll through the UPOINT website. You are only required to complete an enrollment form or login to the UPOINT website if you are making Open Enrollment election changes. Open Enrollment changes for Dental and Vision plans can only be made via phone. **It is mandatory for you to complete a waiver form each year that you decline medical coverage, and return the benefit selection form to the FPSD payroll office.**

If we do not receive an enrollment form or you do not complete enrollment through the UPoint website (UPoint for dental and vision only), your current elections will continue for the 2019 short plan year, with the exception of Flexible Spending Account (FSA) elections. As a reminder any changes to the medical plan will require the carrier paper application.

FLEXIBLE SPENDING ACCOUNT (FSA/SECTION 125)

You must complete a Flexible Spending Account (FSA) enrollment form to participate in the short 2019 plan year - even if you were previously enrolled. Use the resources online at: www.GBSwa.com/BenefitManager, password: fpps, to help determine how much money to contribute to your FSA. Participating in an FSA plan allows you to save on taxes when paying for eligible healthcare and dependent care expenses. Please see the Flexible Spending Account section on page 17 for more details. There is no carryover into the 2020 plan year, the money has to be used.

VOLUNTARY BENEFITS

Your voluntary benefit elections carry forward year to year. If you want to make any changes to your election, you must contact the carrier or the Payroll Office by the Open Enrollment deadline. See page 19 for additional details.

NEW HIRE ENROLLMENT CHECKLIST

***For newly eligible employees*. Please follow the steps below to choose your benefits and enroll.**

o PREPARE EVERYTHING YOU WILL NEED

- Social security numbers for you and your family members whom you want to enroll in your benefits
- Dates of birth for your family members

o CHOOSE YOUR BENEFITS

Take the time to review the benefit outlines provided in this Guide. This will help you understand the plans that are offered and how they will fit your lifestyle and budget. To make sure your family doctor and dentist are covered by the plans you have chosen, check the Provider Directory online or call customer service (see "Your Benefits Contacts" near the end of this Guide).

o DECIDE HOW MUCH TO CONTRIBUTE TO FLEXIBLE SPENDING ACCOUNTS

Determine how much money you should put into your Flexible Spending Account (FSA) to save on taxes when paying for healthcare and dependent care expenses. Please see the Flexible Spending Accounts section on page 17 of this Guide for additional information.

o FILL OUT YOUR ENROLLMENT FORM(S)/COMPLETE ONLINE ENROLLMENT

To enroll in the Kaiser Permanente medical plan, complete and return to Payroll:

- Kaiser Permanente enrollment form (obtain form from Payroll)
- FPSD Benefit Selections Form and return to Payroll - **Mandatory**

To enroll in a Premera Blue Cross medical plan, complete and return to Payroll:

- Premera Blue Cross enrollment form (obtain form from Payroll)
- Symetra beneficiary form
- FPSD Benefit Selections Form and return to Payroll – **Mandatory**

To enroll in a WEA sponsored plan (Delta Dental of Washington, Willamette Dental, and/or VSP):

- Create an account on the Your Benefits Resources (UPoint) website at http://digital.alight.com/WEA
  - If you are unable to login, you may contact the WEA Select Benefits Team for assistance at 855.668.5039
- Complete the FPSD Benefit Selections Form and return to Payroll - **Mandatory**

If you are electing not to enroll in either medical plan for the 2019 short plan year, you must complete and submit the mandatory FPSD waiver form and return to Payroll.

IMPORTANT

Employees who would like to make a change must call the WEA Select Benefits Center at 855.668.5039. Participants will not be able to make changes using UPoint for these plans:

- DDWA
- Willamette Dental
- VSP
- American Fidelity

o CHOOSE YOUR VOLUNTARY BENEFITS – For the short plan year you may have specific limitations due to SEBB

- To enroll in voluntary benefits offered through Wage Works (Flexible Spending Account) & AFLAC, contact:
  - Don Ruzicka – 360.703.4967 or don_ruzicka@us.aflac.com
- To enroll in voluntary benefits offered through American Fidelity, contact:
  - Katherine Hamilton – 405.212.2614 / 866.703.1191 or katherine.hamilton@americanfidelity.com
- To enroll in the 403 (b) Plan – Tax Sheltered Annuity or the 457 Plan – Deferred Compensation Plan contact:
  - Benefits Office – Cathy Young at 253.298.3032 or cyoung@fpschools.org

o YOU ARE DONE!

Please return your completed forms to Payroll within 30 days of your hire/eligibility date. Note: A waiver form is required if you are declining coverage.

IMPORTANT 2019 PLAN CHANGES

With open enrollment approaching, we want to make you aware of some of the changes with the introduction of SEBB, important dates for enrollment, and resources available to you and your family.

Starting January 1, 2020, the School Employees Benefits Board (SEBB) Program will administer health insurance and other benefits to all school district employees in Washington. Since SEBB benefits will be based on a calendar year while our benefits have renewed October 1st or November 1st each year, your current benefits will renew again for a short plan year until December 31, 2019. If you would like more information on SEBB benefits, you may visit their website included below.

For those who would like to participate in the Flexible Spending Accounts (FSAs) with WageWorks through Aflac, please keep the following information in mind when deciding how much to elect. The maximum contributions will be limited for the three-month plan year (October 1 – December 31, 2019). You can elect up to $600 for the Healthcare FSA and/or $1,250 for the Dependent Care FSA. While you will have the flexibility to carry over up to $500 of your unused Healthcare FSA balance at the end of the 2018-2019 plan year into the short plan year, you will not be able to carry over any funds from the short plan year into the 2020 FSA through SEBB. Find more information in the benefit guide posted on the District benefits site. IRS tax year limitations still apply.

Important Open Enrollment Dates and Deadlines

The Benefit Fair will be held at McGavick Center beginning at 7:30 am on Thursday, August 22nd. There you can meet with our carriers to help answer your questions and find out more information about SEBB prior to our District-wide meeting.

