



**Chimacum
School District**
Benefit Handbook
2011-2012

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The brief information contained in this Benefit Handbook may not apply to your specific circumstances. This information is in no way a guarantee of claim payment and is not a Summary Plan Description (SPD). Always refer to the SPD issued by the insurance carrier for definitive answers to specific questions. The Employer reserves the right to interpret, revise, supplement or rescind all or any portion of the Employee Benefit Handbook at any time at the employer's discretion.

IMPORTANT NOTES:

1. While it is hoped that the plans summarized in this Benefit Handbook will continue indefinitely, your employer reserves the right to change or terminate any plan or plans in the future.
2. Each carrier retains discretionary authority to administer their program according to the terms of the Master Group Contract.
3. You must exhaust all claim appeal remedies outlined in the carrier's Master Group Contract before pursuing further/other legal action.
4. All care must meet medical criteria as determined by the carrier.

BENEFITS OFFERED

MEDICAL INSURANCE

The district offers a range of plan choices for each employee. Employees may choose from two KPS Health Plans and three Premera Blue Cross plans. Chimacum Education Association (CEA) members are able to select only from the three Premera Blue Cross plans.

MAINTENANCE AND CUSTODIAL STAFF

Maintenance and Custodial Staff have medical, dental and vision benefits through PEBB (Agency #600-E05). For more information, contact Public Employees Benefits Board (PEBB) at 1-800-200-1004 or 360-412-4200 in Olympia, or visit their website at <http://www.pebb.hca.wa.gov/>.

DENTAL INSURANCE

Dental coverage is provided through Washington Dental. Washington Dental pays a percentage of charges for preventive care, basic care, major care and a portion of orthodontia (children only).

VISION INSURANCE

Classified and certificated employees have vision coverage through VSP (Vision Service Plan) that covers both routine vision exams and vision hardware.

SALARY INSURANCE

Each employee has the opportunity to purchase voluntary salary insurance through American Fidelity at their own expense through payroll deduction. See the Payroll Department for additional information.

ADDITIONAL INSURANCE

Each employee has the opportunity to purchase additional insurance benefits (i.e. cancer insurance, intensive care insurance, etc.) from AFLAC at their own expense through payroll deduction.

FLEXIBLE SPENDING ACCOUNTS

You may set aside your own pre-tax dollars to pay for unreimbursed medical, dental, and vision expenses as well as dependent childcare or disabled dependent care expenses.

CUSTOMER SERVICE

If you have questions regarding specific benefits or claims processing problems call the following numbers. If you have difficulty obtaining answers to questions or resolving issues through the numbers listed below, contact Jessica Carr at Berg Andonian, Inc. at 888-858-5115 or Jessica@bergandonian.com.

	GROUP NUMBER	CUSTOMER SERVICE PHONE NUMBER	WEBSITE
MEDICAL			
KPS HEALTH PLANS Claims: PO Box 339 Bremerton, WA 98337	Enhanced 20045 Basic 22045	800-552-7114	www.kpshealthplans.com
PREMERA BLUE CROSS Claims: PO Box 91080 Seattle, WA 98111-9180	8000031-0001	800-932-9221	www.premera.com/wea
MAINTENANCE AND CUSTODIAL STAFF PUBLIC EMPLOYEES BENEFITS BOARD Claims:	Agency #600-E05	800-200-1004 360-412-4200	www.pebb.hca.wa.gov/
DENTAL			
WASHINGTON DENTAL Claims: PO Box 75688 Seattle, WA 98125	00186-03910	800-554-1907	www.deltadentalwa.com/wea
VISION			
VSP Claims: PO Box 997105 Sacramento, CA 95899	Plan C 8000031-0001	800-877-7195	www.vsp.com
FLEXIBLE SPENDING ACCOUNTS			
AFLAC Fax number for unreimbursed medical / dependent daycare claims: (877) 353-9256	J5683	253-229-5301	www.aflac.com
STATE RETIREMENT			
DRS (Department of Retirement Systems)		800-547-6657	www.drs.wa.gov
BENEFIT ADVISOR			
Berg Andonian, Inc. Jessica Carr – Account Manager Jessica@bergandonian.com		888-858-5115	www.bergandonian.com

NOTABLE CHANGES TO BENEFITS, 2011/2012

The following is not an exhaustive listing of contract changes. It is recommended that you call your carrier's Customer Service Department for answers to specific benefit questions.

KPS MEDICAL

- Covered medical expenses incurred as a result of accidental injuries will now be subject to the deductible.
- Smoking cessation is covered the same as any other professional service.

PREMERA BLUE CROSS MEDICAL

- This fall, an audit of enrolled dependents will be conducted to verify their eligibility.
- Plan 1 out-of-pocket maximum is changing from \$444 per individual to \$500 per individual and \$1,500 per family.
- Plan 2 out-of-pocket maximum is changing from \$1,375 per individual to \$1,500 per individual and \$4,500 per family.
- Plan 3 out-of-pocket maximum is changing from \$2,500 per individual to \$2,750 per individual and \$8,250 per family.
- Out-of-Pocket Maximums now include the calendar year deductible.

- Life insurance of \$20,000 (through Unum) included with the medical coverage is decreasing to \$12,500 (Life benefits will reduce to \$8,125 for ages 65-69, and \$6,250 for ages over 70).
- Smoking cessation is covered the same as any other professional service.

