



Blaine School District #503

YOUR BENEFIT REFERENCE GUIDE FOR THE 2009-2010 SCHOOL YEAR

Benefits Fair

Tuesday, September 1
7:00 – 8:30 a.m.
Middle School Cafeteria

Open Enrollment

August 27
through
September 10, 2009

Applications are to be turned into the Payroll Office. **TO BE EFFECTIVE BY OCTOBER 1, your application must be received by the Payroll Office no later than September 10.**

The information herein is not a contract. It is a summary of the benefits available. It is not intended to be an all-inclusive description of Plan benefits, limitations or exclusions, and should not be used in lieu of a Plan book. Be sure to consult your Plan booklet, or consult with the insurance company representative before making your selection. If there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets prevail. Questions may be directed to Allysa Bronson at (360) 332-5881 x1712, Laura Lucas at (360) 332-5881 x1719 or **Baldwin Resource Group, Inc at 877-455-5640**. This summary was printed on August 20, 2009. Any information not provided by that time or revisions by bargaining units or by insurers after this date could change or modify the information contained herein.

Please Note: All plan changes have been outlined in bold.

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HOW TO SELECT A MEDICAL PLAN

You have a choice of **6** different plans which offer a variety of plan designs. An explanation of each plan design and the plan names follow:

HEALTH MAINTENANCE ORGANIZATION (HMO) type plans provide you with the best benefits and the lowest cost at the time of service. However, these plans require that you select a primary care provider (PCP) from their list of providers. Your PCP will then either provide or coordinate all of your care (except in the case of a medical emergency).

HMO Plan:

- Group Health Cooperative Traditional Plan
- Group Health Cooperative Deductible Welcome Plan

PREFERRED PROVIDER ORGANIZATION type plans contract with a large number of providers. If you choose to receive your care through a preferred provider the insurance company will pay a percentage of the charges. If you choose to go to a non-preferred provider, then the insurance company will pay a lower percentage of the charges. Services are subject to a copay or deductible before the percentage is paid.

Preferred Provider Plan Choices:

- Regence Blue Shield Whatcom Educational Insurance Consortium Modified Copay Plan
- Regence Blue Shield Whatcom Educational Insurance Consortium Engage 80 Plan
- Regence Blue Shield Whatcom Educational Insurance Consortium High Option Plan
- Regence Blue Shield Whatcom Educational Insurance Consortium Innova 500 Plan

NOTE: The Regence Blue Shield Modified Copay and Engage 80 plans cover on-the-job injuries for self-employed individuals and their spouses to a \$250,000 lifetime maximum. The Regence WEIC High Option and Innova 500 plans cover on-the-job injuries for self-employed individuals to a \$250,000 lifetime maximum (employee only). Group Health does not cover on-the-job injuries.

All enrollment forms have to be submitted by September 10, 2009.

SPECIAL ENROLLMENT RIGHTS DESCRIPTION

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Unless the above applies, understand that you may not be able to obtain coverage under the group insurance plan until the next open enrollment period. Obtaining coverage in the future will be subject to administrative rules and laws in force at that time.

BASIC MEDICAL BENEFITS COMPARISON 2009-2010 (PIF: Paid in Full)

SERVICE	GROUP HEALTH CO-OP TRADITIONAL Managed Care	GROUP HEALTH CO-OP DEDUCTIBLE Managed Care	REGENGE / WEIC MODIFIED COPAY PLAN	REGENGE / WEIC ENGAGE 80 PLAN (Formerly Deductible Plan)	REGENGE WEIC HIGH OPTION	REGENGE WEIC INNOVA 500 (Formerly FourFront Plan)
Deductible	None	\$500/person \$1,500/family	\$200/person \$600/family	\$200/person \$600/family	\$200/person \$600/family	\$500/person \$1,500/family
Coinsurance maximum	\$2000/person \$4000/family	\$2000/person \$6000/family	\$2500/person \$7500/family	\$1000/person \$2000/family	\$1000/person \$3000/family	\$2500/person \$7500/family
Physicians	Primary Care Physician (PCP) referral needed for a specialist, except at GHC Specialty Centers in Seattle and Bellevue. Women may also self refer to a women's health care provider.	Primary Care Physician (PCP) referral needed for a specialist, except at GHC Specialty Centers in Seattle and Bellevue. Women may also self refer to a women's health care provider.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.
Change PCP	Anytime	Anytime	N/A	N/A	N/A	N/A
Physician's Office Visit	\$20 copay	First Four visits subject to a \$20 copay, subsequent visits are subject to copay, deductible and coinsurance.	100% after \$20 copay	80% after deductible	90% after \$20 copay	All office visits subject to a \$15 copay.
X-Ray Laboratory	Covered at 100%	Covered in full first \$500 per calendar year. Deductible, then 80%	100%, deductible waived	80%. Deductible waived for mammogram and pap smear.	90%. Deductible waived.	Covered in full first \$500 per calendar year. Deductible, then 80% thereafter.
Prescriptions Pharmacy (34 Day Supply)	\$15 copay per 30 day supply	\$15 copay generic; \$30 copay brand; per 30 day supply	\$5 copay generic formulary. \$20 copay brand formulary. Non-form: \$40.	\$10 copay generic formulary. \$15 copay brand formulary. Non-form: \$30.	\$5 copay generic formulary. \$20 copay brand formulary. Non-form: \$40.	\$5 copay generic formulary. \$20 copay brand formulary. Non-form: \$40 .
Prescriptions Mail Order (90 Day Supply)	\$30 copay per 90 day supply	\$30 copay generic \$60 copay brand per 90 day supply	\$10 copay generic formulary. \$20 copay brand formulary. Non-form: \$80.	\$20 copay generic formulary. \$30 copay brand formulary. Non-form: \$60.	\$10 copay generic formulary. \$40 copay brand formulary. Non-form: \$80.	\$10 copay generic formulary. \$40 copay brand formulary. Non-form: \$80 .
Maternity	Dr. visits \$20 copay Delivery cov 100%	Covered at 80% after deductible.	90% after deductible	80% after deductible	90% after deductible	80% after deductible
Preventive Care	\$20 copay	100%. Not subject to deductible, copay or coinsurance.	\$20 copay. No preventive care annual max.	80%, deductible waived	\$20 copay, 90% \$500 max. per calendar year.	\$15 copay. No cal. yr. max.
Emergency Outpatient	\$75 copay Non-GHC \$125 ded.	\$75 copay, then ded.& 80%. Non-GHC \$125 copay then ded. and 80%	\$75 copay, then deductible and 90%; copay waived for admission	\$75 copay, then deductible and 80%; copay waived for admission	\$75 copay, then deductible and 90%; copay waived for admission	\$75 copay, then deductible and 80%; copay waived for admission
Hospital Inpatient	Covered 100% No day or dollar limits	Covered 80% after annual deductible. No day or dollar limits	90% after deductible	80% after deductible	90% after deductible.	80% after deductible.
Ambulance	80%	80%	90% after deductible	80% after deductible	90% after deductible	80% after deductible

Please Note: All plan changes have been outlined in bold.