Benefits	Action Needed	Enrollment Dates	How to Enroll or Make Changes	Effective Date
FPS Benefits – Premera and Kaiser Medical/Rx, Lincoln Life and Disability, Legal, Mortgage Assistance, Auto and Home Insurance	If you are waiving coverage, a new Waiver Form is required. Otherwise, only need to contact District to make changes to enrollment.	September 2 – September 19, 2019	Contact the District Payroll Department 253-298-3000 payroll@fpschools.org	November 1, 2019
FPS Benefits – Aflac Coverage	Must contact Aflac if you want to re-enroll in FSA. Otherwise, only changes	September 2 – September 19, 2019	Contact Don Ruzicka 360-703-4967 Don_Ruzicka@us.aflac.com	October 1, 2019
WEA Benefits – VSP Vision, Delta Dental and Willamette Dental, American Fidelity Short- and Long-Term Disability	Only contact WEA to make changes to enrollment	September 10 – September 19, 2019	Call WEA Select Benefits Center at 855-668-5039 *No online enrollment this year and no new enrollments in STD and LTD*	November 1, 2019
SEBB Benefits	Mandatory enrollment process and dependent verification	October 1 – November 15, 2019	Follow the SEBB enrollment procedures payroll@fpschools.org	January 1, 2020

Resources for Benefit Information

Benefit Advocates: Monday - Friday, 6 am - 6 pm, bac.franklinpiercesd@ajg.com, 425-201-9056
District Benefits Site (benefit guide and other resources posted): www.GBSwa.com/BenefitManager, password: fpps
SEBB Benefits Site: https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program

ELIGIBILITY FOR BENEFITS THROUGH 12/31/19

New employees are eligible for group mandatory and optional benefits first of the month following working 11 paid days in a month, provided enrollment forms are completed and returned to payroll within 30 days. You may enroll your eligible dependents for medical, dental, and vision. Your eligible dependents include:

- Your legal spouse or state-registered domestic partner
- Your children up to age 26
- Any overage dependent child who is incapable of self-support because of a physical or mental disability and meets carrier requirements for coverage

IMPORTANT

Enrollment timeline may vary in certain situations. See "Special Enrollment Rights" on page 14.

Franklin Pierce School District extends benefits to employees' domestic partners. However, the value of these benefits must be included in the employee's gross income and is subject to federal income tax and FICA tax (unless the domestic partner is the employee's tax dependent). This means a portion of your benefit contribution (the difference between the cost to cover you plus your domestic partner and the cost to cover just you) is deducted from your pay after taxes have been applied (referred to as "post-tax"). It also means the premium your employer is paying on your behalf when you choose to cover your domestic partner is added to your taxable income. For more information, please contact the Payroll Office.

As a reminder, employees who enroll new dependents on the WEA Select Dental and/or Vision Plans may be asked to provide documentation to verify their dependents' eligibility for coverage under the WEA Select Plans. When adding new dependents in the UPOINT system, you will be asked to "certify" that you are adding valid dependents. Please keep in mind that certification does not verify dependent eligibility. Shortly thereafter, you may receive a request notice from the WEA Select Dependent Verification Team which will describe the process, including the documentation needed to verify eligibility and the deadline. **Unverified dependents may be removed from the plan(s) prospectively.**

Note: Employees who have already verified the eligibility of their dependents won't be asked to provide additional documentation for the short plan year, even if they change WEA Plans.

MAKING CHANGES TO YOUR BENEFITS

You may make changes to your healthcare and insurance benefit choices once a year during the Open Enrollment period. All benefits you select will be effective for the entire short plan year, unless you have a "qualified change in status" or lose eligibility under the plan (e.g., leave employment). Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

If you have a qualified change in status, you can make changes to your benefits by contacting Payroll within 30 days of the change. The change to your benefits must be consistent with the change in family status. For example, if you have a new baby, you can enroll the child as a dependent under your current health plan, but you may not remove another dependent who is already covered. To determine if a life event qualifies, please contact Payroll or a Gallagher Benefit Advocate.

QUALIFIED CHANGE IN STATUS EXAMPLES

- Birth or adoption of a child
- Loss of your or a dependent's coverage under another group plan
- Change in marital status
- You waive medical coverage for yourself or your family members because of other health coverage - and you lose that other coverage for certain reasons

QUESTIONS

Contact a Benefit Advocate
(a service provided by Gallagher).
You can reach a Benefit Advocate at:
bac.franklinpiercesd@ajg.com or by phone:
425.201.9056,
toll free: 800.542.3737,
6:00 a.m. - 6:00 p.m. PT,
Monday - Friday

NOTES

COST: WHAT DOES THE POOLING COVER & HOW MUCH CAN I EXPECT TO PAY?

STATE FUNDING AND POOLING

The District provides a benefit allotment to help pay for mandatory benefits (dental and vision) and voluntary medical for you and your family members. The beginning allotment for a full time employee before pooling is $973.00 per month. This amount will be prorated for employees who work less than full time employment.

If you do not use your entire benefit allotment, the remaining amount is put into a "pool" for your employee group and distributed based on the ratio of full time employees to members in your group who have elected medical coverage.

Note: The benefit allotment and pooling are available for use toward domestic partner coverage as well as legal spouses and dependent children. Please see the "Dependents" section on page 5 for information regarding the taxation of domestic partner premiums. Please remember everyone has a minimum mandatory deduction for participation in the medical plans.

WHEN CAN I EXPECT PREMIUMS TO BE DEDUCTED FROM MY PAYCHECK?

A payroll deduction will occur if the monthly premiums for your mandatory benefits and voluntary medical are greater than your benefit allotment and pooling distribution, less the mandatory plan deduction. You will also incur a payroll deduction for the other voluntary benefits you select.

Deductions for medical insurance premiums are taken, pre-tax, from the current month's pay warrant (last working day of the month) to pay for the next month's coverage. You are automatically enrolled in the Premium Conversion Plan, allowing the premium for your medical coverage to be deducted before taxes, which reduces your taxable income, resulting in more take-home pay.

Because your medical insurance premiums are taken from your paycheck on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year. Without an approved status change, your payroll deduction amount will remain in effect through December 31, 2019. Only post-tax payroll deductions allow you to drop medical coverage without a qualifying event. The District automatically takes your medical deductions on a pre-tax basis. If you would like to opt out of pre-tax deductions, contact the Payroll Office by the enrollment deadline.

An approved status change is always required if you have pre-tax deductions. If you have post-tax deductions, an approved status change is always required to add a dependent or modify your benefit selection.

If you are participating in the Healthcare or Dependent Care portion of the Flexible Spending Account (FSA), 1/3 of your short plan year (October 1, 2019 – December 31, 2019) election will be deducted from your paycheck each month. If you are newly eligible during the plan year, deductions will be taken once per month over the remaining months of the plan year. Tax year limitations still apply.

