Clarkston School District
Employee Benefits Enrollment Guide

Plan Year: November 1, 2014 – October 31, 2015

Page Intentionally Left Blank

Table of Contents

Page Intentionally Left Blank

Welcome to Your 2014-2015 Benefits

Open Enrollment

Elections you make during open enrollment will become effective November 1, 2014.

Clarkston School District offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Open Enrollment Period
August 25, 2014 through September 30, 2014

The information herein is not a contract. It is a summary of benefits. Each plan described excludes certain conditions and types of treatment from coverage or payment. Detailed information regarding the contractual benefits, limitations, and exclusions are available through the Payroll Department. Please direct any questions to Jeanne Fuller at 509-758-2531 Ext. 5344.

Please note that revisions may be made by bargaining units or insurers at any time after this date. Please refer to the most current contract for up to date coverage limits.

New Employee

All new employees have 30 days to enroll. Enrollment elections must be turned in by the 10th of the month for an effective date of the 1st day of the next month.

Employees who do not enroll during the initial enrollment period may not be able to enroll until the next open enrollment period unless there has been a qualifying change in status. Evidence of insurability may be required for some types of coverage

Effective Date of Enrollment

- Enrollment for a newly eligible employee and listed dependents is effective on the first day of the month following date of hire.
- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the date eligibility requirements is met.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children is effective from the date that the adoptive child is placed with the employee for the purpose of adoption or the employee assumes total or partial financial support of the child.

Customer Service Directory

If you or your family members have questions about your benefit options, eligibility, or a more specific question about your coverage, a representative at the numbers below may be able to help you. You may also refer to each plan's Summary Plan Description (SPD) for detailed information.

Plan Contacts	Website	Customer Service
Regence BlueShield of ID	www.regence.com/ID	888-901-4636
UNUM	www.unum.com	866-679-3054
WEA – Premera BlueCross Nurse Line	www.premera.com/wea	800-932-9221 800-857-8343
WEA – Willamette Dental Group	www.willamettedental.com	800-360-1909
Flex-Plan Services Inc.	www.flex-plan.com	425-452-3438
WEA – Select Benefits Center Your Benefits Resource (YBR)	http://resources.hewitt.com/wea	855-668-5039
Propel Insurance Benefits Website	www.propelinsurance.com	800-499-0933

Clarkston School District Contacts	Email	Customer Service
Jeanne Fuller	FullerJe@csdk12.org	509-758-2531 Ext. 5344

Benefit Information Online!

Although this guide is a great resource, more information is available through the Clarkston School District's personalized Benefits Website, available 24/7 online, at www.propelinsurance.com in Resources go to Online Benefits, then password: **clarkston**.

On this website you may access a variety of information including:

- Benefits Available by Employee Group
- Plan Summaries
- Contracts
- Common Forms
- Eligibility Requirements

It is a *very* user-friendly tool. Please check it out!

Eligibility and Enrollment Information

Who is Eligible?

If you are a Clarkston School District full-time employee **working 18.75 or more hours per week** you are eligible to enroll in the benefits described in this guide.

Employee
Employees hired after the 15th of any month during the school year will have until the 15th of the following month in which they were hired to submit enrollment forms to the Payroll Department. Benefits will be effective the 1st of the month following the submission deadline date.

Dependent(s)
To elect coverage for your dependents, you must make sure each meets the plan's definition of an eligible dependent, shown below. It's important to know that the plan's eligibility requirements are strictly enforced. If any of your dependents are not eligible for coverage at the time you enroll them or if they become ineligible at a future time when they are still enrolled, their coverage will be terminated.

An **"eligible dependent"** is defined as:

- Your spouse; common-law spouse; or same sex spouse.
- Your same-sex domestic partner.
- Your children up to age 26 if they are:
    - your natural children
    - your legally adopted children
    - children placed with you for legal adoption
    - your stepchildren (natural or legally adopted children of your legal spouse)
- You may also be able to cover your grandchildren who live with you in a parent-child relationship, but only if you have court-appointed legal guardianship.
- Your disabled children age 26 and older who, when they first became disabled, would have met the definition of an eligible dependent and who are incapable of self-sustaining employment because of mental or physical disability.