This benefits comparison provides general information only and is subject to plan limitations and restrictions. Refer to the plan booklets for specific coverage.

Blaine School District
Health Insurance Rates 2009-2010
(monthly rates)

	Group Health Cooperative Traditional Plan	Group Health Cooperative Deductible Welcome Plan	Regence Blue Shield WEIC Modified Copay Plan	Regence Blue Shield WEIC Engage 80 Plan	Regence Blue Shield WEIC High Option	Regence Blue Shield WEIC Innova 500
Medical						
Subscriber	\$624.21	\$399.46	\$707.23	\$567.59	\$628.89	\$378.09
Subscriber & Spouse	\$1,198.83	\$766.84	\$1,356.19	\$1,086.77	\$1,205.85	\$725.77
Subscriber & Children	\$952.47	\$609.35	\$994.14	\$796.27	\$884.02	\$586.38
Entire Family	\$1,526.06	\$976.11	\$1,643.10	\$1,315.45	\$1,460.98	\$934.06

Dental	Washington Dental Service	Vision	Northwest Benefit Network	EAP	Health Promotion Network
Entire Family	\$129.30	Entire Family	\$20.00	Employee	\$2.05

Please Note: For exclusions, limitations and clarifications see the individual plan booklets. This comparison is not a contract.

OPTION I

GROUP HEALTH COOPERATIVE TRADITIONAL PLAN

Eligible Health Care Providers	Group Health Participating Providers.
Definition of Dependent Child	Unmarried child(ren) from birth to their 25 th birthday.
Cost Containment Provisions	As specified. Refer to booklet.
MEDICAL COVERAGE	
Annual Deductible	No deductible.
General Benefits Reimbursement Formula	Most services provided in full at GHC contracted facilities except for copayments. Annual out-of-pocket limit is \$2,000 individual/\$4,000 family.
Hospital Inpatient	Covered in full.
GHC Emergency Room	\$75 copay per visit (waived if admitted).
Non-GHC Emergency Room	\$125 copay per visit (waived if admitted). Patient must notify GHC within 24 hours if admitted.
Surgery	Inpatient surgery covered in full. Outpatient surgery subject to \$20 copay.
Office Calls	\$20 copay per office visit. Hearing exams covered once every twelve months. Acupuncture visits are limited to 8 per condition per calendar year. Naturopathic visits are limited to 3 per condition per calendar year.
Diagnostic Lab & X-Ray	Covered at 100% for all covered services.
Prescription Drugs	Most drugs*, including contraceptives, prescribed by and obtained from GHC are covered with a \$15 copay per 30 day supply. Mail order - \$30 copay per 90 day supply. Formulary applies.
Ambulance	Covered at 80%. GHC initiated non-emergency transfers are covered in full.
Mental Health Inpatient Services	Covered in full up to 12 days per calendar year when referred by GHC.
Mental Health Outpatient Services	Covers a total of 20 visits per calendar year, with \$20 co-pay for individual sessions
Chiropractic	Self referral for manipulative therapy of spine by GHC contracted providers is covered to a maximum of 10 visits per calendar year with a \$20 copay per visit. Medical necessity for manipulative therapy must meet GHC protocol.
Preventive Care	Covered after a \$20 copay, including well baby care, well adult visits, according to adult/child schedules.
Vision Care	Routine eye exam covered once every 12 months, subject to a \$20 copay.
Maximum Lifetime Benefit	\$2,000,000.
Life Insurance	Not applicable.

* Under the Devices, Equipment & Supplies benefit, external insulin pumps, glucose monitors and orthopedic appliances are covered at **80%**, not subject to out of pocket maximum.

OPTION II

GROUP HEALTH COOPERATIVE DEDUCTIBLE WELCOME PLAN

Eligible Health Care Providers	Group Health Participating Providers.
Definition of Dependent Child	Unmarried child(ren) from birth to their 25 th birthday.
Cost Containment Provisions	As specified. Refer to booklet.
MEDICAL COVERAGE	
Annual Deductible	\$500 per person / \$1,500 per family
General Benefits Reimbursement Formula	After the applicable calendar year deductible has been met, services are paid at 80%. Annual out-of-pocket limit is \$2,000 individual/\$6,000 family.
Hospital Inpatient	80% coinsurance. Subject to deductible.
GHC Emergency Room	\$75 copay per visit (waived if admitted). Deductible and 80% coinsurance apply.
Non-GHC Emergency Room	\$125 copay (waived if admitted). Deductible and 80% coinsurance apply. Patient must notify GHC within 24 hours if admitted.
Surgery	Inpatient – 80% coinsurance. Outpatient, \$20 copayment, then 80%. Subject to deductible.
Office Calls	First four office visits in a calendar year: \$20 copayment, paid in full thereafter, deductible and coinsurance waived, copays do not apply toward the deductible. Fifth and subsequent visits: \$20 copayment, subject to the deductible, 80% coinsurance, copayments apply toward deductible. Hearing exams covered as medically necessary. Acupuncture visits are limited to 8 per condition per calendar year. Naturopathic visits are limited to 3 per condition per calendar year.
Diagnostic Lab & X-Ray	Covered in full for the first \$500 per calendar year. Deductible, then 80% thereafter.
Prescription Drugs	Most drugs*, including contraceptives, prescribed by and obtained from GHC are covered with a \$15 copay for generic / \$30 copay for brand name, per 30 day supply**. Mail order available with a \$30 copay for generic / \$60 copay for brand name, per 90 day supply.** The deductible <u>does not</u> apply. Formulary applies.
Ambulance	Covered at 80%**. The deductible <u>does not</u> apply.
Mental Health Inpatient Services	Services covered at 80% up to 12 days per calendar year when referred by GHC. Subject to the annual deductible.
Mental Health Outpatient Services	Covers total of 20 visits per calendar year, with \$20 copay for individual sessions. Subject to the annual deductible.
Chiropractic	Self-referral for manipulative therapy of spine & extremities by GHC providers is covered to a maximum of 10 visits per calendar year with a \$20 copay and 80% coinsurance per visit. Medical necessity for manipulative therapy must meet GHC protocol. Subject to the annual deductible.
Preventive Care	Covered, including well baby care, well adult visits, following adult/child schedules. Copay, calendar year deductible and coinsurance <u>do not</u> apply.
Vision Care	Routine eye exam covered once every 12 months, subject to a \$20 copay**. The deductible <u>does not</u> apply.
Maximum Lifetime Benefit	\$2,000,000.
Life Insurance	Not applicable.