NOTES

COST WORKSHEET FOR 2019 SHORT PLAN YEAR

PAYROLL DEDUCTION WORKSHEET

Each eligible employee receives a benefit allocation based on his/her assigned annual hours to a maximum of $973.00 per month. The benefit allocation will first be used to pay for dental and vision, then the balance can be used to help pay for medical insurance. If you do not use all of your benefit allocation, the balance will go into a pool for your employee group. If you spend more than your benefit allocation, you may receive dollars from that pool to reduce your payroll deductions. Pre-tax dollars will be used to pay for medical payroll deductions, unless you have requested post-tax deductions. If you have questions in using this table, contact Payroll.

Enter District Allocation*	1.	$
Enter Dental Premium	2.	$
Vision Premium	3.	$30.80
Total cost of mandatory benefits - lines 2+3	4.	$
Subtract line 4 from line 1	5.	$
Enter Medical Premium	6.	$
Enter total from line 5 (this is the total you have to spend on Medical insurance)	7.	$
Subtract Line 7 from line 6 (this is your payroll deduction amount)**	8.	$

*For your district allocation please contact:

Administration Staff – Cathy Young at 253.298.3032 or cyoung@fpschools.org
Certified Staff – Rhonda Grissom at 253.298.3031 or rgrissom@fpschools.org
Classified Staff – Kristen Desmond at 253.298.3033 or kdesmond@fpschools.org

****A mandatory minimum contribution applies. Your monthly contribution will be the greater of Line 8 or the mandatory minimum contribution.**

DENTAL/ORTHODONTIA AND VISION MONTHLY PREMIUMS		Clerical, Administrators, and Teachers	Paras, Unrep, NS, and Support Services
Delta Dental of Washington	Family Coverage	$109.69	$99.79
Willamette Dental of Washington, Inc.	Family Coverage	$92.40	$82.95
Vision Service Plan	Family Coverage	$30.80	$30.80

BENEFIT COSTS

Medical Monthly Cost (Optional)	Kaiser HMO	Premera Blue Cross Plan 2	Premera Blue Cross Plan 3	Premera Blue Cross QHDHP	Premera Blue Cross EasyChoice A	Premera Blue Cross EasyChoice B	Premera Blue Cross Basic Plan
Employee Only	$897.84	$880.18	$804.70	$464.22	$592.60	$592.60	$478.36
Employee & Spouse	$1,876.51	$1,611.20	$1,473.20	$842.61	$1,076.70	$1,076.70	$868.41
Employee & Child(ren)	$1,418.59	$1,175.25	$1,074.56	$615.58	$786.24	$786.24	$634.39
Employee, Spouse & Child(ren)	$2,397.26	$1,931.69	$1,766.39	$995.61	$1,290.19	$1,290.19	$1,040.32

MEDICAL BENEFITS OVERVIEW

Comprehensive and preventive health care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Franklin Pierce School District offers you a choice of six plans through Premera Blue Cross and one plan through Kaiser Permanente Cooperative. All seven plans cover most of the same benefits, but your out-of-pocket expenses and network physicians vary with some of the plans. All plans provide excellent coverage of preventive services, such as routine physical exams and immunizations which are very important to you and your family's health. Prescription drug coverage is also included with all medical plan options.

Please read the descriptions of the plans below; then, review the highlights of what each plan covers on the following pages.

PREMERA BLUE CROSS PPO PLANS

Please see the plan highlights on the pages to follow for the difference in coverage between in-network and out-of-network providers. If you choose an in-network provider, your cost will be less. You can find Premera Blue Cross providers online, by mobile app, or by phone – please see the information in "Your Benefits Contacts" at the end of this Guide.

Premera Blue Cross has multiple provider networks. All plans use the **Heritage Plus Network**. Use the Find a Doctor tool available at www.premera.com to confirm your providers are in the plan's network.

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

The Qualified High Deductible Health Plan (QHDHP) works in a similar manner as the Premera PPO plans described above. The main differences are that the deductible is higher for the QHDHP and applies for most services (with the exception of preventive care and certain preventive medications). However, the premium is lower and this plan is compatible with a Health Savings Account (HSA) which allows you to set aside funds pre-tax to pay for future healthcare needs. These funds are yours and any unused amounts will roll-over every year. For more information on HSAs please refer to page 12.

KAISER PERMANENTE MANAGED CARE PLAN

With this plan, there are low out-of-pocket expenses and you must seek services from a Kaiser Permanente provider. You will need to select a Primary Care Physician (PCP) who will coordinate care with your other providers. Please note that out-of-network services will not be covered. You can find providers online, by mobile app, or by phone – please see the information in "Your Benefits Contacts" towards the end of this Guide.

For Benefit Questions Please Email

payroll@fpschools.org

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KAISER PERMANENTE®

CALENDAR YEAR DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses. The family deductible applies if you have family members enrolled in your plan along with you. The deductible starts over each January 1.

COPAY & COINSURANCE

A copay is a flat dollar amount you pay for a medical service. Coinsurance is when you pay a percentage of the cost.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you pay in a calendar year for covered medical and prescription drug services. Once the out-of-pocket maximum is met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for covered services. The out-of-pocket maximum starts over each January 1.

QUESTIONS

Contact a Benefit Advocate
(a service provided by Gallagher).
You can reach a Benefit Advocate at:
bac.franklinpiercesd@ajg.com or by
phone: 425.201.9056,
toll free: 800.542.3737,
6:00 a.m. - 6:00 p.m. PT,
Monday - Friday