WDS DENTAL

- Contract year is changing from 9/1 to 10/1. The current benefit year will be extended one month and all enrollees will receive an additional \$170 towards their annual plan maximum for the month of September. Enrollees will then receive their new annual maximum benefit effective 10/1/2011.
If you are planning major dental work, you may wish to schedule your visit after October 1st.

ENROLLMENT INFORMATION

YOUR ELIGIBILITY

September: The month of September is open enrollment. During open enrollment you may change, add or delete coverage for yourself and for your eligible dependents.

September 30: Deadline for making any open enrollment changes.

September 9: Open enrollment changes submitted by this date are effective October 1.

September 10-September 30: Open enrollment changes submitted during these dates are effective November 1.

PAYROLL DEDUCTIONS

Payroll deductions in September will reflect the new pricing that becomes effective October 1st.

YOUR INSTRUCTIONS

1. Once you are eligible, choose the medical and/or voluntary insurance plans in which you wish to participate.
2. Fill out the appropriate applications in full (applications available at the Payroll Department).
3. Return completed forms to the Payroll Department (see above deadlines).

MONTHLY RATES

MEDICAL	KPS ENHANCED PLAN	KPS BASIC PLAN	PREMERA BLUE CROSS PLAN I	PREMERA BLUE CROSS PLAN 2	PREMERA BLUE CROSS PLAN 3
DEDUCTIBLE	\$0	\$200	\$50	\$100	\$200
OFFICE VISIT COPAY	\$15	\$20	\$20	\$25	\$30
INPATIENT COVERAGE	Covered at 80% after a \$150 copay per day (max 5 copays)	Covered at 80% after deductible and a \$200 copay per day (max 5 copays)	Covered at 90% after deductible and a \$100 copay per day (max 3 copays)	Covered at 80% after deductible and a \$150 copay per day (max 3 copays)	Covered at 80% after deductible and a \$300 copay per day (max 3 copays)
PRESCRIPTION COPAYS	\$5 generic \$15 brand name 50% non-preferred brand name (minimum \$35 copay)	\$10 generic \$25 brand name 50% non-preferred brand name (minimum \$35 copay)	\$10 generic \$15 brand name \$30 non-preferred brand name	\$10 generic \$20 brand name \$35 non-preferred brand name	\$15 generic \$25 brand name \$40 non-preferred brand name
CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT AND EXEMPT GROUPS					
Emp	\$913.61	\$683.35	\$892.00	\$683.35	\$611.80
Emp/Spouse	\$1,831.61	\$1,366.68	\$1,659.95	\$1,292.70	\$1,156.70
Emp/Children	\$1,342.59	\$1,007.89	\$1,233.45	\$941.35	\$842.70
Emp/Sp/Children	\$2,262.84	\$1,689.22	\$2,038.85	\$1,550.70	\$1,387.60
CHIMACUM EDUCATION ASSOCIATION (CEA) RATES					
Emp			\$806.15	\$617.95	\$552.80
Emp/Spouse	n/a	n/a	\$1,531.15	\$1,166.15	\$1,043.45
Emp/Children			\$1,113.10	\$850.20	\$760.75
Emp/Sp/Children			\$1,838.10	\$1,398.40	\$1,251.40

MONTHLY PREMIUM

DENTAL Washington Dental	\$123.00
VISION VSP	\$27.35

MONTHLY COST WORKSHEET

District Contribution per 1.0 FTE \$768.00

Dental Premium – WDS – mandatory -\$123.00

Vision Premium – VSP – mandatory -\$27.35

Total dollars available towards optional medical premium = \$617.65

Enter your medical premium rate -

Monthly payroll deduction =

Note:

Any excess dollars will be applied to your pool as required by Washington State law. The total monthly payroll deduction will, in some cases, be different (lower) than your calculation above

due to pooling, and Section 125 law allowing payroll deduction amounts to be taken from gross pay (pre-taxed) instead of take home pay. Payroll deductions in September will reflect the new pricing effective October 1st.

CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT and EXEMPT GROUPS MEDICAL BENEFITS

	KPS Enhanced Plan	KPS Basic Plan
Rates		
Employee Only	\$913.61	\$683.35
Employee & Spouse	\$1,831.61	\$1,366.68
Employee & Children	\$1,342.59	\$1,007.89
Employee, Spouse & Children	\$2,262.84	\$1,689.22
BENEFITS AT A GLANCE		
Provider Network	To receive the benefit shown below you must use a provider from the KPS or First Choice network	To receive the benefit shown below you must use a provider from the KPS or First Choice network
Annual Deductible	No deductible	\$200 per individual, \$600 per family
Office Calls and Urgent Care	\$15 copay	\$20 copay
Out-of-pocket Maximum	\$1,200 per individual, \$3,600 per family	\$2,500 per individual, \$7,500 per family
Prescription Drugs		
Generic	\$5 copay	\$10 copay
Preferred Brand Name	\$15 copay	\$25 copay
Non-Preferred Brand Name	50% copay; \$35 minimum	50% copay; \$35 minimum
Days Supply	30 Maintenance Rx 90-day supply for 2 copays (applies to retail or mail order)	30 Maintenance Rx 90-day supply for 2 copays (applies to retail or mail order)
Spinal Manipulations (Chiropractic)	\$15 copay, 20 visit limit	\$20 copay, 12 visit limit
Diagnostic X-Ray / Lab	80% in hospital, 100% in physician's office	80% after deductible in hospital, 100% in physician's office
PREVENTIVE CARE		
Well Child Care	Covered in full	Covered in full
Routine Physicals	Covered in full	Covered in full
Benefits Accrue	Based on Contract Year (contract year begins 10/1)	Based on Contract Year (contract year begins 10/1)

CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT AND EXEMPT GROUPS MEDICAL BENEFITS

WEA Premera Blue Cross Select Plan 1	WEA Premera Blue Cross Select Plan 2	WEA Premera Blue Cross Select Plan 3
\$892.00	\$683.35	\$611.80
\$1,659.95	\$1,292.70	\$1,156.70
\$1,233.45	\$941.35	\$842.70
\$2,038.85	\$1,550.70	\$1,387.60
To receive the benefit shown below you must use a provider from the Premera Heritage network	To receive the benefit shown below you must use a provider from the Premera Heritage network	To receive the benefit shown below you must use a provider from the Premera Heritage network
\$50 per person, \$150 per family per calendar year	\$100 per person, \$300 per family per calendar year	\$200 per person, \$600 per family per calendar year
\$20 copay	\$25 copay	\$30 copay
\$500 per individual, \$1,500 per family (Includes deductible)	\$1,500 per individual, \$4,500 per family (Includes deductible)	\$2,750 per individual, \$8,250 per family (Includes deductible)
Retail Mail Order \$10 copay \$10 copay \$15 copay \$15 copay \$30 copay \$30 copay 34 100	Retail Mail Order \$10 copay \$10 copay \$20 copay \$20 copay \$35 copay \$35 copay 34 100	Retail Mail Order \$15 copay \$15 copay \$25 copay \$25 copay \$40 copay \$40 copay 34 100
\$20 copay	\$25 copay	\$30 copay
90% after deductible	80% after deductible	80% after deductible
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
Based on Calendar Year	Based on Calendar Year	Based on Calendar Year

CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT AND EXEMPT GROUPS MEDICAL BENEFITS

	KPS Enhanced Plan	KPS Basic Plan
HOSPITAL		
Inpatient Care	80% after \$150 copay per day (5 copay limit)	80% after deductible and \$200 copay per day (5 copay limit)
Emergency Care	\$75 copay	\$75 copay
OTHER BENEFITS		
Acupuncture	\$15 copay, 12 visit limit	\$20 copay, 12 visit limit
Ambulance Services	80%, \$5,000 limit Air Ambulance per trip	80% after deductible, \$5,000 limit Air Ambulance per trip
Chemical Dependency	Inpatient: 80% after \$150 copay per day (5 copay limit) Outpatient: \$15 copay	Inpatient: 80% after deductible and \$200 copay per day (5 copay limit) Outpatient: \$20 copay
Lifetime Maximum	Unlimited	Unlimited
Maternity	Covered as any other service (Subscriber and Spouse only)	Covered as any other service (Subscriber and Spouse only)
Mental Health	Inpatient – (must be pre-authorized) 80% after \$150 copay per day (5 copay limit) Outpatient - \$15 copay	Inpatient – (must be pre-authorized) 80% after deductible and \$200 copay per day (5 copay limit) Outpatient - \$20 copay
Naturopathic	\$15 copay	\$20 copay
Outpatient Surgery	80%	80% after deductible
Rehabilitation (includes Physical Therapy)	Outpatient 80%, \$1,500 limit No inpatient benefit	Outpatient 80% after deductible, \$1,000 limit No inpatient benefit
Dependents covered to	Age 26	Age 26

CLASSIFIED (CIA), TRANSPORTATION DEPARTMENT AND EXEMPT GROUPS MEDICAL BENEFITS

WEA Premera Blue Cross Select Plan 1	WEA Premera Blue Cross Select Plan 2	WEA Premera Blue Cross Select Plan 3
90% after deductible and \$100 copay per day (\$300 maximum copays collected)	80% after deductible and \$150 per day copay (\$450 maximum copays collected)	80% after deductible and \$300 per day copay (\$900 maximum copays collected)
90% after deductible and \$75 copay	80% after deductible and \$75 copay	80% after deductible and \$100 copay
\$20 copay, 12 visits	\$25 copay, 12 visits	\$30 copay, 12 visits
90% after deductible	80% after deductible	80% after deductible
Inpatient: 90% after deductible and \$100 copay per day (\$300 maximum copays collected) Outpatient: \$20 copay	Inpatient: 80% after deductible and \$150 copay per day (\$450 maximum copays collected) Outpatient: \$25 copay	Inpatient: 80% after deductible and \$300 copay per day (\$900 maximum copays collected) Outpatient: \$30 copay
Unlimited	Unlimited	Unlimited
90% after deductible; \$100 inpatient copay per day (\$300 maximum copays collected)	80% after deductible; \$150 inpatient copay per day (\$450 maximum copays collected)	80% after deductible; \$300 inpatient copay per day (\$900 maximum copays collected)
Inpatient: 90% after deductible and \$100 copay per day (\$300 maximum copays collected) Outpatient: \$20 copay	Inpatient: 80% after deductible and \$150 copay per day (\$450 maximum copays collected) Outpatient: \$25 copay	Inpatient: 80% after deductible and \$200 copay per day (\$900 maximum copays collected) Outpatient: \$30 copay
\$20 copay	\$25 copay	\$30 copay
\$50 copay and 90% after deductible	\$100 copay and 80% after deductible	\$150 copay and 80% after deductible
Inpatient: 90% after deductible and \$100 copay per day (\$300 maximum copays collected), 120 day maximum Outpatient: \$20 copay, 45 visit limit Physical Therapy: 90% after deductible, no visit limit	Inpatient: 80% after deductible and \$150 copay per day (\$450 maximum copays collected), 120 day maximum Outpatient: \$25 copay, 45 visit limit Physical Therapy: 80% after deductible, no visit limit	Inpatient: 80% after deductible and \$300 copay per day (\$900 maximum copays collected), 30 day limit Outpatient: \$30 copay, 45 visit limit Physical Therapy: 80% after deductible, no visit limit
Age 26	Age 26	Age 26