*Under the Devices, Equipment & Supplies benefit, external insulin pumps, glucose monitors and orthopedic appliances are covered at 80%, not subject to out of pocket maximum.

**Benefits are not subject to the deductible and copays do not accrue towards the deductible: Ambulance, Durable Medical Equipment, Pharmacy, Optical Care (annual eye exam).

**OPTION III
REGENCE BLUE SHIELD WEIC MODIFIED COPAY PLAN**

Category 1 – Preferred Providers

Category 2 – Participating Providers

Eligible Health Care Providers	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence’s allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.	
Definition of Dependent Child	Unmarried child(ren) from birth to 25 th birthday.	Unmarried child(ren) from birth to 25 th birthday.
Cost Containment Provisions	Preauthorization is required for some inpatient hospitalization. Refer to booklet. Voluntary second surgical opinion.	Preauthorization is required for some inpatient hospitalization. Refer to booklet. Voluntary second surgical opinion.
MEDICAL COVERAGE		
Annual Deductible	\$200/Individual, \$600/Family. Waived for office calls.	\$200/Individual, \$600/Family. Waived for office calls.
General Benefits Reimbursement Formula	Preferred Physicians paid at 100% of allowable charges for office, home, or outpatient hospital visits after \$20 copay. Hospital facility subject to deductible, then 90%. \$2,500 (individual) / \$7,500 (family) out-of-pocket maximum; 100% thereafter.	Participating Physicians paid at 70% of allowable charges for office, home, or outpatient hospital visits after \$35 copay. Hospital facility subject to deductible, then 70% . \$2,500 (individual) / \$7,500 (family) out-of-pocket maximum; 100% thereafter.
Hospital Inpatient	Deductible, then 90%.	Deductible, then 70% .
Emergency Room	Deductible, then 90% after \$75 copay per visit; waived if admitted.	Deductible, then 70% after \$75 copay per visit; waived if admitted.
Surgery	Deductible, then professional at 100%, facility at 90%.	Deductible, then professional and facility at 70% .
Office Calls	Deductible waived. Home and office visits are paid at 100% after a \$20 copay. All other professional services subject to deductible, then paid at 100%. Acupuncture treatment is limited to 12 visits per year. Massage therapy requires a physician’s prescription.	Deductible waived. Home and office visits are paid at 70% after a \$35 copay. All other professional services subject to deductible, then paid at 70% . Acupuncture treatment is limited to 12 visits per year. Massage therapy requires a physician’s prescription.
Diagnostic Lab & X-Ray	100%; deductible waived.	70% ; deductible waived.
Prescription Drugs	At Participating pharmacies, paid in full after \$5 copay for generic formulary drugs/\$20 copay for brand name formulary drugs (34 day supply). Non-formulary drugs paid in full after \$40 copay. Mail order available with a \$10 copay for generic/\$40 copay for brand and a \$80 copay for non-formulary drugs (90 day supply).	At Participating pharmacies, paid in full after \$5 copay for generic formulary drugs/\$20 copay for brand name formulary drugs (34 day supply). Non-formulary drugs paid in full after \$40 copay. Mail order available with a \$10 copay for generic/\$40 copay for brand and a \$80 copay for non-formulary drugs (90 day supply).
Ambulance	Deductible, then 90%.	Deductible, then 90%.
Mental Disorders Inpatient	Deductible, then covered at 100% of allowable professional charges, 90% facility charges. 15 day limit per year.	Deductible, then 70% . 15 day limit per year.
Mental Disorders Outpatient	Deductible, then 100%. 25 visit/year limit.	Deductible, then 70% . 25 visit/year limit.
Spinal Manipulations	Deductible, then 100%. Limited to 12 visits per year.	Deductible, then 70% . Limited to 12 visits per year.
Preventive Care	\$20 copay, then 100%. No Annual Maximum. Deductible waived.	\$35 copay, then 70% . No Annual Maximum. Deductible waived.
Vision Care	Not covered.	Not covered.
Maximum Lifetime Benefit	\$2,000,000.	\$2,000,000.
Life Insurance	Not applicable.	Not applicable.

OPTION IV

REGENCE BLUE SHIELD WEIC ENGAGE 80 PLAN

Category 1 – Preferred Providers

Category 2 – Participating Providers

Eligible Health Care Providers Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence’s allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.

Definition of Dependent Child Unmarried child(ren) from birth to 25th birthday. Unmarried child(ren) from birth to 25th birthday.

Cost Containment Provisions Preauthorization is required for some inpatient hospitalization. Refer to booklet. Voluntary second surgical opinion. Preauthorization is required for some inpatient hospitalization. Refer to booklet. Voluntary second surgical opinion.

MEDICAL COVERAGE

Annual Deductible \$200/Individual, \$600/Family \$200/Individual, \$600/Family

General Benefits Reimbursement Formula Subject to annual deductible unless indicated. Preferred Providers paid at 80% of allowable charges thereafter. Annual out-of-pocket maximum is \$1,000/individual, \$2,000/family. Subject to annual deductible unless indicated. Participating Providers paid at **80%** of allowable charges thereafter. Annual out-of-pocket maximum is \$1,000/individual, \$2,000/family.

Hospital Inpatient Deductible, then 80%. Deductible, then **80%**.