How to Enroll

The first step is to review your current benefit elections. Verify your personal information and make any changes if necessary. Make your benefit elections. Once you have made your elections you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

A **"qualified change in status"** is defined as:

- Marriage, legal separation, divorce or annulment for you or an eligible child.
- Death of your spouse, your eligible child's spouse or your eligible child.
- Birth, adoption or placement for adoption.
- Change in work status for you, your spouse, your eligible child or your eligible child's spouse, e.g., full-time to part-time, when the change affects medical or dental eligibility.
- Loss of eligibility for your child because of marriage, exceeding the plan's age eligibility limit or no longer being disabled and/or dependent on you for financial support.
- If your spouse, your eligible child or your eligible child's spouse moves to an area where he/she is outside the service area.
- Change in other medical or dental coverage as a result of the annual enrollment for the employer of your spouse, eligible child, or your eligible child's spouse occurring at a different time than the school district.
- A significant change in the cost of medical or dental coverage under this Plan or a plan available through the employer of your spouse, your eligible child or your eligible child's spouse.
- A significant change in the medical or dental coverage available through the employer of your spouse, your eligible child or your eligible child's spouse.

Benefit changes must be consistent with the eligible life event. An enrollment change form must be completed and signed within 30 days of the change in status, 60 days for newborns and adoptions; otherwise, you must wait until next year's open enrollment period.

When to Enroll

The open enrollment period runs from **August 25, 2014 through September 30, 2015**. The benefits you elect during open enrollment will be effective from November 1, 2014 through October 31, 2015.

How to Make Changes

Newly Eligible Employee
Enrollment form and/or online enrollment must be completed and received by Human Resources within 30 days from the date of employment or eligibility. Employees who do not enroll during the initial enrollment period may not be able to enroll until the next open enrollment period unless there has been a qualifying change in status. Evidence of insurability may be required for some types of coverage.

Open Enrollment
During this time, you may add or delete coverage, change medical carriers, and add or delete dependents. Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period.

If all of your dependents are not listed by the end of open enrollment, you will have to wait until the next Open Enrollment to add them and they will not have dental coverage until that time. There is nothing to do for this process and no forms need to be completed.

To add, change or terminate non-WEA plans:

- Go to your Employee Online account at: http://www.propelinsurance.com. Click in Resources: Online Benefits, then password: **clarkston**.
- Print the Enrollment Change Form, complete, date and sign and send it to the benefits office. You may send it through the district courier service, or mail to: Clarkston School District, Attn: Payroll Office, PO Box 70, Clarkston, WA 99403.
- Benefit staff will review your requested change(s) and let you know if additional forms are needed via email. Please check your district email regularly during this time and make sure you receive a confirmation email – if you don't receive an email correspondence from the benefits office within two weeks of your requested change, please follow up by sending an email to: Jeanne Fuller at FullerJe@csdk12.org
- All changes will go into effect on November 1st and will be reflected on your October 31st paycheck. Please check your October 31st paycheck to make sure changes have been processed and you are paying correctly for coverage you have signed up for.
- To continue enrollment in the Flexible Spending Account program, an enrollment form must be submitted every year. Visit our online enrollment website for details.

To add, or change WEA medical / dental plans:

- Manage your WEA Select benefits by going to Your Benefits Resources (YBR) at http://resources.hewitt.com/wea available 24 hours a day, or call the WEA Select Benefits Center at 1-855-668-5039 (select Open Enrollment prompt).
- To add or change your benefits, go online to YBR or call the WEA Select Benefits Center.
- **For termination,** call WEA Select Benefits Center at 1-855-668-5039. An explanation of termination is not required other than you are not selecting a WEA medical plan.

Page Intentionally Left Blank

What's New for **2014-2015**

REQUIRED BENEFITS

Dental

Regence BlueShield of ID

Expressions $1,000
No Plan Change

Expressions $2,000
No Plan Change

Willamette Dental Group

Plan 1
No Plan Change

Vision

Regence BlueShield of ID

No Plan Change

OPTIONAL MEDICAL PLANS

Medical

WEA Premera BlueCross

Plan 2
No Plan Change

Plan 3
No Plan Change

EasyChoice A
Out of pocket maximum: $5,000 **to $4,000 per individual**; $15,000 **to $12,000 per family**

EasyChoice B
Out of pocket maximum: $4,000 **to $3,500 per individual**; $12,000 **to $10,500 per family**

EasyChoice C
Deductible: $0 **to $100 per individual**; $0 **to $300 per family**
Out of pocket maximum: $7,500 **to $4,200 per individual**; $22,500 **to $12,600 per family**

Qualified High Deductible Plan (QHDP)
$2 million annual limit removed

VOLUNTARY BENEFITS

Health Savings Account

Flex-Plan Services Inc.

No Plan Change

Voluntary Products

Unum

No Plan Change

Flexible Spending Account

Flex-Plan Services Inc.

No Plan Change

REQUIRED BENEFITS

Dental

Regence BlueShield of ID

This plan will provide payment for the services at the percentages listed below up to the calendar year maximum. Payment of benefits is based on a percentage of the allowed amount. Participating providers have agreed to accept the allowed amounts as payment for services. Services of a nonparticipating provider are based on a percentage of the allowed amount. The member will be responsible for any additional charges over the allowed amount. There is no deductible for either plan.