CHIMACUM EDUCATION ASSOCIATION (CEA) MEDICAL BENEFITS

	WEA Premera Blue Cross Select Plan 1	WEA Premera Blue Cross Select Plan 2	WEA Premera Blue Cross Select Plan 3
Rates			
Employee Only	\$806.15	\$617.95	\$552.80
Employee & Spouse	\$1,531.15	\$1,166.15	\$1,043.45
Employee & Children	\$1,113.10	\$850.20	\$760.75
Employee, Spouse & Children	\$1,838.10	\$1,398.40	\$1,251.40
BENEFITS AT A GLANCE			
Provider Network	To receive the benefit shown below you must use a provider from the Premera Heritage network	To receive the benefit shown below you must use a provider from the Premera Heritage network	To receive the benefit shown below you must use a provider from the Premera Heritage network
Annual Deductible	\$50 per individual, \$150 per family	\$100 per individual \$300 per family	\$200 per individual \$600 per family
Office Calls and Urgent Care	\$20 copay	\$25 copay	\$30 copay
Out-of-pocket Maximum	\$500 per individual \$1,500 per family (Includes deductible)	\$1,500 per individual \$4,500 per family (Includes deductible)	\$2,750 per individual \$8,250 per family (Includes deductible)
Prescription Drugs	Retail Mail Order	Retail Mail Order	Retail Mail Order
Generic	\$10 copay \$10 copay	\$10 copay \$10 copay	\$15 copay \$15 copay
Preferred Brand Name	\$15 copay \$15 copay	\$20 copay \$20 copay	\$25 copay \$25 copay
Non-Preferred Brand Name	\$30 copay \$30 copay	\$35 copay \$35 copay	\$40 copay \$40 copay
Days Supply	34 100	34 100	34 100
Spinal Manipulations (Chiropractic)	\$20 copay	\$25 copay	\$30 copay
Diagnostic X-Ray / Lab	90% after deductible	80% after deductible	80% after deductible
PREVENTIVE CARE			
Well Child Care	Covered in full	Covered in full	Covered in full
Routine Physicals	Covered in full	Covered in full	Covered in full
Benefit Accrue	Based on Calendar Year	Based on Calendar Year	Based on Calendar Year

CHIMACUM EDUCATION ASSOCIATION (CEA) MEDICAL BENEFITS

	WEA Premera Blue Cross Select Plan 1	WEA Premera Blue Cross Select Plan 2	WEA Premera Blue Cross Select Plan 3
HOSPITAL			
Inpatient Care	90% after deductible and \$100 copay per day (\$300 maximum copays collected)	80% after deductible and \$150 per day copay (\$450 maximum copays collected)	80% after deductible and \$300 per day copay (\$900 maximum copays collected)
Emergency Care	90% after deductible and \$75 copay	80% after deductible and \$75 copay	80% after deductible and \$100 copay
OTHER BENEFITS			
Acupuncture	\$20 copay, 12 visits	\$25 copay, 12 visits	\$30 copay, 12 visits
Ambulance Services	90% after deductible	80% after deductible	80% after deductible
Chemical Dependency	Inpatient: 90% after deductible and \$100 copay per day (\$300 maximum copays collected) Outpatient: \$20 copay	Inpatient: 80% after deductible and \$150 copay per day (\$450 maximum copays collected) Outpatient: \$25 copay	Inpatient: 80% after deductible and \$300 copay per day (\$900 maximum copays collected) Outpatient: \$30 copay
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Maternity	90% after deductible; \$100 inpatient copay per day (\$300 maximum copays collected)	80% after deductible; \$150 inpatient copay per day (\$450 maximum copays collected)	80% after deductible; \$300 inpatient copay per day (\$900 maximum copays collected)
Mental Health	Inpatient: 90% after deductible and \$100 copay per day (\$300 maximum copays collected) Outpatient: \$20 copay	Inpatient: 80% after deductible and \$150 copay per day (\$450 maximum copays collected) Outpatient: \$25 copay	Inpatient: 80% after deductible and \$200 copay per day (\$900 maximum copays collected) Outpatient: \$30 copay
Naturopathic	\$20 copay	\$25 copay	\$30 copay
Outpatient Surgery	\$50 copay and 90% after deductible	\$100 copay and 80% after deductible	\$150 copay and 80% after deductible
Rehabilitation (includes Physical Therapy)	Inpatient: 90% after deductible and \$100 copay per day (\$300 maximum copays collected), 120 day maximum Outpatient: \$20 copay 45 visit limit Physical Therapy: 90% after deductible, no visit limit	Inpatient: 80% after deductible and \$150 copay per day (\$450 maximum copays collected), 120 day maximum Outpatient: \$25 copay 45 visit limit Physical Therapy: 80% after deductible, no visit limit	Inpatient: 80% after deductible and \$300 copay per day (\$900 maximum copays collected), 30 day limit Outpatient: \$30 copay 45 visit limit Physical Therapy: 80% after deductible, no visit limit
Dependent Age	Age 26	Age 26	Age 26

OTHER MEDICAL INSURANCE OPTIONS

If you are not eligible or feel you cannot afford district medical insurance, the following options are available. These plans are not endorsed by the district. The information is provided as a courtesy. No state allocation dollars may be used towards these insurance options and the district cannot deduct premiums from your paycheck.