Emergency Room 80% after \$75 copay/visit. Deductible is waived. 80% after \$75 copay/visit. Deductible is waived.

Surgery Deductible, then 80%. Deductible, then **80%**.

Office Calls Deductible, then 80% (includes acupuncture, massage therapy and naturopathic treatment). Acupuncture is limited to 12 visits per year. Massage therapy requires a prescription. Deductible, then **80%** (includes acupuncture, massage therapy and naturopathic treatment). Acupuncture is limited to 12 visits per year. Massage therapy requires a prescription.

Diagnostic Lab & X-Ray Deductible, then 80%. Deductible is waived for a preventive mammogram and pap smear. Deductible, then **80%**. Deductible is waived for a preventive mammogram and pap smear.

Prescription Drugs At Participating pharmacies, paid in full after \$10 copay for generic formulary drugs/\$15 copay for brand name formulary drugs (34 day supply). Non-formulary drugs paid in full after \$30 copay. Mail order available with a \$20 copay for generic/\$30 copay for brand and a \$60 copay for non-formulary drugs (90 day supply). At Participating pharmacies, paid in full after \$10 copay for generic formulary drugs/\$15 copay for brand name formulary drugs (34 day supply). Non-formulary drugs paid in full after \$30 copay. Mail order available with a \$20 copay for generic/\$30 copay for brand and a \$60 copay for non-formulary drugs (90 day supply).

Ambulance Deductible, then 80%. Deductible, then 80%.

Mental Disorders Inpatient Deductible, then 80%. 15 day/year limit. Deductible, then **80%**. 15 day/year limit.

Mental Disorders Outpatient Deductible, then 80%. 20 visit/year limit. Deductible, then **80%**. 20 visit/year limit.

Spinal Manipulations Deductible, then 80%. Limited to 12 per year. Deductible, then **80%**. Limited to 12 per year.

Preventive Care 80%. Deductible is waived. **80%**. Deductible is waived.

Vision Care Not covered. Not covered.

Maximum Lifetime Benefit \$2,000,000. \$2,000,000.

Life Insurance Not applicable. Not applicable.

OPTION V

REGENCE BLUE SHIELD WEIC HIGH OPTION PLAN

Category 1 – Preferred Providers

Category 2 – Participating Providers

Eligible Health Care Providers	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence's allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence's allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.
Definition of Dependent Child Cost Containment Provisions	Unmarried child(ren) from birth to 25th birthday. Refer to benefit booklet.	Unmarried child(ren) from birth to 25th birthday. Refer to benefit booklet.
MEDICAL COVERAGE		
Annual Deductible	\$200 (individual) / \$600 (family)	\$200 (individual) / \$600 (family)
General Benefits Reimbursement Formula	Preferred Physicians/Hospitals paid at 90% of allowable charges. \$1,000 (individual) / \$3,000 (family) coinsurance out-of-pocket max.; 100% thereafter.	Participating Physicians/Hospitals paid at 70% of allowable charges. \$1,000 (individual) / \$3,000 (family) coinsurance out-of-pocket maximum; 100% thereafter.
Hospital Inpatient	Subject to deductible, then covered at 90% of allowable charges.	Subject to deductible, then covered at 70% of allowable charges.
Emergency Room	\$75 copay per visit, waived if admitted. Subject to deductible.	\$75 copay per visit, waived if admitted. Subject to deductible.
Surgery	Inpatient: Subject to deductible, then covered at 90% of allowable charges. Outpatient: Subject to deductible, then covered at 90% of allowable charges (no copay).	Inpatient: Subject to deductible, then covered at 70% of allowable charges. Outpatient: Subject to deductible, then covered at 70% of allowable charges (no copay).
Office Calls	\$20 copay, then covered at 90% of allowable charges. Deductible waived.	\$35 copay, then covered at 90% of allowable charges. Deductible waived.
Diagnostic Lab & X-ray	Covered at 90% of allowable charges. Deductible waived.	Covered at 70% of allowable charges. Deductible waived.
Prescription Drugs	At Participating pharmacies, up to a 34 day supply, paid in full after: \$5 copay/formulary-generic; \$20 copay/formulary-brand; \$40 copay/non-formulary; Mail Order: (90 day supply) \$10/\$40/\$80.	At Participating pharmacies, up to a 34 day supply, paid in full after: \$5 copay/formulary-generic; \$20 copay/formulary-brand; \$40 copay/non-formulary; Mail Order: (90 day supply) \$10/\$40/\$80.
Ambulance	Subject to deductible, then covered at 90% of allowable charges.	Subject to deductible, then covered at 90% of allowable charges.
Mental Disorders Inpatient	Subject to deductible, then covered at 90% of allowable charges. Maximum of 15 days per cal. yr.	Subject to deductible, then covered at 70% of allowable charges. Maximum of 15 days per cal. yr.
Mental Disorders Outpatient	Subject to deductible, then covered at 90% of allowable charges. Maximum of 25 visits per calendar year.	Subject to deductible, then covered at 70% of allowable charges. Maximum of 25 visits per calendar year.
Spinal Manipulations	Subject to deductible, then covered at 90% of allowable charges. Maximum of 10 spinal manipulations per calendar year.	Subject to deductible, then covered at 70% of allowable charges. Maximum of 10 spinal manipulations per calendar year.
Preventive Care	\$20 copay, then covered at 90% of allowable charges. No Annual Maximum. Deductible waived.	\$35 copay, then covered at 90% of allowable charges. No Annual Maximum. Deductible waived.
Vision Care	Not covered.	Not covered.
Maximum Lifetime Benefit	\$2,000,000.	\$2,000,000.
Life Insurance	Not applicable.	Not applicable.