	Regence BlueShield of ID Expressions $1,000	Regence BlueShield of ID Expressions $2,000
Provider Network		
In Network	Participating Provider	Participating Provider
Out of Network	Nonparticipating Provider	Nonparticipating Provider
Annual Deductible		
Individual & Family	None	None
Services		
Diagnostic & Preventive		
Office Visit	None	None
Exam, Cleaning, X-ray,	Covered in Full	Covered in Full
Fluoride, Sealants	85%	85%
Restorative		
Restorations, Oral Surgery	85%	85%
Endodontics and Periodontics	85%	85%
Stainless Steel Crown	85%	85%
Porcelain-Metal Crown	85%	85%
Major		
Dentures, Partials	85%	85%
Bridge	85%	85%
Implants	85%	85%
Annual Benefit Maximum		
Per Individual	$1,000	$2,000
TMJ		
Surgical and Non-surgical	85%	85%
Annual Max/ Lifetime Max	$1,000 / $5,000	$1,000 / $5,000
Orthodontia		
Adult	Not Included	Not Included
Child(ren) Under 19 Years	Not Included	Not Included

REQUIRED BENEFITS

Dental

Willamette Dental Group

To receive the excellent benefits of your Willamette Dental Group plan you must receive care from a Willamette Dental Group dentist or specialist. You are free to select your Willamette Dental Group dentist and whichever location is best for you. There is no annual maximum.

	Willamette Dental Group Plan 1
Provider Network	
In Network	Willamette Dental Group Only
Out of Network	Not Covered
Annual Deductible	
Individual & Family	None
Services	
Diagnostic & Preventive	
Office Visit	$15 Copay
Exam, Cleaning, X-ray,	Covered in Full
Fluoride, Sealants	Covered in Full
Restorative	
Restorations, Oral Surgery	Covered in Full
Endodontics and Periodontics	Covered in Full
Stainless Steel Crown	Covered in Full
Porcelain-Metal Crown	$50
Major	
Dentures, Partials	$50
Bridge	$50 (per tooth)
Implants	Not Covered
Annual Benefit Maximum	
Per Individual	None
TMJ	
Surgical and Non-surgical	Covered in Full
Annual Max/ Lifetime Max	$1,000 / $5,000
Orthodontia	
Adult	Not Included
Child(ren) Under 19 Years	Not Included

REQUIRED BENEFITS

Vision

If you utilize the services of a provider listed in the Preferred Provider Directory, your benefits include routine vision exams and preferred pricing on a large selection of brand-name, designer frames, lenses, and lens options.

	Regence BlueShield of ID
Coverage and Benefit Frequency	
Exam	Every 12 Months
Copay	Covered in Full
Hardware	Every 12 Months
Allowance	$150

Each eligible employee pays the monthly composite rate, which covers the employee and all eligible dependents. An employee may be enrolled as a subscriber on only one WEA Select Plan.

Your Dental Cost in 2014

MONTHLY PREMIUM				
Enrollee	**Employee Only**	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
Regence BlueShield of ID $1,000 Maximum	$ 65.10	$ 126.96	$ 87.81	$ 149.57
Regence BlueShield of ID $2,000 Maximum	$ 87.08	$ 169.97	$ 117.54	$ 200.33

MONTHLY PREMIUM	
Enrollee	**Composite Rate**
Willamette Dental Group Plan 1	$ 74.70

Your Vision Cost in 2014

MONTHLY PREMIUM				
Enrollee	**Employee Only**	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
Regence BlueShield of ID	$ 17.82	$ 34.24	$ 23.91	$ 40.76

MEDICAL PLANS

How the Medical Plans Work

Annual Deductible

Several of the plans have an annual deductible. This means you pay for the first portion (the deductible) of most covered medical expenses that you incur each calendar year. Once you have met this deductible, the plan pays its portion of the claims incurred (coinsurance). The deductible does not apply to certain expenses – the plan pays these benefits right away. The expenses that do not apply to the deductible vary by the plan but generally include certain outpatient office visits and prescription drugs.

Before you reject a plan because it has a deductible, you should do the math. Depending on your situation, a plan with a deductible might cost you less over the year when you consider the total cost (payroll deductions plus your other expected out-of-pocket expenses).

Coinsurance Percentage

After the deductible is paid, coinsurance is the cost sharing between you and the insurance company. For example, if the coinsurance percentage is 85%, the insurance company pays 85% and you pay the remaining 15%. In some plans the deductible is waived and there is simply a co-pay or flat dollar amount paid for physician office visits. You will pay a coinsurance for most other services.

