

Bremerton School District Employee Benefit Handbook for the 2009-2010 School Year

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I. IMPORTANT DISTRICT AND VENDOR INFORMATION

In the following section you will find important information about Bremerton School District and the vendors with whom we conduct our employee benefits business. It includes names and addresses of both District and vendor contacts.

Medical Plans	Group #	Phone #	Website/E-mail
Group Health Cooperative PO Box 34585 Seattle, WA 98124-1585	0139000	1-888-901-4636	www.ghc.org
KPS Healthplans PO Box 339 Bremerton, WA 98337	22185 - – 20044 (Enhanced) – 22044 (Basic) – 22053 (Plan 4)	1-800-552-7114	www.kpshealthplans.com
Premera Blue Cross PO Box 91080 Seattle, WA 98111 Prescriptions	8000014- – 8180200 (PPO1) – 8180202 (PPO2) BCWAPDP	1-800-932-9221	www.premera.com Plan benefit book: www.premera.com/wea

Dental Plans

Washington Dental Service PO Box 75688 Seattle, WA 98125-0688	WEA0186	1-800-554-1907	www.ddpwa.com
Standard Insurance Co. PO Box 209 Portland, OR 97207 SEIU BPEA	513916-01 513916-02	1-800-547-9515	www.standard.com
Willamette Dental 6950 NE Campus Way Hillsboro, OR 97124 SEIU ALL OTHERS	Customer Service: Appointments & Emergencies: WW10CO1-WEAFM4 WW10CT1 - WEA	1-800-360-1909 1-800-359-6019	www.willamettedental.com

Vision Plan

Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	07112406	1-800-877-7195	www.vsp.com
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Life/AD&D Plan

Standard Insurance Co. 411 108 th Avenue NE, Suite 400 Bellevue, WA 98004	644023 - A	1-800-848-5132	www.standard.com
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Long Term Disability

Standard Insurance Co. 411 108 th Avenue NE, Suite 400 Bellevue, WA 98004	644023 - B	1-800-848-5132	www.standard.com
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State Retirement**Group #****Phone #****Website/E-mail**

Dept. of Retirement Systems PO Box 48380 Olympia, WA 98504-8380 (Mandated 401(a) Plan)		1-800-547-6657	www.drs.wa.gov
Plan 3 Self Investment ICMA Retirement Corp. 777 North Capitol Street NE Washington, DC 20002-4240		Fax: 1-888-711-8773 202-962-4601	www.icmarc.org

403(b) Tax Sheltered Annuities (TSA) Administrator

PenServe Plan Services 103 Trade Zone Drive West Columbia, SC 29170		1-800-848-4001	403bservice@penserv.com
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COBRA Administrator

Planned Benefit Systems, Inc. COBRA Department, Suite 350 6377 South Revere Parkway Centennial, CO 80111		1-800-800-0133	COBRA@cci-pbs.com
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VEBA Administrator

c/o Meritain Health PO Box 27810 Minneapolis, MN 55427-0810	Plan Questions: Account Questions:	1-800-422-4023 Brian Riehs 1-888-828-4953 Meritain Health	www.veba.org
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Health Care Authority

PEBB Health Care Benefits (Upon retirement)		1-800-200-1004	www.wa.gov/hca/pebb
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Social Security Administration

For name changes and related items		1-800-772-1213	www.ssa.gov
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Deferred Compensation Group # Phone # Website/E-mail

Dept. of Retirement Systems PO Box 40931 Olympia, WA 98504-0931		1-888-327-5596	www.wa.gov/DRS/dcp
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Employee Assistance Program

First Choice Health 601 Union Street, Suite 1100 Seattle, WA 98101	TDD:	1-800-777-4114 1-800-777-4939	www.firstchoicceap.com
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Voluntary Life

Standard Insurance Co. 411 108 th Avenue NE, Suite 400 Bellevue, WA 98004	644023	1-800-848-5132	www.standard.com
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Voluntary AD&D

Standard Insurance Co. 411 108 th Avenue NE, Suite 400 Bellevue, WA 98004	644023	1-800-848-5132	www.standard.com
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Voluntary Short Term Disability