**OPTION VI
REGENCE BLUE SHIELD WEIC INNOVA 500 PLAN**

Category 1 – Preferred Providers

Category 2 – Participating Providers

Eligible Health Care Providers	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence’s allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.	Members may utilize Category 1 (Preferred) or Category 2 (Participating) providers from the Regence BlueShield Provider Network. Category 1 and 2 Providers agree to accept Regence’s allowance as payment in full. Regence BlueShield contracts with providers nationwide. Most services from Category 3 (Non-Contracted) providers are subject to deductible and coinsurance and these providers may balance bill members for services.
Definition of Dependent Child	Unmarried child(ren) from birth to 25th birthday.	Unmarried child(ren) from birth to 25th birthday.
Cost Containment Provisions	Refer to benefit booklet.	Refer to benefit booklet.
MEDICAL COVERAGE		
Annual Deductible	\$500 (individual) / \$1,500 (family); <i>Deductible is waived for professional services per year billed as office visits in the office, home or hospital outpatient & the first \$500 per year of outpatient diagnostic laboratory & x-ray services.</i>	\$500 (individual) / \$1,500 (family); <i>Deductible is waived for professional services per year billed as office visits in the office, home or hospital outpatient & the first \$500 per year of outpatient diagnostic laboratory & x-ray services.</i>
General Benefits Reimbursement Formula	Preferred Physicians/Hospitals paid at 100% of allowable charges (<i>for office, home, hospital outpatient & the first \$500 per year of outpatient diagnostic lab & x-ray</i>); Other Professional Services subject to deductible, then 80% of allowable charges (<i>and diagnostic lab & x-ray exceeding \$500 per year</i>). \$2,500 (individual) / \$7,500 (family) coinsurance out-of-pocket maximum; 100% thereafter.	Participating Physicians/Hospitals paid at 60% of allowable charges. \$2,500 (individual) / \$7,500 (family) coinsurance out-of-pocket maximum; 100% thereafter.
Hospital Inpatient	Subject to deductible, then covered at 80% of allowable charges.	Subject to deductible, then covered at 60% of allowable charges.
Emergency Room	\$75 copay per visit, waived if admitted. Subject to deductible.	\$75 copay per visit, waived if admitted. Subject to deductible.
Surgery	Inpatient: Subject to deductible, then covered at 80% of allowable charges. Outpatient: Subject to deductible, then covered at 80% of allowable charges (no copay).	Inpatient: Subject to deductible, then covered at 60% of allowable charges. Outpatient: Subject to deductible, then covered at 60% of allowable charges (no copay).
Office Calls	\$15 copay, then covered at 100% of allowable charges	\$30 copay, then covered at 100% of allowable charges
Diagnostic Lab & X-ray	Covered at 100% of allowable charges (<i>first \$500 per calendar year</i>) (no copay). Subject to deductible, then covered at 80% of allowable charges (<i>exceeding \$500</i>) (no copay).	Covered at 100% of allowable charges (<i>first \$500 per calendar year</i>) (no copay). Subject to deductible, then covered at 60% of allowable charges (<i>exceeding \$500</i>) (no copay).
Prescription Drugs	At Participating pharmacies, paid in full after \$5 copay for generic formulary drugs/ \$20 copay for brand name formulary drugs (34 day supply). Non-formulary drugs paid in full after \$40 copay. Mail order available with a \$10 copay for generic/ \$40 copay for brand and a \$80 copay for non-formulary drugs (90 day supply).	At Participating pharmacies, paid in full after \$5 copay for generic formulary drugs/ \$20 copay for brand name formulary drugs (34 day supply). Non-formulary drugs paid in full after \$40 copay. Mail order available with a \$10 copay for generic/ \$40 copay for brand and a \$80 copay for non-formulary drugs (90 day supply).
Ambulance	Subject to deductible, then covered at 80% of allowable charges.	Subject to deductible, then covered at 80% of allowable charges.
Mental Disorders Inpatient	Subject to deductible, then covered at 80% of allowable charges. Max. of 8 days per cal. yr.	Subject to deductible, then covered at 60% of allowable charges. Max. of 8 days per cal. yr.
Mental Disorders Outpatient	Subject to deductible, then covered at 80% of allowable charges. Maximum of 12 visits per calendar year.	Subject to deductible, then covered at 60% of allowable charges. Maximum of 12 visits per calendar year.
Spinal Manipulations	Subject to deductible, then covered at 80% of allowable charges. Maximum of 10 spinal manipulations per calendar year.	Subject to deductible, then covered at 60% of allowable charges. Maximum of 10 spinal manipulations per calendar year.
Preventive Care	\$15 copay, then covered at 100% of allowable charges. No calendar year maximum. Deductible waived.	\$30 copay, then covered at 100% of allowable charges. No calendar year maximum. Deductible waived.
Vision Care	Not covered.	Not covered.
Maximum Lifetime Benefit	\$2,000,000.	\$2,000,000.
Life Insurance	Not applicable.	Not applicable.

Basic Health of Washington

Basic Health is a low cost health insurance program offered through the State of Washington, for residents who qualify. If you qualify for a subsidized rate (depending upon total family monthly income and family size) you could receive health insurance coverage for your children at a low cost through this program (minimum of \$10.00 per month). Parents do not have to enroll in Basic Health in order to enroll their children. Anyone interested should contact Basic Health to get on the waiting list. Basic Health can be reached 1-800-660-9840 or on the Web at <http://www.basichealth.hca.wa.gov/forms.shtml>.

	Number of persons in your family (Income Table Valid from July 1, 2009 – June 30, 2010)						
	1	2	3	4	5	6	7
Gross monthly income to qualify for Basic Health	\$1,805.09 or under	\$2,428.45 or under	\$3,051.81 or under	\$3,675.18 or under	\$4,298.54 or under	\$4,921.91 or under	\$5,545.27 or under

For more information on Basic Health, please call 1-800-660-9840 or visit www.basichealth.hca.wa.gov.

Healthy Kids Now! **Healthcare for Washington's Kids**

**Do You Know a Child in Washington State Who
Needs Health Insurance?**

Free or Low-Cost Health Insurance for Kids & Teens in Washington State

Infants through teenagers can receive free or low-cost health insurance. Many families in Washington State qualify and don't know it. The programs are flexible and cover kids in many types of households. The health insurance programs cover a full range of services that all children need to stay healthy. Don't wait until someone in your family is sick.

Thousands of Kids Under 19 Are Eligible!

- Kids with single parents
- Kids with two parents
- Kids with working parents
- Kids living with grandparents or friends
- Young adults (under 19) living on their own

What Kinds of Services Are Covered?

- Doctor and nurse visits
- Hospital and emergency care
- Dental Care
- Prescriptions
- Immunizations
- Eyeglasses and hearing aids
- Physical and speech therapy
- Family planning
- Transportation for office visits
- Counseling and more!