Co-pay

Your co-pay is the flat dollar amount which is your responsibility to pay at the time of service.

Out-of-Pocket Maximum

An out-of-pocket maximum is the most you would have to pay out of your own pocket for eligible expenses. Copayments for prescription drugs do not accrue toward the medical out-of-pocket maximum. Once you reach the out-of-pocket maximum for a given calendar year, the plan would pay all eligible expenses for covered services at 100%. This insurance protection limits your monetary exposure if you have a year with a large amount of medical expenses.

Note: The WEA EasyChoice plans have a separate out-of-pocket maximum for prescription drugs.

MEDICAL PLANS

Medical and Prescription Drugs

Our health care costs are driven by our usage of the benefit plans. Contributing factors to the rise in costs include the increasing use of expensive new technologies, a rise in chronic diseases, an aging workforce, subsidization of Medicare costs and new benefits, and taxes and fees from the Affordable Care Act. These forces combine to create a rate action higher than we have seen in recent years.

The combination of large cost increases with no change in the state allocation for insurance premiums means the employee and family contributions are the only source of funding these increases. As such, the employee contributions will be heavily impacted this renewal. The District is very sensitive to this fact and encourages you to look carefully at all the plans offered to determine the plan that is most appropriate for you and your family.

Your Medical Cost in 2014

The state allocation varies based on bargaining group and full-time eligible status. The allocation is first used to pay for negotiated required benefits such as dental and vision coverage. The balance of the allocations is available for employees to apply to the purchase of medical benefits. Any allocated dollars remaining are 'pooled' within the bargaining unit and divided amount employees with payroll deductions help defray the cost of medical premiums. No portion of the state allocation or pooling dollars can be applied to the purchase of other voluntary benefit programs.

ALL EMPLOYEE MEDICAL PREMIUM				
Enrollee	**Employee Only**	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
Group Health HMO	$ 649.02	$ 1,260.10	$ 907.75	$ 1,518.83
WEA Select Premera Plan2	$ 837.75	$ 1,532.75	$ 1,118.25	$ 1,837.50
WEA Select Premera Plan3	$ 749.70	$ 1,371.80	$ 1,000.85	$ 1,644.55
WEA Select Premera EasyChoice (A, B, C)	$ 535.25	$ 971.65	$ 709.80	$ 1,164.05
WEA Select QHDHP	$ 420.90	$ 763.05	$ 557.75	$ 901.45

MEDICAL PLAN OPTIONS

Group Health Medical Plan

The Group Health HMO plan does not provide coverage when you use out-of-network providers. You must use Group Health physicians and hospital. Services received outside of the Group Health network are not covered.

DW – Deductible Waived PCY – Per Calendar Year	Group Health HMO
Deductible (Individual/Family)	None
Out of Pocket Maximum	$1,000 / $2,000
Coinsurance (% Employee Pays)	**None**
Covered Services	
Preventive Care	
Immunizations	Covered In Full
Physical Exam/Screenings	Covered In Full
Well-Baby Care	Covered In Full
Women's Preventive Exam/Care	Covered In Full
Office Visit	
Routine / Primary Care	$25
Specialist	$25
Urgent Care Facility	$25
Alternative Care Services	
Massage	$25 up to 60 visits
Manipulative Therapy	$25 up to 10 visits
Naturopathy	$25 up to 3 visits
Diagnostic Services	**Subject to Applicable Copays, Deductible (Ded) + Coinsurance (Coin)**
Lab, X-Ray Services	Covered In Full
MRI, CT Scan / Imaging	Covered In Full
Hospital/Facility Care	**Subject to Applicable Copays, Deductible (Ded) + Coinsurance (Coin)**
Inpatient Care	$100/admit
Outpatient Surgery	$20
Emergency Room	$100
Prescription Drug Coverage	
Deductible / OOP	None
Generic	$10
Preferred Brand	$20
Non-Preferred	Not Covered
Vision	
Exam	$25 / 12 Months
Hardware	Not Covered
Out-of-Network Services	
Deductible (Individual/Family)	In Network Only
Coinsurance (% Employee Pays)	

MEDICAL PLAN OPTIONS

Premera BlueCross Medical Plan

These are PPO medical plans that pay the highest level of benefits when you use a Premera Blue Cross PPO Provider. You may also go outside of the PPO network and receive a lesser benefit. The PPO plan allows you the freedom to use providers in and out-of-network.