MEDICAL BENEFITS – PLAN HIGHLIGHTS

PCY = Per Calendar Year (January 1 - December 31)	Premera Blue Cross Plan 2		Premera Blue Cross Plan 3		Premera Blue Cross QHDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual/Family)	$300/$900		$500/$1,500		$1,750/$3,500*	$3,000/$6,000*
Coinsurance (What You Pay)	20%	40%	20%	40%	20%	50%
Annual Out-of-Pocket Maximum (Individual/Family)	$2,000/$6,000	$3,400/$10,200	$3,000/$9,000	$5,900/$17,700	$5,000/$10,000	No limit
Preventive Care						
• Exams/Immunizations	No charge	20%	No charge	20%	No charge	Not covered
• Preventive Screenings	No charge	20%	No charge	20%	No charge	50% after deductible
Outpatient Services						
Primary Care Visit	$25 per visit	$30 per visit	$30 per visit	$40 per visit	20% after deductible	50% after deductible
Specialist Visit	$35 per visit	$40 per visit	$40 per visit	$50 per visit	20% after deductible	50% after deductible
Diagnostic Lab & X-Ray	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible
Surgery	$100 copay + 20% after deductible	$100 copay + 40% after deductible	$150 copay + 20% after deductible	$150 copay + 40% after deductible	20% after deductible	50% after deductible
Rehabilitation	$35 per visit	$40 per visit	$40 per visit	$50 per visit	20% after deductible	50% after deductible
	45 visits combined PCY		45 visits combined PCY		15 visits combined PCY	
Physical Therapy	20% after deductible	40% after deductible	20% after deductible	40% after deductible	See Outpatient Rehabilitation	
	Unlimited visits combined PCY		Unlimited visits combined PCY			
Other Services						
Acupuncture	$25 per visit	$30 per visit	$30 per visit	$40 per visit	20% after deductible	50% after deductible
	12 visits combined PCY		12 visits combined PCY		12 visits combined PCY	
Chiropractic Care	$25 per visit	$30 per visit	$30 per visit	$40 per visit	20% after deductible	50% after deductible
	Unlimited visits combined PCY		Unlimited visits combined PCY		12 visits combined PCY	
Emergency Room (copay waived if admitted)	$75 copay + 20% after deductible		$100 copay + 20% after deductible		20% after deductible	
Inpatient Hospitalization	$150 per day to $450 max PCY + 20% after deductible	$150 per day to $450 max PCY + 40% after deductible	$300 per day to $900 max PCY + 20% after deductible	$300 per day to $900 max PCY + 40% after deductible	20% after deductible	50% after deductible
• Rehabilitation Limitation	120 days combined PCY		30 days combined PCY		30 days combined PCY	
Prescription Drugs						
Annual Deductible (Individual/Family)	None		None		Shared with medical	
Annual Out-of-Pocket Maximum (Individual/Family)	Shared with medical		Shared with medical		Shared with medical	
Preferred Retail Pharmacies	(34-day supply)		(34-day supply)		(30-day supply)	
• Generic	$10		$15		20% after deductible	
• Brand Name, Preferred	$20		$25		20% after deductible	
• Brand Name, Non-Preferred	$35		$40		20% after deductible	
• Specialty	$50 (30-day supply)		$60 (30-day supply)		20% after deductible	
Mail Order (Generic/Preferred/Non-Preferred)	$20/$40/$65 (100-day supply)		$30/$50/$70 (100-day supply)		20% after deductible (90-day supply)	
Life/AD&D Benefits						
Underwritten by Symetra	$25,000 employee benefit		$25,000 employee benefit		$25,000 employee benefit	

***QHDHP Notes:** The Family deductible must be met when 2 or more members are enrolled.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

MEDICAL BENEFITS – PLAN HIGHLIGHTS

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PCY = Per Calendar Year (January 1 - December 31)	Premera Blue Cross EasyChoice A		Premera Blue Cross EasyChoice B		Premera Blue Cross Basic	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual/Family)	$1,250/$3,750	$2,000/$6,000	$750/$2,250	$1,500/$4,500	$2,100/$4,200	$2,500/$5,000
Coinsurance (What You Pay)	20%	50%	25%	50%	30%	50%
Annual Out-of-Pocket Maximum (Individual/Family)	$4,000/$8,000	No limit	$3,500/$7,000	No limit	$6,600/$13,200	No limit
Preventive Care						
• Exams/Immunizations	No charge	Not covered	No charge	Not covered	No charge	Not covered
• Preventive Screenings	No charge	50% after deductible	No charge	50% after deductible	No charge	50% after deductible
Outpatient Services						
Primary Care Visit	$25 per visit	50% after deductible	$30 per visit	50% after deductible	$35 per visit	50% after deductible
Specialist Visit	$35 per visit	50% after deductible	$40 per visit	50% after deductible	$50 per visit	50% after deductible
Diagnostic Lab & X-Ray	No charge up to $1,000 PCY, then: 20% after deductible	50% after deductible	25% after deductible	50% after deductible	30% after deductible	50% after deductible
Surgery	20% after deductible	50% after deductible	25% after deductible	50% after deductible	30% after deductible	50% after deductible
Rehabilitation & Physical Therapy	$35 per visit; 30 visits combined PCY	50% after deductible	$40 per visit; 45 visits combined PCY	50% after deductible	$50 per visit; 30 visits combined PCY	50% after deductible
Other Services						
Acupuncture	$25 per visit; 12 visits combined PCY	50% after deductible	$30 per visit; 12 visits combined PCY	50% after deductible	$35 per visit; 12 visits combined PCY	50% after deductible
Chiropractic Care	$25 per visit; 12 visits combined PCY	50% after deductible	$30 per visit; 12 visits combined PCY	50% after deductible	$35 per visit; 12 visits combined PCY	50% after deductible
Emergency Room (copay waived if admitted)	$100 copay + 20% after deductible		$150 copay + 25% after deductible		$200 copay + 30% after deductible	
Inpatient Hospitalization	20% after deductible	50% after deductible	25% after deductible	50% after deductible	30% after deductible	50% after deductible
• Rehabilitation Limitation	30 days combined PCY		45 days combined PCY		30 days combined PCY	
Prescription Drugs						
Annual Deductible	$500 per person PCY (waived for generics)		$250 per person PCY (waived for generics)		$750 per individual/$1,500 per family	
Annual Out-of-Pocket Maximum (Individual/Family)	Shared with medical		Shared with medical		Shared with medical	
Preferred Retail Pharmacies (30-day supply)						
• Generic	$10		$5		$15 after deductible	
• Brand Name, Preferred	30% after deductible		$30 after deductible		$30 after deductible	
• Brand Name, Non-Preferred	30% after deductible		$45 after deductible		$50 after deductible	
• Specialty	30% after deductible		30% after deductible		30% after deductible	
Mail Order (90-day supply) (Generic/Preferred/Non-Preferred)	$20/30% after deductible/30% after deductible		$10/$75 after deductible/$112 after deductible		$30 after deductible/$60 after deductible/$100 after deductible	
Life/AD&D Benefits						
Underwritten by Symetra	$25,000 employee benefit		$25,000 employee benefit		$25,000 employee benefit	