Toll-free 1-877-KIDS-NOW (1-877-543-7669)
www.insurekidsnow.gov

MANDATORY BENEFITS FOR ALL DISTRICT EMPLOYEES

WEA DENTAL INSURANCE

WASHINGTON DENTAL SERVICE (WDS) (Policy #186)

Deductible (calendar year)	None
Preventive (Exams, X-rays, Cleaning, etc.)	70% - 100% Incentive*
Restorative (Fillings, Extractions, Crowns, etc.)	70% - 100% Incentive*
Major Care (Dentures, Partials, Bridges, etc.)	50%
Orthodontics (Children only to age 25)	50% to \$1,250 (lifetime maximum)
Implants (Pre-authorization required)	50% (applied towards annual maximum)
Temporomandibular Joint Disorder (TMJ)	\$1,000 Annual Maximum Benefit \$5,000 Lifetime Maximum Benefit
Annual Maximum Benefit	\$1,750 per person per benefit year (September 1 – August 31)
Definition of Dependent Children	Unmarried dependent children from birth to age 25

*How the Incentive Program Works:

This plan encourages regular dental care. During the first benefit year on the plan, 70% of covered benefits are paid. This advances by 10 percent annually (on September 1) to a maximum of 100% - providing you use the program at least once each benefit year. Failure to use the program once each benefit year causes your level to drop by 10% below the last level of payment, but never below the original 70%. Each eligible employee and dependent creates his or her own percentage level. Percentage levels do not affect the established constant 50% payment level for the cost of allowable prosthetics (dentures and bridges) and orthodontics.

Member Dentists:

You may select a licensed dentist. Tell your dentist you are covered by Washington Dental Service program **Group #0186**. **If your dentist is a member dentist**, your claims will be submitted directly to WDS, and no more than the filed fee can be charged. **If your dentist is not a member dentist**, it is your responsibility to have a claim form completed. You are responsible for paying the dentist's bill and for submitting the claim to WDS. Since WDS does not have filed fees for nonmember dentists, payment for services performed by a nonmember dentist is based on usual, customary and reasonable charges.

MANDATORY BENEFITS (Continued)

VISION INSURANCE

Northwest Benefit Network (Plan #WS)

There is no copayment required on materials or eye exams for either Panel (Participating) or Non-Panel Providers. Many benefits obtained from Panel Providers are covered at 100%, with a few of the exceptions listed below. For Non-Panel Providers, members pay all charges and are reimbursed up to the allowances listed below under "Non-Panel Providers". Either contacts or glasses may be obtained in a benefit period - not both. Unmarried dependent children are eligible from birth to age 25, provided they depend upon the member for support.

Payment will be made on behalf of the subscriber as follows:

	<u>Frequency</u>	<u>NBN Panel Providers</u>	<u>Non-Panel Providers</u>
Eye Exam	Every year	100%	\$35
Single Vision Lenses	Every year	100%*	\$30
Bifocal Lenses	Every year	100%*	\$40
Trifocal Lenses	Every year	100%*	\$45
Lenticular Lenses	Every year	100%*	\$90
Continuous Blend	Every year	100%**	\$40
Lens Coating, Tints, Oversize	Every year	Some covered	Not covered
Frames	Every 2 years	100%***	\$30
Elective Contacts	Every year	\$175****	\$90
Necessary Contacts	Every year	100%	\$200

*Lenses necessary to correct the visual acuity of the patient are fully covered. Specialized lenses, special features and "extras" may not be covered.

**Standard grades of 'continuous blend' lenses are covered.

***Plan pays 100% of a selection of frames; subscriber pays additional amount for more expensive frames.

****\$175 contacts allowance is for exam, fitting and lenses combined in lieu of all other services.

If a non-covered lens extra or a frame that exceeds the plan allowable is ordered, the subscriber is responsible for any additional provider charges including a small dispensing fee.

Group Health offers coverage for eye exams. Group Health subscribers can maximize their NBN contact allowance by billing their eye exam to Group Health if it is an approved Group Health provider.

Note: This is a summary and cannot cover all plan details. If you have any questions regarding your vision benefits or your eligibility for services, please refer to your vision benefits booklet or contact NBN at 800-732-1123.

STATE-MANDATED RETIREE BENEFIT

A Washington State health care reform bill enables retirees and disabled school employees to purchase health care insurance from the state Health Care Authority. In order to support the K-12 retiree health care plan, school districts are required to forward to the Health Care Authority **fifty-nine and 59/100 (\$59.59)** per month per full time employee.

LONG-TERM DISABILITY INSURANCE

CIGNA

Description: Mandatory long-term disability.

Eligibility: Mandatory coverage for all eligible district employees working 17.5 hours or more.

Benefit Amount: 60% of salary to a maximum monthly benefit of \$6,000.

Waiting Period: 90 days from the onset of disability.

CIGNA LIFE INSURANCE COMPANY

All District Employees are eligible for \$30,000 of Life insurance coverage through CIGNA. If you leave the District, convertibility to an individual policy is available. At age 70, benefit reduces by 50%.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Health Promotion Network (EAP) is a voluntary and confidential, professional assessment and referral program for employees and their immediate families (spouse and dependent children). Dependent upon the counselor's assessment of the situation, up to 4 visits can be available at no cost to the employee. The EAP offers assessments and referral sessions, short-term counseling, and 24-hour emergency consultation services. It is staffed by trained and licensed professionals. The EAP line is 715-6565 or 800-244-6142.

WORKERS COMPENSATION & OCCUPATIONAL SAFETY & ACCIDENT PREVENTION PROGRAM

The Blaine School District is an insured employer through the Washington State Department of Labor & Industries. Our occupational safety and accident prevention program applies to any work-related injury or illness. If you sustain a work-related injury, the following steps are to be followed:

- Immediately report any injury (treated or untreated) to your supervisor and complete the Accident Report Form.
- The Return to Work Release Form is to be completed by the doctor and returned to the District Claims Manager prior to returning to work.
- If time loss is required or transitional work possible a Physical Capacities Evaluation is to be completed by the doctor and returned to the District Claims Manager prior to returning to work.
- Obtain the Washington State Fund Report of Industrial Injury or Occupational Disease Form from the doctor and mail to the State. The employer portion is mailed to the district for completion of "Employer Information".