DW – Deductible Waived PCY – Per Calendar Year	Premera BlueCross Plan 2	Premera BlueCross Plan 3
Deductible (Individual/Family)	$200 / $600	$300 / $900
Out of Pocket Maximum	$1,500 / $4,500	$2,750 / $8,250
Coinsurance (% Plan Pays)	**80%**	**80%**
Covered Services		
Preventive Care		
Immunizations	Covered In Full	Covered In Full
Physical Exam/Screenings	Covered In Full	Covered In Full
Well-Baby Care	Covered In Full	Covered In Full
Women's Preventive Exam/Care	Covered In Full	Covered In Full
Office Visit		
Routine / Primary Care	$25	$30
Specialist	$25	$30
Urgent Care Facility	$25	$30
Alternative Care Services		
Massage	$25 up to 45 visits	$30 up to 45 visits
Manipulative Therapy	$25 unlimited	$30 unlimited
Naturopathy	$25 unlimited	$30 unlimited
Diagnostic Services	**Subject to Applicable Copays, Deductible (Ded) + Coinsurance (Coin)**	
Lab, X-Ray Services	Ded+Coin	Ded+Coin
MRI, CT Scan / Imaging	Ded+Coin	Ded+Coin
Hospital/Facility Care	**Subject to Applicable Copays, Deductible (Ded) + Coinsurance (Coin)**	
Inpatient Care	$150/day; Ded+Coin	$300/day; Ded+Coin
Outpatient Surgery	$100+Ded+Coin	$150+Ded+Coin
Emergency Room	$75+Ded+Coin	$100+Ded+Coin
Prescription Drug Coverage		
Deductible / OOP	None	None
Generic	$10	$15
Preferred Brand	$20	$25
Non-Preferred	$35	$40
Vision Exam		
Hardware	Not Covered	Not Covered
Out-of-Network Services		
Deductible (Individual/Family)	$200/$600	$300/$900
Coinsurance (% Plan Pays)	60%	60%

MEDICAL PLAN OPTIONS

Premera BlueCross Medical Plan

Easy Choice A and B use a network of contracted providers known as "Heritage Network" to provide health care services to you. Your plan provides the higher level of benefits (and lower out-of-pocket costs) when you use Heritage Network providers.

Easy Choice C uses a network of contracted providers known as "Foundation Network" to provide health care services to you. Your plan provides the higher level of benefits (and lower out-of-pocket costs) when you use Foundation Network providers.

DW – Deductible Waived PCY – Per Calendar Year	Premera BlueCross EasyChoice A	Premera BlueCross EasyChoice B	Premera BlueCross EasyChoice C
Deductible (Individual/Family)	$1,000 / $3,000	$750 / $2,250	$100 / $300
Out of Pocket Maximum	$4,000 / $12,000	$3,500 / $10,500	$4,200 / $12,600
Coinsurance (% Plan Pays)	**80%**	**75%**	**65%**
Covered Services			
Preventive Care			
Immunizations	Covered In Full	Covered In Full	Covered In Full
Physical Exam/Screenings	Covered In Full	Covered In Full	Covered In Full
Well-Baby Care	Covered In Full	Covered In Full	Covered In Full
Women's Preventive Exam/Care	Covered In Full	Covered In Full	Covered In Full
Office Visit			
Routine / Primary Care	$15	$30	$35
Specialist	$15	$30	$35
Urgent Care Facility	$15	$30	$35
Alternative Care Services			
Massage	$15 up to 30 visits	$30 up to 45 visits	$35 up to 45 visits
Manipulative Therapy	$15 up to 12 visits	$30 up to 12 visits	$35 up to 12 visits
Naturopathy	$15 unlimited	$30 unlimited	$35 unlimited
Diagnostic Services	**Subject to Applicable Copays, Deductible (Ded) + Coinsurance (Coin)**		
Lab, X-Ray Services	Ded+Coin*	Ded+Coin	Ded+Coin
MRI, CT Scan / Imaging	Ded+Coin*	Ded+Coin	Ded+Coin
Hospital/Facility Care	**Subject to Applicable Copays, Deductible (Ded) + Coinsurance (Coin)**		
Inpatient Care	Ded+Coin	Ded+Coin	Ded+Coin
Outpatient Surgery	Ded+Coin	Ded+Coin	Ded+Coin
Emergency Room	$100+Ded+Coin	$150+Ded+Coin	$200+Ded+Coin
Prescription Drug Coverage			
Deductible / OOP	$500/person PCY	$250/person PCY	$500/person PCY
Generic	$0-DW	$0-DW	$0-DW
Preferred Brand	30%	$30	$30
Non-Preferred	30%	$45	$45
Vision			
Exam Hardware	Not Covered	Not Covered	Not Covered
Out-of-Network Services			
Deductible (Individual/Family)	$2,000/$6,000	$1,500/$4,500	$250/$750
Coinsurance (% Plan Pays)	50%	50%	50%

MEDICAL PLAN OPTIONS

Premera BlueCross Medical Plan

The **QHDHP** is a PPO medical plan paired with a tax-free Health Savings Account. You will receive the highest level of benefits by seeking care from a Premera Blue cross PPO provider. Benefits for services below will be provided at the percentage of the allowed amount specified after the deductible is met and until the out of pocket maximum is met.