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

MEDICAL BENEFITS – PLAN HIGHLIGHTS

KAISER PERMANENTE®

PCY = Per Calendar Year (January 1 - December 31)	Kaiser Permanente HMO **In-Network Only**
Annual Deductible (Individual/Family)	$0/$0
Annual Out-of-Pocket Maximum (Individual/Family)	$2,000/$4,000
Preventive Care	No charge
Outpatient Services	
Primary Care Visit	$25 per visit
Specialist Visit	$25 per visit
Diagnostic Lab & X-Ray	No charge
Surgery	$50 per visit
Rehabilitation	$25 per visit 45 visits PCY
Other Services	
Acupuncture	$25 per visit 12 visits PCY
Chiropractic Care	$25 per visit 10 visits PCY
Emergency Room (copay waived if admitted)	$100 per visit
Inpatient Hospitalization	$100 per day up to 3 days per admit
• Rehabilitation Limitation	30 days PCY
Prescription Drugs	
Preferred Retail Pharmacies	(30-day supply)
• Generic, Preferred	$10
• Brand Name, Preferred	$30
• Brand Name, Non-Preferred	N/A
• Specialty	See retail copays for Brand Name
Mail Order	2x retail copay (90-day supply)

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

QUESTIONS

Contact a Benefit Advocate
(a service provided by Gallagher).
You can reach a Benefit Advocate at:
bac.franklinpiercesd@ajg.com or by
phone: 425.201.9056,
toll free: 800.542.3737,
6:00 a.m. - 6:00 p.m. PT,
Monday - Friday

REMEMBER!

Log into the BenefitManager website to find additional resources regarding your benefits.

Go to www.GBSwa.com/BenefitManager

Password: fpps

For Benefit Questions Please Email

payroll@fpschools.org

HEALTH SAVINGS ACCOUNT (HSA)

HOW DOES IT WORK?

- A Health Savings Account (HSA) is a bank account which works side by side with a High Deductible Health Plan (HDHP).
- It is your money set aside on a pre-tax basis to pay for expenses which the HDHP does not cover – deductible, coinsurance, etc.
- HSAs were created to help give control back to consumers and help lower healthcare costs.
- An HSA is your bank account. If you switch jobs, the HSA goes with you.
- As long as you are enrolled in a qualified High Deductible Health Plan (HDHP) and meet certain eligibility requirement, you can still make contributions into your account.
- If you are no longer enrolled in a HDHP you cannot make contributions, but you can still make qualified withdrawals from your account.
- Your money rolls over every year. There is no "use it or lose it" rule.

ELIGIBILITY / YOU ARE ELIGIBLE IF YOU:

- Are covered by a qualified High Deductible Health Plan (HDHP);
- Are not covered by any other health insurance, including through a spouse's health plan or HRA;
- Your spouse is not enrolled in a general purpose Flexible Spending Account through their employer;
- Are not covered by or eligible to make claims for a non-limited Healthcare Flexible Spending Account;
- Are not enrolled in or covered by Medicare or Tricare benefits, and have not used Indian Health Services coverage within a three-month period;
- Have not used Veterans Health Services coverage for a non-service-connected disability within a three-month period; and
- Cannot be claimed as a dependent on another person's tax return (such as a parent).

HealthEquity

CONTRIBUTIONS

Contributions cannot exceed $3,450/Individual or $6,900/Family in 2019.

For individuals age 55 or older an additional amount of $1,000 "catch-up" contributions are allowed for 2019.

You may contribute the annual maximum amount, regardless of when your coverage begins, if you maintain coverage for the 12 month period beyond the calendar year in which you first became eligible. Pro-rating of contributions only occurs when the status of an HSA changes from family to single or if your medical coverage with the HSA-qualified health plan is terminated.

Your contributions are not subject to Federal Income, Social Security, or Medicare taxes. State income tax may apply. Please ask your tax advisor for details.

DISTRIBUTIONS

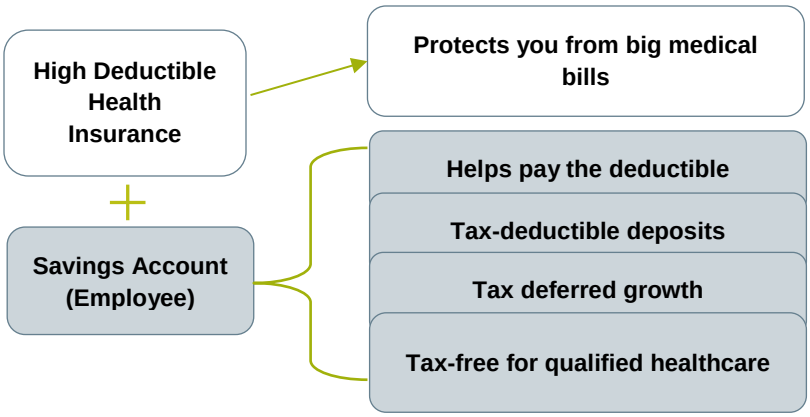
- You can use your money tax-free at any time for eligible medical, dental, and vision expenses.
- When you turn 65, you are not limited to using the money for eligible healthcare expenses. If you choose to use the money for purposes other than eligible healthcare expenses the money is subject to income tax, and there are no IRS penalties.
- If you are under age 65 and use your money for non-eligible healthcare expense, you will be subject to income tax and a 20% tax penalty.
- You are responsible for determining if the distributions are qualified.
- You should keep records of your expenses to show that distributions are used exclusively for qualified expenses in case the IRS requests them.

IMPORTANT

To open an HSA Account contact:
Cathy Young at
253.298.3032
payroll@fpschools.org

WHAT IS AN HSA?

The intent of this information is to provide general information about HSA regulations. It is not intended to address specific situations or provide tax advice. Questions regarding specific issues should be discussed with a tax advisor.



IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLANS

NON-NETWORK COSTS

Premera Blue Cross: The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

Kaiser Permanente: This plan does not cover services provided by non-network providers.

ORGAN TRANSPLANT

Premera Blue Cross: There is no pre-existing condition limitations for this health plan. Organ and bone marrow transplants have a $7,500 travel and lodging maximum. Please see your plan contract booklet for further details.

Kaiser Permanente: There is no waiting period for organ transplants. Please see your plan contract booklet for further details.

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.

OUT-OF-AREA BENEFITS

Premera Blue Cross: Like all Blue Cross and/or Blue Shield Licensees, Premera Blue Cross participates in a program called "BlueCard." Whenever enrollees access health care services outside their program's service area, the claim for those services may be processed through BlueCard and presented to Premera Blue Cross for payment. Blue Cross/Blue Shield Licensees outside the service area may charge certain fees, which will be passed to you. The access fee may be charged only if that Licensee's arrangement with the provider prohibits billing enrollees for amounts in excess of the discounted rate. However, providers may still bill for deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for excluded services.