The Blaine School District's Return to Work Program is a team effort involving the injured employee, immediate supervisor, district safety officer, claims manager, personnel administrator and doctor. Should you become injured, it is important that you return to employment as early as it is medically safe for you to do so. We will stay in contact with you and your doctor to keep up to date on your recovery process. We have developed transitional duty assignments for employees who are unable to return to their normal duties while recovering from their injuries. Medical studies show that transitional work speeds the healing process.

The Blaine School District has a sick leave buy back process. Should you receive compensation from the State Fund for time off work due to an injury, bring it to the Payroll Office to buy back a portion of your sick leave.

VOLUNTARY BENEFITS FOR ALL DISTRICT EMPLOYEES

The following voluntary products are not endorsed by the Blaine School District, but are offered as benefit enhancements.

WEA SELECT AMERICAN FIDELITY*

Eligible Classes: **Voluntary short-term disability (WEA Select)**
Description: Administrative, Certificated, Clerical Classified and Non-Represented Employees
(These classes fall under the Labor & Industries code #613)
Benefit Amount: Up to 66 2/3% of your weekly income to a maximum of \$6,000 per month.
Waiting Period: 0 days for accident / 3 days for sickness.
Benefit Period: 90 days

Eligible Classes: **Voluntary short-term disability (WEA Select)**
Description: Non-Clerical Classified
(These classes fall under the Labor & Industries code #614)
Benefit Amount: Up to 66 2/3% of your weekly income to a maximum of \$6,000 per month.
Waiting Period: 0 days for accident / 3 days for sickness.
Benefit Period: 90 days
Offset for Workers' Compensation received.

**See Select Disability brochure for summary of rates, specific benefits, limitations and exclusion information for each plan.*

AFLAC SUPPLEMENTAL INSURANCE

Employees have the opportunity to select supplemental insurance coverage through AFLAC. Most policies can be paid on a pre-tax basis through payroll deduction. AFLAC provides supplemental insurance policies to help with medical and living expenses associated with serious injuries or illnesses. Policy benefits are paid directly to you, unless assigned, regardless of any other coverage you may have. Benefits cannot be reduced because of other insurance. Also, payroll rates may be retained upon retirement or job change. AFLAC policy lines include: Personal Short Term Disability, Accident, Intensive Care, Cancer Expense, Life Assurance, Dental and Personal Recovery (a policy for heart attacks, strokes and more). *NOTE: Not all benefits available in every district.* Contact Elena Johnson at (360) 676-4848 for more information.

VOLUNTARY LONG TERM CARE INSURANCE

Medical plans provide little to no coverage for long term care, from home care to nursing home care. The District offers you the opportunity to purchase long term care insurance through UNUM Insurance Company **at low group rates**. Long term care insurance provides you with benefits to pay for care when you cannot take care of yourself and need services either in your own home, an assisted living facility or a convalescent care facility. This can include short or long term rehabilitative care, which is very expensive. The coverage is available to all benefit eligible employees, spouses, parents and grandparents. **Employees, who enroll within 30 days of eligibility, are guaranteed acceptance regardless of medical conditions.** You may also enroll any year during open enrolment with medical underwriting for acceptance. All other family members require medical underwriting. This is a very flexible plan, which allows you to purchase the amount and type of coverage that makes sense for you and your family. Monthly premium depends on your age and the amount purchased.

For more information, please contact Laura Lucas at (360) 332-5881 x1719 OR you may contact the plan administrator directly: Terry Wood at Lehmann/Wood & Associates, Inc. at 800.696.1939 or www.lehmannwood.com

FLEXIBLE BENEFIT SPENDING ACCOUNTS / PLAN 125

Three Flexible Spending Accounts (FSAs) are offered in your benefit package-premium only program, dependent care expenses and un-reimbursed health care expenses. These benefits enable participating employees to reduce their income tax liability by setting aside pre-tax dollars from their earning to pay for out-of-pocket premiums, health care and dependent care costs. Consider the following reasons to participate.

Tax Advantage -This program helps you lower your taxes and thereby, increase your take-home pay.

Control -You decide how much to put in the program

Reduce the Cost of Insurance Premiums - Employees may pay certain out-of-pocket insurance premium expenses on a before tax basis, thereby reducing employee expenses. This program should be a financial benefit to almost all employees that have out-of-pocket premium, health and/or dependent care expenses.

Help with Health Care Expenses -The Health Care Flexible Benefit Spending Account helps with those unreimbursed health care expenses for you and your dependents that you normally would have to pay with after-tax dollars.

Reduced Dependent Care Cost - The flexible Benefit Spending Account will pay certain dependent care costs (e.g. daycare) with pre-tax dollars and thus reduce your out-of-pocket costs.

The premium only program is limited to dental, health, vision, insurance premiums. **The premium only plan will be automatically given to each employee.** If an employee **does not** want to participate in this program, they must sign and return an Election Form opting out by August 31. An employee cannot change or revoke this election (except for qualifying events) during the contract year. Cancellations or changes are allowed only during the next annual open enrollment period.

To take advantage of either or both of these health or dependent care programs, you must complete an application(s) and return it/them to the Payroll Office prior to March 31, 2010.

All employees currently participating in these two programs also need to submit a new application for 2010 to the Payroll Office.

FAMILY MEDICAL LEAVE ACT OF 1993 (FMLA)

The Federal Family and Medical Leave Act (FMLA) was signed into law in February 1993. The law took effect on August 5, 1993 and guarantees up to 12 weeks of unpaid leave each year to workers who need time off for birth or adoption of a child, to care for a spouse or immediate family member with a serious illness, or who are unable to work because of a serious health condition.

The FMLA is an employer law; it covers employers with 50 or more employees and affects many job-related rights of employees. Among other things, this law also affects the health benefit plans maintained by employers who are required to comply. Employers are required by FMLA to continue to provide group health benefits at the same level and under the same conditions as if the employee had continued to be actively at work. A person who fails to return from an FMLA leave may be entitled to continuation of coverage under COBRA. For specific questions, contact the personnel department or contact the Department of Labor for a copy of the FMLA law.