DW – Deductible Waived PCY – Per Calendar Year	Premera BlueCross Qualified High Deductible Health Plan (QHDHP)
Deductible (Individual/Family)	$1,500 / $3,000
Out of Pocket Maximum	$4,000 / $8,000
Coinsurance (% Plan Pays)	**80%**
Covered Services	
Preventive Care	
Immunizations	Covered In Full
Physical Exam/Screenings	Covered In Full
Well-Baby Care	Covered In Full
Women's Preventive Exam/Care	Covered In Full
Office Visit	
Routine / Primary Care	Ded+Coin
Specialist	Ded+Coin
Urgent Care Facility	Ded+Coin
Alternative Care Services	
Massage	Ded+Coin; 15 visits
Manipulative Therapy	Ded+Coin; 12 visits
Naturopathy	Ded+Coin
Diagnostic Services	**Subject to Applicable Copays, Deductible (Ded) + Coinsurance (Coin)**
Lab, X-Ray Services	Ded+Coin
MRI, CT Scan / Imaging	Ded+Coin
Hospital/Facility Care	**Subject to Applicable Copays, Deductible (Ded) + Coinsurance (Coin)**
Inpatient Care	Ded+Coin
Outpatient Surgery	Ded+Coin
Emergency Room	Ded+Coin
Prescription Drug Coverage	
Deductible / OOP	Subject to Ded
Generic	80%
Preferred Brand	80%
Non-Preferred	80%
Vision	
Exam Hardware	Not Covered
Out-of-Network Services	
Deductible (Individual/Family)	$3,000/$6,000
Coinsurance (% Plan Pays)	50%

Health Savings Accounts (HSA)

If you participate in the Clarkston School District high-deductible health plan, you can set aside money in a Health Savings Account (HSA) before taxes are deducted to pay for eligible medical, dental and vision expenses. An HSA is similar to a flexible spending account in that you are eligible to pay for health care expenses with pre-tax dollars. There are several advantages of an HSA. For instance, money in an HSA can be invested much like 401(k) funds are invested. Unused money in an HSA account is not forfeited at the end of the year and is carried forward. Also, your HSA account is yours to keep which means that you can take it with you if you change jobs or retire. If you have any money remaining in your HSA after your retirement, you may withdraw the money as cash.

HSA Contribution Limits

IRS set contribution limits for the tax year January 1—December 31.

Tax Year	2014	2015
Individual Coverage*	$3,300	$3,350
Family Coverage	$6,550	$6,650

*If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000.

What Are The Benefits of an HSA?

High Deductible Health Plan:

- Costs less than more "traditional" copay plans.
- Provides quality health insurance.
- One calendar-year deductible per family.

HSA Savings:

- Used to meet your deductible.
- Tax deductible off of gross income.
- Grow tax-deferred.
- NEVER taxed when used for qualified medical expenses.
- Rolls over year after year -- no "use it or lose it".
- Portable, goes with you wherever you go.

HSA Savings can also be used for:

- Health insurance premiums when you're between jobs.
- Qualified long-term care premiums.
- Medicare premiums and out-of-pocket expenses.
- Living expenses after age 65 (pay ordinary income taxes).

TERM LIFE OPTIONS

Supplemental Term Life and AD&D Insurance

Unum

Clarkston School District offers all employees working at least 15 hours each week in active employment and their eligible spouse and children supplemental term life and accidental death and dismemberment (AD&D) insurance.

If you and your eligible dependents enroll within 31 days of your eligibility date, and later, wish to increase your coverage, you may increase your Life insurance coverage, with evidence of insurability, at anytime during the year. However, you may wait until the next annual enrollment and only Life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability.

If you and your eligible dependents do not enroll within 31 days of your eligibility date, you can apply for coverage only during an annual enrollment period and will be required to furnish evidence of insurability for the entire amount of coverage. AD&D coverage does not require evidence of insurability.