INDIVIDUAL MEDICAL COVERAGE OPTIONS

You may consider insuring your dependent spouse and/or dependent children for medical coverage by applying for an individual medical policy. If you would like to review available options use the quoting services at www.affordable-insurance.com or call (877) 466-1999. If calling, mention that you are a Chimacum School District employee.

APPLE HEALTH FOR KIDS PROGRAM

In Washington State, a program is offered to provide health insurance coverage to children under age 19, and qualification is based on the family income level. The program is funded by federal tax dollars, and almost all states have taken advantage of these dollars and developed similar programs.

Qualification for the Apple Health for Kids program is as shown below:

The Family's Income is:	Up to 200% of "federal poverty level"	250% of "federal poverty level"	300% of "federal poverty level"
Examples of Qualifying Income Levels	For a family of 2 people, 200% of federal poverty level is \$2,429 monthly. For a family of 4, 200% is \$3,675 monthly.	For a family of 2 people, 250% of federal poverty level is \$3,036 monthly. For a family of 4, 250% is \$4,594 monthly.	For a family of 2 people, 300% of federal poverty level is \$3,643 monthly. For a family of 4, 250% is \$5,513 monthly.
Monthly Cost to the Family	Free	\$20 per child per month (\$40 per month maximum).	\$30 per child per month (\$60 per month maximum).

Notes:

- Income levels are determined by the state and are adjusted each year on April. 1st.
- A list of providers can be found at <https://fortress.wa.gov/dshs/p1findaprovider/>.
- A pregnant woman counts as a family size of two. Other programs with different eligibility requirements are available for families and pregnant women. Call toll-free 1-877-543-7669 to find out more.

If you have questions regarding Apple Health for Kids and other programs you might qualify for, please call Apple Health for Kids toll-free at (877) 543-7669.

STATE SPONSORED COVERAGE

If you declined coverage when you were eligible to enroll in the group plan, you may subsequently apply for coverage in the event that the Department of Social and Health Services (DSHS) has determined that it is cost-effective to enroll you or your eligible dependents in a medical plan offered by your employer. Applications must be submitted within 60 days following the determination by DSHS.

CHIPRA NOTIFICATION

If you are eligible for health coverage from your employer, but are unable to afford the premiums, Washington State has premium assistance programs that can help pay for coverage. The state uses 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 use the contact information below to find out how to apply. If you qualify, you can ask if there is 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.

WASHINGTON – Medicaid

Website: <http://hrsa.dshs.wa.gov/premiumpym/Apply.shtm>

Phone: 1-877-543-7669

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

DENTAL BENEFITS

WASHINGTON DENTAL SERVICE (WDS) WEA SELECT DENTAL PLAN

Provider Network	Use any licensed dentist. Use of WDS member dentists provides the highest level of benefits
Deductible	\$0
Annual Maximum October 1 – September 30	\$1,750 (\$2,000 if WDS PPO dentist is used)
Class I- Diagnostic & Preventive * Exams, Prophyls, Fluoride, X-rays, Sealants	70% Year 1 80% Year 2 90% Year 3 100% Year 4
Class II- Restorative** Restorations, Crowns, Inlays, Onlays, Oral Surgery, Root Canals, Endodontics, Periodontics	70% Year 1 80% Year 2 90% Year 3 100% Year 4
Class III- Major** Dentures, Bridges, Partials, Implants	50%
Orthodontia** Dependent children only (to age 26)	50% to \$1,250 lifetime maximum
Dependent Covered To	Age 26

*Washington Dental requires each member to see the dentist at least once per year in order to move up to the next percentage. If you do not visit the dentist at least once in the year, your benefit percentages will drop by 10% below the last level of payment, but never below the original 70%.

You can find a participating dentist in your area by visiting the Washington Dental Service website at www.DeltaDentalWA.com/findadentist. Be sure to select the appropriate plan – Delta Dental PPO or Delta Dental Premier – and follow the prompts.

**If your dental work will be extensive (i.e. crowns, inlays, onlays, surgical periodontics and orthodontics), ask your dentist to call Washington Dental Service at 800-554-1907 or complete and submit a standard ADA claim form to Washington Dental, for a predetermination. This will allow you to know in advance exactly what procedures are covered, the amount Washington Dental will pay toward the treatment, and your financial responsibility.

For questions on your dental benefits, call Washington Dental Customer Service, 800-554-1907.

IMPORTANT: Contract year is changing from 9/1 to 10/1. The current benefit year will be extended one month and all enrollees will receive an additional \$170 for the month of September. Enrollees will then receive their full benefit effective 10/1/2011.

VISION BENEFITS

VISION SERVICE PLAN (VSP)

BENEFIT FREQUENCIES

Examinations	Once each calendar year
Lenses	Once each calendar year
Contact Lenses	Once every 2 calendar years
Frames	Once every 2 calendar years

	VSP PROVIDER	Non-VSP PROVIDERS
Examination Copay	\$5 COPAY	
Examination	Paid in full	\$60 allowance
Materials Copay	\$15 COPAY APPLIES TO ALL MATERIALS	
Lenses		
Single Vision Lenses	Paid in full	\$76 allowance
Bifocal Lenses	Paid in full	\$112 allowance
Trifocal Lenses	Paid in full	\$142 allowance
Lenticular	Paid in full	\$148 allowance
Continuous Blend	Paid in full	\$140 allowance
Lens Tinting, Coating or Oversized Lenses	Paid in full	No additional allowance
Frames	Large selection of frames from which to choose, paid in full up to \$110 allowance	\$60 allowance
Contact Lenses (in lieu of lenses and a frame)	\$200	\$200

To obtain your VSP ID number or a list of VSP member doctors call VSP at **800-877-7195**, or visit their website at www.vsp.com. VSP does not distribute ID cards. New enrollees will receive a letter from VSP with your unique VSP identification number.