SCHOOL EMPLOYEE'S RETIREMENT SYSTEM

Questions regarding PERS / SERS / TRS benefit information please contact the
Department of Retirement Systems @ 800-547-6657 or 360-664-7000.
Department of Retirement Systems Internet Site Address: www.wa.gov/drs/drs.htm

CONTINUATION OF COVERAGE

If you leave the District, certain insurance coverages, which have been provided, may be continued. Should you decide to continue coverage, continuation will become effective when your current plan normally would have terminated. For additional information please refer to your plan booklet.

- 1. GROUP MEDICAL INSURANCE** - Medical insurance may be continued under COBRA. It is also convertible to a guaranteed individual policy. The benefits of the policy will vary and are usually less than provided by your group policy. Other medical plans are available on an individual basis.
- 2. GROUP DENTAL/VISION INSURANCE** – Dental and/or Vision insurance may be continued under COBRA. This is not convertible to individual policies.

Federal law requires most group health plans maintained on behalf of 20 or more employees to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain cases. A “group health plan” includes any employer-provided medical, dental, vision care, or prescription drug coverage. If you or a qualifying family member wish to provide notice of any required events affecting your COBRA coverage, or have any questions about COBRA, please contact your employer representative *Laura Lucas, Blaine School District, (360) 332-5881*.

INDIVIDUAL HEALTH COVERAGE

If you find a family member needs to come off your health plan whether due to age or cost, Meacham Financial can help. You can get affordable, quality health coverage from a variety of plans offering different coverage levels and prices. Meacham Financial represents all of the leading health carriers and short-term medical.

Call Sheri Ferguson at (425) 285-2317 / (800) 822-0822 or email sheri@meachamfi.com for a free quote and assistance in continuing to protect your family's health needs.

***** **GRAMM-LEACH BLILEY ACT OF 1999** *****
(Privacy Act)

The Gramm-Leach Bliley Act of 1999 was implemented on July 1, 2001 by all financial institutions to safe guard the privacy of individuals. This act is also applicable to insurance companies and how they conduct business with regards to applications, claims, customer service inquiries, etc.

For some circumstances, in order for the school district or their agent, Baldwin Resource Group, to act on behalf of a Blaine School District employee, a signed authorization is required. The authorization must be specific to the particular issue and must be submitted to the insurance company before the company can provide any school district personnel or Baldwin Resource Group with any information. This authorization has a 3-12 month limitation depending on the carrier.

BENEFITS ADVISORY COMMITTEE

Russell Carleton Olga Pietrantonio
Janet Mumma Allysa Bronson

ADVISORY COMMITTEE SUPPORT

Human Resources----- Allysa Bronson----- (360) 332-0712----- abronson@blainesd.org
Payroll ----- Laura Lucas----- (360) 332-0719----- llucas@blainesd.org
Insurance Consultants-- Baldwin Resource Grp 1-877-455-5640 x311--- eaustin@baldwinrgi.com

MEDICAL

Group Health Cooperative
Customer Service (www.ghc.org)
888-901-4636
Contract and Rates Renew: October 1
Annual Benefit Maximums Renew: January 1

Regence Blue Shield
Customer Service (www.wa.regence.com)
888-367-2112
Contract and Rates Renew: October 1
Annual Benefit Maximums Renew: January 1

DENTAL

Washington Dental Service
Washington Education Association
Customer Service (www.deltadentalwa.com)
800-554-1907
Contract and Rates Renew: October 1
Annual Benefit Maximums Renew: September 1

VISION

Northwest Benefit Network
Customer Service (www.nwadmin.com)
800-732-1123
Contract and Rates Renew: October 1
Annual Benefit Maximums Renew: *See below

LONG TERM DISABILITY

CIGNA
Customer Service (www.cigna.com)
800-362-4462
Contract and Rates Renew: October 1
Annual Benefit Maximums Renew: N/A

LIFE INSURANCE

CIGNA
Customer Service (www.cigna.com)
800-362-4462
Contract and Rates Renew: October 1
Annual Benefit Maximums Renew: N/A

OTHER

AFLAC – Supplemental Insurance
Elena Johnson (360) 676-4848

American Fidelity – Flexible Spending Account
Salary and Cancer Insurance
Washington Education Association
Customer Service – Regional Office
866-576-0201
Contract and Rates Renew: N/A
FSA Plan Year Renewals: April 1

Department of Retirement Systems
800-547-6657 (www.drs.wa.gov)

VEBA Service Group, LLC
Local Rep: Mike Smolko (mike@veba.org)
800-422-4023 (www.veba.org)
Benefit Questions:
888-828-4953 (Meritain Health)

Employee Assistance Program
Health Promotion Network
(www.peacehealth.org/whatcom/eap)
360-715-6565 or 800-244-6142

Unum Long Term Care
Lehmann/Wood & Associates, Inc.
800-696-1939 (terry@lehmannwood.com)
www.lehmannwood.com

*NBN Vision benefit maximums renew every 365 or 730 days after last service date, depending upon service provided.
Should you have any questions, please contact any of the above insurance carriers or our agent, Baldwin Resource Group, at 877-455-5640 - Emily Austin, ext. 311.

***If you are unable to attend the Blaine School District
Benefits Fair...***

***...many of our vendors will be attending the following
Whatcom County School District benefits fairs.***

Bellingham School District, Monday, August 31st, 2:00 – 6:00 p.m.
Kulshan Middle School
1250 Kenoyer St.
Bellingham, WA 98226

Ferndale School District, Thursday, September 3rd, 1:30-5:30 p.m.
Ferndale High School Library
5830 Golden Eagle Drive
Ferndale, WA 98248-0428

Lynden School District, Thursday, September 3rd, 2:30-5:00 p.m.
Lynden High School Cafeteria
1203 Bradley Rd.
Lynden, WA 98264

Meridian School District, Wednesday, September 2nd, 3:00-5:00 p.m.
High School Cafeteria
194 W. Laurel Rd.
Bellingham, WA 98226-9699

Mt. Baker School District, Wednesday, September 2nd, 3:00-5:30 p.m.
Mt. Baker High Cafeteria
4936 Deming Road
Deming, WA 98244-0095

Nooksack Valley School District, Tuesday, September 1st, 2:00 p.m. – 5:00pm
Nooksack Valley High School
Performing Arts Center Commons
3326 E. Badger Road
Everson, WA 98247

*Summary Prepared by Baldwin Resource Group, Inc. for the Blaine School District
765 H Street, Blaine, WA 98230, (360) 332-5881*