Employee Term Life and AD&D	
Eligible Employees	Work a minimum of 15 hours per week
Coverage Amount:	Increments of $5,000
Benefit amount:	Up to five (5) times salary
Maximum benefit:	$500,000
Guaranteed Issue:	Subject to Evidence of Insurability

Spouse Term Life and AD&D	
Eligible Employees	Work a minimum of 15 hours per week
Coverage Amount:	Increments of $5,000
Benefit amount:	100% of Employee Amount
Maximum benefit:	$500,000
Guaranteed Issue:	Subject to Evidence of Insurability

Dependent Term Life and AD&D		
Child eligibility:	Unmarried dependent children from 14 days to age 19 or to age 26 if full-time student	
Coverage Amount:	Increments of $2,500	
Child benefit amount:	$10,000	
Full child benefit begins:	6 months	
Child benefit by age:	14 days to 6 months	$1,000

VOLUNTARY BENEFITS

Voluntary Products

Unum

Accident and Injury Insurance

Clarkston School District offers to all eligible employees who are actively at work accident / injury protection which are payable after fulfilling a 365-day elimination period. Insurance is available for family coverage to your spouse if actively at work or not disabled, and children up to their 26th birthday, regardless of marital or student status. Accident insurance can provide benefits for covered accidents that occur off the job. You own the policy so you can keep it even if you leave the company or retire.

Critical Illness

Clarkston School District offers critical illness insurance can pay you a lump sum benefit at the first diagnosis of a covered illness. It can also be used however you choose for the expenses health insurance doesn't cover.

Individual Short-Term Disability Insurance

Clarkston School District offers individual short-term disability insurance to all eligible employees who are actively at work. You choose a monthly benefit; coverage up to 60% of your gross monthly salary may be offered. Affordable premiums are based on your age on the policy effective date and are deducted from your paycheck. You own the policy so you can keep it even if you leave the company or retire.

OPTIONAL FLEXIBLE SPENDING ACCOUNT

Health Care and Dependent Care Flexible Spending Accounts

Clarkston School District provides you the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You must enroll/re-enroll in the plan to participate for the plan year. You can save approximately 25 percent of each dollar spent on these expenses when you participate in a FSA.

A health care FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse work.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you **expect** to pay out of pocket for eligible expenses for the plan period. If you do not use the money you contributed it will not be refunded to you or carried forward to a future plan year. **This is the use-it-or-lose-it rule**.

Health Care FSA

IRS regulations allow the maximum amount you can contribute to $2,500 per calendar year of tax-free dollars to pay for out-of-pocket medical, dental or vision expenses, as well as prescriptions, incurred by you and your dependents.

Dependent Care FSA

IRS regulations allow the maximum amount you can contribution to $5,000 per year for a married couple filing taxes jointly or a single head of household; or $2,500 each for a married couple filing separate tax returns. The FSA allows you to set aside tax-free dollars to pay for work-related dependent care costs. This includes private day care, licensed day care or elderly care.

Additional Benefit Offerings

Employee Assistance Program

The Employee Assistance Program (EAP) is confidential and covers employees, spouses, domestic partners, and children up to age 26. First Choice Health provides you services free of charge. Your EAP is available 24 hours a day, 7 days a week.

You may call a skilled Customer Service Representative at 800-777-4117 to assess your concerns, or if preferred you may request an online appointment at www.FirstChoiceEAP.com.

The following services and more are available:

- Marital and Family Issues
- Balancing Work and Home
- Legal Services
- ID Theft and Fraud Resolution
- Depression and Anxiety
- Personal/Family Concerns
- Financial Services
- Childcare and Eldercare Consultation

To Explore Online Tools and Resources:
Go to www.FirstChoiceEAP.com and click on the 'Work/Life Resources' button.

Username: clarkstonsd
Password: employee

IRC 403(b) Tax-Sheltered Annuity Plans

A 403(b) plan (also called a tax-sheltered annuity or TSA plan) is a retirement plan offered by public schools and certain 501(c) (3) tax-exempt organizations. Employees save for retirement by contributing to individual accounts. Employers can also contribute to employees' accounts. For more information, please visit the Plan Administrator, TSA Consulting Group Inc. website at www.tsacg.com.

Washington State: Department of Retirement System 457 Deferred Compensation Plan

The Washington State Deferred Compensation Program (DCP) is available to participating Washington State public employers and their employees. DCP is a supplemental retirement savings program (an IRC Section 457 plan) that offers you the opportunity to invest money toward securing the retirement you envision. Whether you've been saving for years, or just getting started, **DCP offers you an excellent opportunity to enhance your financial future.**

There is much more information about DCP on this website, but it may be more helpful to answer your questions by phone or email. You may reach a representative by email at **dcpinfo@drs.wa.gov**, or call a DCP representative at 360-664-7839 or 800-547-6657.