When services are received from a VSP member doctor, reimbursement is made directly to the doctor. The patient will have no out-of-pocket expense other than the copayment, unless optional items are selected that VSP does not cover. Optional items include, but are not limited to, oversize lenses, coated lenses, no-line multifocal lenses or a frame that exceeds the wholesale allowance. If you obtain vision services from a non-participating vision provider, pay the bill and request an itemized copy of the bill showing the eye exam and materials, including lense type. Submit the following information for reimbursement:

- Itemized copy of the bill (breaking out the cost of the eye exam, materials and lense type)
- The name, address and phone number of the non-VSP provider
- The employee's VSP identification number and date of birth

- The employee's name, address, and phone number
- The name of your employer
- The patient's name, date of birth, address and phone number
- The patient's relationship to the covered member (such as self, spouse, child, student, etc.)

Send the above information for claims reimbursement according to the above schedule to:

VSP Claims
PO Box 997105
Sacramento, CA 95899-7105

Note: Some non-participating vision providers will submit claims directly to VSP on your behalf, including Wal-Mart, Sam's Clubs and some Costco locations.

Your individual benefit information is available to view at www.vsp.com. Once you are registered, you can view when to schedule your next eye exam as well as when you are eligible for new frames and lenses or contact lenses.

FLEXIBLE SPENDING ACCOUNTS

AVAILABLE THROUGH AFLAC

PREMIUM CONVERSION PROGRAM

The district's Section 125 Premium Conversion Plan allows employees to avoid Social Security and federal income taxes on monthly amounts that are deducted for eligible group insurance (medical, dental, vision, life and disability insurance) premiums. The Payroll Department will automatically deduct qualifying insurance premiums from gross pay (pre-tax), unless you request in writing not to participate in the premium conversion program.

FLEXIBLE SPENDING ACCOUNT PROGRAM

The flexible spending account program gives you a tax break when you pay out-of-pocket medical/dental bills by using pre-tax pay. Expenses that are either not covered by medical insurance or have deductibles and copayments are eligible. If you enroll in the program, you may set aside your own pre-tax money each month into an account to pay eligible expenses.

The flexible spending account program lets you set aside any amount up to an annual maximum of \$1,500. Your contribution will be deducted from your gross pay (pre-tax) salary in equal amounts for the plan year. The following example illustrates the benefit of using a flexible spending account.

Eligible Expenses

The expenses covered by, but not paid by, insurance such as the deductible, coinsurance (the percentage of charges not covered) and expenses over the maximum:

- Non-reimbursed medical expenses for preventive, diagnostic, and therapeutic care
- Medicine or other drugs prescribed by a medical doctor
- Non-reimbursed dental expenses for preventive, diagnostic, endodontic, orthodontic and therapeutic care

- Medicine or other drugs prescribed by a dentist
- Non-reimbursed vision expenses

Non-Eligible Expenses

- As of January 1, 2011, over-the-counter (OTC) medicines and drugs will need a prescription to be considered an eligible benefit.
- Expenses reimbursed through any insurance policy or plan
- Expenses incurred before you enroll in the plan
- Expenses you claim as a deduction or credit for income tax purposes

DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account is a tax-effective way to pay childcare or other dependent care services that enable you or you and your spouse to work outside the home.

You may use this account to pay for eligible day care expense incurred for:

- A child up to age 13 for whom you claim a deduction on your income tax form, or
- A spouse or disabled dependent age 13 or older (your parent, for instance) who is physically or mentally incapable of self-care, who normally spends at least eight hours in your home each day, and for whom you pay more than half the cost of support.

Eligible day care expenses include costs for nursery schools, day care providers, babysitters and other types of day care. A provider cannot be another dependent of yours, such as an older child. Nursery schools and day care centers must comply with state and local regulations if their expenses are to be eligible for reimbursement.

You may set aside up to \$5,000 each plan year in your Dependent Care Spending Account through automatic payroll deductions or \$2,500 if you are married filing a separate return.

FLEXIBLE SPENDING ACCOUNTS

Dependent Care Spending Account vs. the Dependent Care Tax Credit

For most employees, the Dependent Care Spending Account is a better method than taking the dependent care tax credit on the income tax return. Generally, the

tax credit is more beneficial if your adjusted gross income is less than \$24,000.

Government Rules on Unused Funds

Federal tax law says that any money left in your account at the end of the plan year must be forfeited.