Kaiser Permanente: Kaiser provides worldwide emergency and urgent care. If you experience an emergency medical condition, you should call 911 or go to the nearest medical facility. The emergency room copay will apply. If you are admitted to a hospital, you need to contact your health plan immediately or as soon as reasonably possible. If you need urgent care when you are outside of the service area, you should call your family doctor's office during office hours or call Kaiser's 24-hour consulting nurse. If possible, Kaiser will help you arrange care at a Kaiser Permanente facility. Be prepared to pay up front for your medical care and Kaiser will reimburse you for the covered costs when you submit the medical claim. You are responsible for the applicable office visit copay.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN *(CONTINUED)*

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 60 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 Franklin Pierce School District to notify its employees that a privacy notice is available from the Payroll Office. To request a copy of the District's Privacy Notice or for additional information, please contact Payroll at 253.298.3032.

PATIENT PROTECTION DISCLOSURE NOTICE – KAISER PERMANENTE PLAN ONLY

Kaiser Permanente generally allows the designation of a primary care provider. You may have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente listed under "Your Benefits Contacts" in the back of this Guide.

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

You may not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a 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 Kaiser Permanente 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.

DENTAL BENEFITS

Oral care is very important to your health and general wellbeing. Franklin Pierce School District provides comprehensive dental coverage through Delta Dental of Washington and Willamette Dental of Washington, Inc.

Under the Delta Dental of Washington (DDWA) plan, you may access dental care services from any dentist you wish. However, if you obtain services from a Delta Dental PPO dentist, you will save money on your out-of-pocket expenses.

The Delta Dental Premier Incentive Program is designed to promote regular dental care by increasing from one incentive period to the next for the amount paid for preventive care and regular visits. During the first incentive period, the payment level for covered and allowable Class I and Class II benefits will be 70%. This payment level increases by 10% up to a maximum of 100% each successive incentive period in which benefits are used at least once by the eligible person(s). If the once-a-year visit is missed, the payment level will be decreased by 10% for each period during which benefits are not used. In no event will the payment level be less than 70%.

The Willamette Dental of Washington, Inc. plan offers access to the exclusive providers in the Willamette Dental Group dental practice. All group dentists are employed by Willamette Dental Group and provide services in their 50+ locations to you at predictable, low co-pays. If you use non-Willamette Dental Group dental providers, you will not have coverage.

DELTA DENTAL

Delta Dental of Washington

Willamette Dental Group

MAXIMUM ALLOWABLE FEE (DDWA)

When you use out-of-network services under the DDWA plan, your plan will pay a percentage of the maximum allowable fee. If your dentist charges more than the maximum allowable fee, you will be responsible for the difference. The Willamette plan does not cover out-of-network services.

Dental coverage for Teamsters is provided through the Washington Teamsters Welfare Trust (Northwest Benefit Administrators).

	Delta Dental of Washington		Willamette Dental Group
	Delta Dental PPO Providers	**Delta Dental Premier or Any Other Licensed Provider**	**Willamette Providers Only**
Plan Year Deductible Individual/Family	None		None
Plan Year Maximum (14-months; to 12/31/19) Per Person	$2,300	$2,000	No Maximum
Diagnostic & Preventive Services (Class I) Exams, X-rays, Cleanings, Fluoride Application, Sealants	1st year: 30% 2nd year: 20% 3rd year: 10% 4th Year+: Covered in Full		$15 office visit copay
Basic Services (Class II) Restorations, Oral Surgery, Periodontics, Endodontics	1st year: 30% 2nd year: 20% 3rd year: 10% 4th Year+: Covered in Full		$15 office visit copay
Crowns & Onlays (Class II)	1st year: 30% 2nd year: 20% 3rd year: 10% 4th Year+: Covered in Full		$15 office visit copay Stainless Steel Crowns: Covered in Full Porcelain-Metal Crowns: $50 copay
Major Services (Class III) Bridges, Dentures	50%		$15 office visit copay then $50 copay per service
Implants	50%		Not Covered
Clerical, Administrators, and Teachers Only			
Orthodontia Children Only	50% up to $1,000 lifetime maximum		$150 copay for pre-orthodontia service; $1,500 copay for orthodontic services

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

Cost-shares and the annual maximum will be eliminated for children ages 14 and under as part of Delta Dental's Healthy Start for Kids program when a Delta dental provider is seen.

VISION BENEFITS

To help you take care of your eyesight, Franklin Pierce School District provides vision care coverage through VSP. VSP offers access to a large network of doctors nationwide. You may choose to obtain your vision care services from any provider you wish. When you access care from network providers, your benefits are greater and your out-of-pocket costs are less.

Vision coverage for Teamsters is provided through the Washington Teamsters Welfare Trust (Northwest Benefit Administrators).

	In-Network Provider	Any Licensed Provider
Basic Examination *-once every calendar year-*	$5 copay	Reimbursed up to $60 after copay
Hardware Copay	$15 copay	$15 copay
After the copayments have been satisfied, your cost shares will be as follows:		
Lens Allowance* *-once every calendar year-* Single Vision Lined Bifocals Lined Trifocals Lenticular Progressive	 No charge No charge No charge No charge No charge	Reimbursed up to: $76 per pair $112 per pair $142 per pair $148 per pair $140 per pair
Contact Lenses (in lieu of eyeglasses) *-once every calendar year-*	Up to $180 allowance	Reimbursed up to $180
Frames** *-once every 2 calendar years-*	Up to $150 allowance	Reimbursed up to $60

HOW DO YOU USE THE BENEFIT?

To make an appointment, call a VSP network provider and make sure you identify yourself as a VSP member. The VSP network provider will contact VSP to verify your eligibility and plan coverage. The VSP member doctor will also obtain authorization so you can receive services and materials. The provider will bill VSP directly for all covered services.

You can find VSP network providers online – please see the information in "Your Benefits Contacts" in the back of this guide.

*If you purchase oversize lenses or have anything "special" done to your lenses (i.e., tinting, scratch guard, etc.), you may be responsible for this cost.

IMPORTANT

Members receive a 35-40% discount off non-covered lens options when services are received from a VSP network provider.

Discuss your lens options with your provider and determine with your provider whether or not you want to continue with their recommendations for lens options based on your out-of-pocket cost.

**Patients choose from a wide selection of fully covered frames. You will receive a 20% discount on the amount over your allowance. Because of the cosmetic nature of frames and the rapidly changing styles, VSP has a limit on the cost of frames provided under the program. More expensive frame styles are also available for an additional charge. Your vision care provider will advise you of which frames are covered at 100%.