ESSB 5940
The Public School Employees' Insurance Benefits Bill

The Public School Employees' Insurance Benefits Bill, ESSB 5940, requires several changes to K–12 public school employee health benefits. These changes are **effective July 11, 2012**. Office of Superintendent of Public Instruction (OSPI) will be the lead for communication and coordination of information regarding the new law and its requirements. We are anticipating additional changes in the upcoming years as the bill is further clarified. However, here are some of the changes our district has experienced due to ESSB 5940:

School district and health plan providers

- Must offer a plan with high deductible and health savings account and a plan with full-time premium the same as that for state employees.
- Must make progress toward more affordable full family insurance coverage; ratio of 3:1.
- Must submit expanded health benefit plan financial and enrollment data to the Office of the Insurance Commissioner (OIC)

Employees

- Each K-12 public school employee pays a minimum premium charge.
- Employee premiums are structured to ensure that employees who select richer benefit plans pay the higher premium.

The Office of Insurance Commissioner

- Must consult with school districts to ensure the data and reports from the benefit providers will meet legislative requirements.
- Must report annually on district data beginning Dec. 1, 2013.

Under ESSB 5940, the Office of the Insurance Commissioner (OIC) is required to report on health benefits provided to school district employees, on a district-by-district basis; information regarding health benefit plan provisions, premiums, claims costs, and administrative costs will be provided by insurance carriers.

The first such report was submitted to the state legislature in December 2013 and subsequent reports will be submitted yearly thereafter.

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

Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

To see which States have a premium assistance program, or for more information on special enrollment rights, you can contact either:

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

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

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

This law was effective for group health plans for plan years beginning on or after January 1, 1998.

On October 27, 1998, the Department of Labor, in conjunction with the Departments of the Treasury and Health and Human Services, published interim regulations clarifying issues arising under the Newborns' Act. The changes made by the regulations are effective for group health plans for plan years beginning on or after January 1, 1999.

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan. Please call your Plan Administrator for more information.

Important Notices from Clarkston School District about Your Prescription Drug Coverages 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 Clarkston 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. **Clarkston School District has determined that the prescription drug coverage offered by Group Health Cooperative underwritten by Group Health Cooperative 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 to 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 Clarkston School District coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Group Health Cooperative underwritten by Group Health Cooperative coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Clarkston School District 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 Clarkston School District 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: 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).

Date:	**August 7, 2014**
Name of Entity:	**Clarkston School District**
Contact:	**Jeanne Fuller**
Address:	**PO Box 70, 1294 Chestnut, Clarkston, WA 99403**
Phone:	**509-758-2531 Ext. 5344**

General Notice of COBRA Continuation Coverage Rights
Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notification in writing must be provided within 30 days to the Plan contact information below.

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Information about the plan and COBRA continuation coverage can be obtained on request by contacting:

Employer: **Clarkston School District**
Contact: **Jeanne Fuller**
Address: **PO Box 70, 1294 Chestnut, Clarkston, WA 99403**
Phone: **509-758-2531 Ext. 5344**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by Clarkston School District.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if Clarkston School District does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in Clarkston School District's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if Clarkston School District does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from Clarkston School District that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by Clarkston School District, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by Clarkston School District, please check your summary plan description go to: **www.propelinsurance.com** -> current clients -> online benefits site login -> password: **clarkston**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs

PART B: Information About Health Coverage Offered by your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name	2. Employer Identification Number (EIN)	
CLARKSTON SCHOOL DISTRICT		
3. Employer Address	4. Employer Phone Number	
1294 CHESTNUT	509-758-2531 Ext. 5344	
5. City	6. State	7. Zip
CLARKSTON	WA	99403
8. Who can we contact about employee health coverage at this job?		
JEANNE FULLER		
10. Phone number (if different from above)	11. Email Address	
	FullerJe@csdk12.org	

Here is some basic information about health coverage offered by Clarkston School District:

- As your employer, we offer a health plan to:

☒All employees who work a minimum of 18.75 hours per week.

- With respect to dependents:

☒We do offer coverage to qualified dependents.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if Clarkston School District intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Disclaimer

This enrollment guide is a brief description of your coverage. It is not intended as a complete description of benefits. Although we've made every effort to ensure that this guide is accurate, provisions of the official plan documents and contracts will govern in the case of any discrepancy. This program is subject to review and (according to the provisions of any applicable collective bargaining agreement) may be modified or terminated in whole or in part at any time for any reason. This guide does not create a contract of employment between the district and any employee.

The information included in the communication is provided for informational and demonstration purposes only and is not intended as a contract. Neither Propel Insurance, bargaining units nor do insurance carriers noted in this publication guarantee the accuracy or completeness of the information. Neither Propel Insurance nor carriers shall in any circumstances be liable for economic loss due to your reliance on this information.

Recipients should note that said publication is objective and impartial in content unless clearly noted otherwise. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.


propeL
INSURANCE®