EXAMPLES OF TAX SAVINGS WITH FLEXIBLE REIMBURSEMENT ACCOUNTS

<i>Without Flexible Spending Account</i>		<i>With Flexible Spending Account</i>	
Gross Monthly Salary	\$2,500	Gross Monthly Salary	\$2,500
Income Tax @ 15% plus FICA @ 7.65%	-566	Qualifying Insurance Premiums	- 100
		Qualifying Health Care Expenses	- 100
		Qualifying Dependent Care Expenses	- 350
Net Income (after taxes)	\$1,934	Gross Taxable Income	\$1,950
Qualifying Insurance Premiums	-100	Income Tax @ 15% plus FICA @ 7.65%	-441
Qualifying Health Care Expenses	-100		
Qualifying Dependent Care Expenses	-350		
Net Spendable Income	\$1,384	Net Spendable Income	\$1,509

As you can see, with only \$550 in monthly qualified expenses, by enrolling in the plan, you would have an extra \$125 each month (\$1,500 per year) of net spendable income, saving dollars you would otherwise be paying in taxes.

IMPORTANT PLAN RULES

CAUTION: The IRS requires that you use all the money you contribute to your account or forfeit the remainder at the end of the plan year. This is commonly referred to as the "use it or lose it" provision.

Services provided to you or any covered dependent are eligible for reimbursement. Expenses must be incurred during the plan year.

Medical and dental care expenses from a given year can only be paid with money deposited in your account that same year. You have 60 days from the end of the plan year to submit claims.

Making Changes

Your selection will be effective for the entire plan year. The plan year is October 1 through September 30. You may change your benefit selection during the plan year within 31 days of a change in family status. These changes include: marriage, legal separation or divorce; birth, adoption or change in custody of a minor child; change in your spouse's employment status; death of your spouse or child; change between full-time and part-time status by an employee or spouse; unpaid leave of absence by employee or spouse; or significant change in coverage of employee or spouse due to spouse's employment.

Unless you have a change in family status, you cannot change your elections until the next open enrollment.

Making Claims

When you incur an eligible expense during the year, file a request for reimbursement form (forms are available at www.AFLAC.com). Enclose proof of payment, such as an invoice, receipt or canceled check.

FAMILY AND MEDICAL LEAVE ACT

NOTIFICATION

The Family and Medical Leave Act of 1993 (FMLA) is a federal law that became effective on August 5, 1993 for most companies and non profit organizations with 50 or more employees.

FMLA applies to all employees who have:

- 12 months of employment with the company *and*
- 1,250 hours or more of service in the preceding 12 months.

FMLA provides 12 weeks of unpaid leave in any 12 month period for the following reasons:

- To care for oneself, a child, spouse, or parent with a "serious health condition", or "covered service member" who is injured in the line of duty;
- To the immediate family members (spouses, children, or parents) of military personnel or reservists who have "any qualifying exigency" arising out of the service member's active duty or call to active duty in support of a contingency operation.

FMLA provides 12 weeks of unpaid leave in any 12 month period for public employees for the following reasons:

- Birth, adoption or placement of a child for foster care.

A SERIOUS HEALTH CONDITION IS DEFINED AS

- One that requires continuing treatment from a health care provider.
- Conditions that require an absence from work or regular daily activities for more than 3 days.
- Treatment for pregnancy and certain chronic conditions such as diabetes and asthma even though treatment may last less than three days.
- Conditions and medical treatments that are not ordinarily incapacitating on a day to day basis such as chemotherapy and radiation treatment, kidney dialysis, and physical therapy for severe arthritis.
- Mental illness may qualify.
- Specifically excluded are common colds, flu, upset stomach, routine dental problems and stress.

EMPLOYEE RESPONSIBILITIES

- Provide a 30-day notice for foreseeable leaves for birth, adoption, foster placement, or planned medical treatment.
- Continue to pay any required health plan contributions.

IT IS IMPORTANT TO REMEMBER

- With employer's approval, leave may be taken intermittently or by working a reduced week. However, an exception exists for an employee or family member's serious health condition whereby leave is taken whenever medically necessary.
- An employer is allowed to substitute an employee's accrued paid leave for any portion of the 12-week period.
- The employer is allowed to recover the cost of health benefits paid during the leave if the employee does not return to work.
- During the leave, the employee is ineligible for unemployment compensation.

COBRA

WHAT IS COBRA?

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring most employers sponsoring group health plans to offer employees and their families the opportunity to continue to be enrolled on the health plan even after termination of employment (and other scenarios). This coverage is simply an extension of the employer's current plan. In most instances the former employee is required to pay the full cost of the coverage.

COBRA QUALIFYING EVENTS

COBRA continuation coverage is continuation of Plan coverage (medical, dental and/or vision) when coverage would otherwise end because of a "qualifying event."

Common qualifying events are:

1. Termination of employment
2. A reduction in your hours of employment that would cause a loss of coverage

If you are the spouse or dependent child of an employee enrolled in a group medical, dental, and vision plans, you have the right to choose continuation of coverage for yourself if you lose group coverage for any of the following reasons:

1. Termination of your spouse's employment
2. Death of your spouse
3. Divorce or legal separation from your spouse
4. Your spouse becomes eligible for Medicare (resulting in the loss of dependent coverage)
5. Your retired spouse's employer files for Chapter 11 reorganization
6. Your child ceases to be a dependent or attains the maximum age allowed
7. Your spouse's hours of employment are reduced to a level that would cause a loss of coverage

HIPAA SPECIAL ENROLLMENT RIGHTS

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

LENGTH OF COVERAGE

In most instances, the law requires you be offered the opportunity to maintain continuation of coverage for up to 18 months, in some instances you can maintain coverage for 29 or 36 months. The law also provides your continuation coverage may be terminated for any of the following reasons:

1. Your employer ceases to provide group health coverage to any of its employees
2. The premium for your continuation coverage is not paid in a timely fashion
3. You become covered under another group health plan which does not contain a pre-existing conditions limitation; or
4. You become entitled (covered) under Medicare after COBRA has been elected

You do not have to show you are insurable to choose continuation coverage. However, you may have to pay all or part of the premium for your continuation, including a 2% add-on administrative expense (50% for the 11-month extension for Social Security disability). These rates are subject to change whenever the corresponding rates for the plan are increased.