FLEXIBLE SPENDING ACCOUNTS (FSA)

IRS-regulated reimbursement accounts, also called Section 125 Flexible Spending Accounts (FSAs), allow you to save by setting pre-tax money aside for use in paying approved expenses.

Enrollment occurs before the beginning of each plan year or for new employees during your initial enrollment period. **You must enroll each year in order to participate in the Healthcare and/or Dependent Care FSA.**

Please note that elections cannot be changed during the plan year unless you have a qualified change in status. You have the flexibility to carryover up to $500 of your unused Healthcare FSA balance at the end of the 2018-2019 plan year in the short plan year (October 1, 2019 – December 31, 2019). **You will not be able to carry over any funds from the short plan year into the 2020 FSA through SEBB.**

IMPORTANT TO KNOW

- The Healthcare and Dependent Care FSAs are not connected. Money placed into one account will not transfer to the other.
- Once you have elected your annual deductions, you cannot change your elections under most circumstances.
- You may use these accounts for eligible claims incurred by you, your spouse, and your dependents as long as they are a tax dependent. Enrollment in the group sponsored medical or dental plan is not required. Unfortunately, you may not consider a domestic partner a "dependent" for purposes of this plan unless he/she is claimed as a dependent on your tax return.
- Enrolling in a general-purpose Healthcare FSA can make you ineligible to contribute to an HSA. Enrolling in the Dependent Care FSA does not impact HSA eligibility.

WageWorks®
formerly Planned Benefit Systems

QUALIFYING EVENTS:

- Marriage
- Divorce
- Birth of a child

To enroll in the Healthcare or Dependent Care FSA contact:

Don Ruzicka – 360.703.4967 or
don_ruzicka@us.aflac.com

REIMBURSEMENTS

Receiving a reimbursement is simple; all you need is a claim form and proper documentation. The documentation needs to show the date of service(s), cost, and the type(s) of expense you are claiming. The date of service for your expense must be within the current plan year. Your welcome packet from WageWorks will contain claim reimbursement details.

AFLAC SUPPLEMENTAL INSURANCES

AFLAC supplemental insurances pay cash directly to the insured to help cover out-of-pocket expenses. The plan year is October 1st to December 31st, 2019. There are specific plans for:

- Accidental Injury
- Short-Term Disability (Guarantee Issue Option)
- Hospitalization (Guarantee Issue Option)
- Cancer
- Heart Attacks/Strokes
- Dental Supplement
- Birth of Child

CONTACT Don Ruzicka – 360.703.4967 or don_ruzicka@us.aflac.com

FLEXIBLE SPENDING ACCOUNTS *(CONTINUED)*

You must enroll each year in order to participate in either FSA.

WageWorks®
formerly Planned Benefit Systems

HEALTHCARE FSA

If you make contributions to a Health Savings Account you are not eligible to make a Healthcare FSA election.

This plan allows you to pay for eligible medical, dental, and vision out-of-pocket expenses with non-taxed dollars.

The amount you designate will be deducted from your paycheck in equal amounts throughout the plan year. Once you incur an eligible expense, you can request reimbursement from your account. Note: You may request reimbursement up to your entire annual election, even though the money has not yet been placed into your account. Tax year limitations still apply.

MAXIMUM HEALTHCARE CONTRIBUTION

$600
($200/month)

October 1, 2019 – December 31, 2019

Examples of eligible healthcare expenses

- Copays for doctor visits and prescription drugs
- Coinsurance for your medical, dental, and vision plans
- Deductible amounts for your medical, dental, and vision plans
- Over-the-counter medicines, except insulin, require a prescription in order to be eligible for reimbursement.

Is enrollment in the Healthcare FSA tied to the medical plan?

No. You and/or your dependents do not have to be enrolled in the medical plan to participate in the healthcare FSA.

DEPENDENT CARE FSA

This plan allows you to pay for daycare expenses on a pre-tax basis so you and your spouse can go to work or school. You can use this account for children up to the age of 13 (other individuals may qualify if they are incapable of self-care and are considered taxable dependents).

The amount you designate will be deducted from your paycheck in equal amounts throughout the short plan year. You are eligible to be reimbursed as the account is funded. Reimbursements cannot exceed the account balance. The IRS will not allow you to claim a dependent care credit on your Federal Tax Return for reimbursed expenses from the dependent care reimbursement account. Consult your professional tax advisor to determine whether you should enroll in this plan. Tax year limitations still apply.

MAXIMUM DEPENDENT CARE CONTRIBUTION

$1,250 for single employees or married employee filing jointly
($416.66/month)

$625 for married employees filing separately
($208.33/month)

October 1, 2019 – December 31, 2019

Examples of qualified daycare providers

- Daycare centers
- Before and after school providers
- In-home daycare providers
- Day camp (not overnight)

Does my daycare provider need to be licensed?

No. Your provider must be over the age of 18 and cannot be a qualified dependent living in your household. Your provider's Social Security number must be provided at the time of claim. The amount you pay this provider will be reported on your Federal Tax Return and the amount paid should be claimed as income on your provider's Federal Tax Return. **You have until 12/15/2019 to file claims for the 2018-2019 year and 3/15/2020 for the short plan year.**

CARRY OVER

You may carry over up to $500 in unused Healthcare FSA funds from the current 2018-2019 plan year into the 2019 short plan year (October 1, 2019 – December 31, 2019). You may not carry over any short plan year fund into the 2020 plan year with SEBB. Unused amounts in your Dependent Care FSA cannot be carried over and will be forfeited.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Franklin Pierce School District provides an Employee Assistance Program (EAP) through ComPsych (through Lincoln Financial Group). The EAP offers free and confidential counseling and assistance in resolving situations that may impact your personal or professional life. All Franklin Pierce School District employees are automatically covered by the EAP. Issues EAP can help with include:

- Managing stress and anxiety
- Depression
- Parenting
- Alcohol or drug problems
- Coping with grief and loss
- Legal assistance
- Debt management and budgeting
- Elder care options

Call: 888.628.4824

Online: guidanceresources.com
Username: LFGsupport
Password: LFGsupport1

EAP counselors are available to assist you 24 hours a day, seven days a week by calling 888.628.4824. When you or a family member contacts the EAP, your call will be answered by a trained professional who will discuss your personal concerns with you and make sure you have access to appropriate resources.

Following your initial call, you may receive coaching over the telephone with an EAP professional, or you may be referred to an appropriate counselor in your area, depending on your situation and your preference.

In addition to the EAP services described above, you can also receive information and referrals through the EAP. Work/life resources and referrals are available for:

- Marriage and family concerns
- Child care (including summer care)
- Elder care (facilities, services, and support groups)
- Legal assistance
- Financial information (budgets, debts, planning)

ComPsych THE GUIDANCE RESOURCE COMPANY®

Lincoln Financial Group®

You're In Charge®

FIND TIPS ON STRESS MANAGEMENT, WELLNESS, AND MORE ONLINE!

ComPsych offers a wealth of educational resources on their website. Please see the access information under "Your Benefits Contacts" in the back of this Guide.

IF YOU VISIT A COUNSELOR

Up to 4 sessions per situation are provided at no charge to you. If more sessions are needed, the EAP professionals can work with your health plan to determine further coverage.

ADDITIONAL EAP FOR PREMERA MEMBERS

Franklin Pierce School District also offers an Employee Assistance Program (EAP) through Premera. Lifestyle Guidance Resources is offered as part of your Premera Blue Cross health plan, at no additional cost to you.

Confidential help is offered 24/7 for:

- Managing stress
- Family/spousal relationships
- Legal or Financial concerns
- And more!

Get Started Today!

Call: 844.862.0898,
TTY: 800.687.0353;

Online: guidanceresources.com
Web ID: premerawellness

VOLUNTARY INSURANCE BENEFITS

Since everyone's insurance needs are different, Franklin Pierce School District gives you the option to buy additional insurance for yourself and your family members on a voluntary basis, but at discounted group rates. If you leave the District, you may be able to take the plans with you.

Plans are available through American Fidelity, AFLAC, Legal Shield, and Enhanced Benefits. Brochures are available in the Payroll Office.

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
Website: http://myalhipp.com/
Phone: 1.855.692.5447

ALASKA – 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

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1.855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
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

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1.877.357.3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
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

IOWA – Medicaid
Website: https://dhs.iowa.gov/hawk-i
Phone: 1.800.257.8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1.785.296.3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 1.800.635.2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1.888.695.2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1.800.442.6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1.800.862.4840

MINNESOTA – Medicaid
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 or 651-431-2670

MISSOURI – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1.800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

CHIP (CONTINUED)

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1.800.992.0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603.271.5218
Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1.800.541.2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1.844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1.888.365.3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1.800.699.9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1.800.692.7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347 , or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1.888.549.0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1.888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1.800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1.877.543.7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1.800.250.8427

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

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1.800.562.3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1.855.MyWVHIPP (1.855.699.8447)

WISCONSIN – Medicaid and CHIP
Website: https://health.wyo.gov/healthcarefin/medicaid/
Phone: 1.800.362.3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307.777.7531

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
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of
Health & Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877.267.2323
(Menu Option 4, Ext. 61565)

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

IMPORTANT NOTICE FROM FRANKLIN PIERCE 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 Franklin Pierce 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:

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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 Premera Blue Cross and Kaiser Permanente is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from 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.

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE (CONTINUED)

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).

Date:	November 1, 2019
Name of Entity/Sender:	Franklin Pierce School District
Contact--Position/Office:	Cathy Young – Payroll Coordinator
Address:	315 129th St. S, Tacoma, WA 98444-5044
Phone Number:	253.298.3032

NOTES

YOUR BENEFITS CONTACTS

FRANKLIN PIERCE SCHOOL DISTRICT BENEFITS WEBSITE

Contains plan descriptions, SBCs, forms, and links to provider directories, drug lists, helpful tools, and other valuable online resources.

www.GBSwa.com/BenefitManager
Password: fpps

GALLAGHER BENEFIT ADVOCATES

If you do not receive satisfactory service from your insurance companies, a Benefit Advocate (a service provided by Gallagher), is available to help with issues pertaining to your benefits.

Please do not include any confidential or sensitive information, such as Social Security numbers or health information, via email. Once you are connected to a Benefit Advocate, more sensitive information can be shared.

You can reach a Benefit Advocate at:
bac.franklinpiercesd@ajg.com or by
phone: 425.201.9056,
toll free: 800.542.3737,
6:00 a.m. - 6:00 p.m. PT,
Monday - Friday

FRANKLIN PIERCE SCHOOL DISTRICT

www.fpschools.org

Payroll	payroll@fpschools.org 253.298.3000
Leave Share Program (Human Resource Department)	253.298.3000
Deferred Compensation (Payroll)	253.298.3000
Workers Compensation (Dept./Bldg. Office Manager)	253.298.3000

YOUR BENEFITS CONTACTS (CONTINUED)

Benefit	Administrator	Contact Information		Website
Medical	Premera Blue Cross	Customer Service 24-hour Nurseline	855.756.0798 800.841.8343	www.premera.com
Medical	Kaiser Permanente	Customer Service 24-hour Nurseline	888.901.4636 800.297.6877	www.kp.org/wa
Dental	WEA - Delta Dental PPO Plan	Customer Service	800.367.4104	www.deltadentalwa.com/wea
Dental	WEA - Willamette Dental	Customer Service	855.433.6825	www.willamettedental.com/wea
Vision	WEA - Vision Service Plan	Customer Service	800.445.6831	www.vsp.com
Trust Dental & Vision	Northwest Administrators	Customer Service	800.732.1123	www.nwadmin.com
Flexible Spending Accounts	WageWorks (through AFLAC)	Customer Service	877.924.3967	www.wageworks.com
Employee Assistance Program	ComPsych (through Lincoln Financial Group)	24/7	888.628.4824	www.guidanceresources.com
Employee Assistance Program	Premera Blue Cross	24/7	844.862.0898	www.guidanceresources.com WebID: premerawellness
Flexible Spending & Voluntary Benefits	AFLAC	Don Ruzicka	360.703.4967	
Voluntary Benefits	American Fidelity	Katherine Hamilton	405.212.2614	
Voluntary Legal	Legal Shield	Steve Hoisington	360.440.7751	
Credit Union	Inspirus Credit Union	Customer Service	206.628.4010	www.inspiruscu.org
Washington State Department Systems		Customer Service	800.547.6657	www.drs.wa.gov
Apple Health	State Children's Health Insurance Program "Apple Health"	Customer Service	877.543.7669	
403(b)	TSA Consulting Group	Customer Service		www.tsacg.com

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Insurance | Risk Management | Consulting

Please note:
This overview has been prepared to briefly highlight key features of your plan and is not to replace your insurance contract or booklet. We have compiled information into summary form to answer questions we most commonly receive. Please refer to the insurance carriers' contracts and booklets for more detailed information and plan limitations. Actual claims paid are subject to the terms and conditions of the individual carriers' contracts.