Look for additional information from your employer that details your COBRA rights. It is your responsibility to make sure your employer has your correct address, as all COBRA notifications will be sent to your last known address.

WOMEN'S HEALTH & CANCER RIGHTS

REGARDING THE WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

Under federal law, group health plans and health insurance issuers providing benefits for a mastectomy must also provide, in connections with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation between the attending physician and the patient.

These benefits may be subject to annual deductibles and coinsurance provisions that are appropriate and consistent with the other benefits under your plan or coverage.

OTHER NOTICES

OPPORTUNITY TO ENROLL DEPENDENT COVERAGE TO AGE 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Group Medical Plan, regardless of marital or student status, place of residence or financial dependence on the employee. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective May 1, 2011. For more information contact Payroll / Benefits office.

LIFETIME LIMIT NO LONGER APPLIES AND ENROLLMENT OPPORTUNITY

The lifetime limit on the dollar value of benefits under the Group Medical Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Payroll / Benefits office.

PRE-EXISTING CONDITION EXCLUSIONS

For plan years beginning after Sept. 23, 2010, pre-existing condition limitations for children younger than 19 will no longer apply to this group health plan. A complete ban on pre-existing condition limitations will be effective for all participants (regardless of age) beginning in 2014. For more information, contact Payroll / Benefits office.

NOTICE OF PRE-EXISTING CONDITION EXCLUSIONS

This plan imposes a pre-existing condition exclusion for Covered Persons over age 19. This means that if you

have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 60 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Payroll / Benefits office.

IMPORTANT NOTICE 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered by your employer's medical plan 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 November 15th through December 31st. 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 Premera Blue Cross coverage will be affected. If you do decide to join a Medicare drug plan and drop your

Premera Blue Cross 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 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 November to join.

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

Contact Payroll / Benefits office 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 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 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).

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (the "HIPAA Privacy Rules"). The HIPAA Privacy Rules are federal laws that seek to ensure the privacy and confidentiality of your health information. The HIPAA Privacy Rules require your employer (the "Plan") to take certain actions to protect the privacy of your health information. Protected Health Information means information related to a past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in written, electronic or any other form. This Notice has been prepared to advise you of the uses and disclosures of your Protected Health Information that may be made by the Plan and to advise you of your rights and the Plan's legal duties relating to the privacy of your Protected Health Information.

As an individual enrolled in the Plan, you should be aware that the Plan may have access to your Protected Health Information from time to time. The Plan may receive your Protected Health Information in a variety of ways. An example of how the Plan may receive this information is when your health care provider, such as your doctor or your hospital, submits bills for services rendered to you to be paid by the Plan. The law permits the Plan to use or disclose Protected Health Information to carry out "treatment," "payment" and other "health care operations". When the Plan makes uses or disclosures of your Protected Health Information for treatment, payment or health care operations purposes, the Plan is not required to notify you or obtain your Authorization.

For uses or disclosures of Protected Health Information that are not made for treatment, payment, or health care operations purposes and for which no exception regarding Authorization applies, the law requires the Plan to obtain your Authorization. You may revoke an Authorization at any time, but a revocation is not effective if the Plan has already reasonably relied on your Authorization to make a particular use or disclosure. Additionally, if you request that the Plan make a use or disclosure of your Protected Health Information to a third party, the Plan may require that you sign an Authorization that permits the Plan to honor your request.

The Plan has the right to disclose your Protected Health Information to the Plan Sponsor, which is usually your employer, subject to certain limitations. The Plan may generally disclose to the Plan Sponsor information regarding whether you are enrolled in the Plan and "summary health information," which means information that summarizes the claims history

and experiences of the individuals enrolled in the plan without specifically identifying you or other plan participants. The Plan may disclose this information without your Authorization, and the Plan Sponsor may only use the information for its activities relating its sponsorship of the Plan.

The Plan may communicate your Protected Health Information to you in a variety of ways, including by mail or telephone. If you believe that the Plan's communications to you by the usual means will endanger you or your health care and you would like the Plan to make its communications that involve Protected Health Information to you at an alternate location, you may contact the Plan's Privacy Officer to obtain the appropriate request form. The Plan will only accommodate reasonable requests and may require information as to how payment, if any, will be handled.

If you believe that the Plan has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules, you may file a complaint by contacting the Plan's Privacy Officer. You may send a letter outlining your complaint to the Privacy Officer. The Plan requests that you attempt to resolve your complaint with the Plan via these complaint procedures since the Plan is in the best position to respond to your complaint. However, if you believe the Plan has violated your privacy rights, you may also file a complaint with the Office of Civil Rights ("OCR") at the United States Department of Health and Human Services ("HHS"). You may contact the HHS OCR at: Medical Privacy, Complaint Division, Office of Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHS Building, Washington, D.C. 20201, Voice Hotline Number (800) 368-1019, Internet Address www.hhs.gov/ocr. It is against the policies and procedures of the Plan to retaliate against any person who has filed a privacy complaint, either with us or with HHS OCR. Should you believe that you are being retaliated against in any way upon your filing a complaint with us or the HHS OCR, please immediately contact the Plan's Privacy Officer, so that the Plan may properly address the issue.