American Fidelity Assurance PO Box 25160 Oklahoma City, OK 73125	Claims Fax:	1-800-662-1113 1-800-818-3453	www.afadvantage.com
Local contact: Paul Loweecey	Enrollment	1-866-576-0201 Ext. 52	paul.loweecey@af-group.com
AFLAC 36991 Madrona Blvd Hansville, WA 98340 Attn: Holly Adams	22392 Fax:	360-638-1622 360-638-2498	urcvrdha@aol.com

Long Term Care

Prudential Financial 601 Union Street, Suite 3525 Seattle, WA 98101		1-800-732-0416	www.prudential.com/gltc
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Pre Paid Legal Services

Pre Paid Legal Services PO Box 464 Manchester, WA 98353 Attn: Cheryl Stevens		360-551-2901	clsteve@juno.com
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Cancer Insurance

American Fidelity Assurance PO Box 25160 Oklahoma City, OK 73125	Claims Fax:	1-800-662-1113 1-800-818-3453	www.afadvantage.com
Local contact: Paul Lowecey	Enrollment	1-866-576-0201 Ext. 52	paul.lowecey@af-group.com
AFLAC 36991 Madrona Blvd Hansville, WA 98340 Attn: Holly Adams	22392 Fax:	360-638-1622 360-638-2498	urcvrdha@aol.com

Flexible Spending Accounts

American Fidelity Assurance PO Box 25510 Oklahoma City, OK 73125	Claims Fax:	1-800-325-0654 1-800-543-3539	
Local contact: Paul Lowecey	Enrollment	1-866-576-0201 Ext. 52	paul.lowecey@af-group.com

If you have difficulty obtaining answers to questions or resolving coverage or claim issues through the numbers previously listed, call:

Insurance Broker/Consultant

John Wallen or Christina Buchholz DiMartino Associates, Inc. 1301 Fifth Avenue, Suite 3701 Seattle, WA 98101		1-800-488-8277 206-623-2430 Fax: 206-682-8027	john@dimarinc.com christina@dimarinc.com
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For questions related to working contract wording, contract compliance, rate of pay, work schedule changes, initial benefit enrollment or other personnel issues contact:

Personnel

Bremerton School District	Fax:	360-473-1020	
Gerrylee Garrett-Classified Judy McKinsey-Certificated		360-473-1023 360-473-1021	gerrylee.garrett@bsd.wednet.edu judy.mckinsey@bsd.wednet.edu

For questions related to reimbursement for approved mileage, travel, meals, supplies and materials contact:

Business Office

Bremerton School District	Fax:	360-473-1041	
Diana Brandvold		360-473-1032	diana.brandvold@bsd.wednet.edu

For questions related to time sheets, leave, payroll deductions, retirement contributions, benefit enrollment changes, coverage or claims issues and any other payroll questions contact:

Payroll

Bremerton School District	Fax:	360-473-1045	
Christina McGaughey	<u>Location</u> MVMS, CH, NA, KL, AJ, ADMIN, CNS, CUSTODIANS	360-473-1038	christina.mcgaughey@bsd.wednet.edu
Wanda Liner	BHS, VR, WH, REN, TRANSP, MAINT, WSTSC	360-473-1039	wanda.liner@bsd.wednet.edu
Alicia Vasquez	Clerical Asst.	360-473-1048	alicia.vasquez@bsd.wednet.edu

II. ENROLLING IN THE PLANS

This section describes when you are eligible for coverage and who may be covered.

A. COVERAGE FOR YOURSELF

In order to be eligible to participate in any of the District's employee benefit programs you must meet the minimum requirements as established by the District, and, in some instances, the insurers. These are summarized below:

- You must work at least a .5 FTE. If you are a member of the Certificated Staff that means a minimum of 18.75 hours per week. If you are a Classified employee or administrator this means a minimum of 20 hours per week. You must be scheduled to work every school day for the full school year or from your date of hire to the last day of school.
- If you are hired on or before the 10th of the month, your mandatory coverages are effective the first day of the following month. Enrollment forms must be submitted to the Payroll Office by the 15th of the month in which you are hired. You are also eligible for optional medical coverage effective the first day of the following month.
- If you are hired after the 10th of the month, your mandatory coverages are effective the first day of the second following month. Enrollment forms must be submitted to the Payroll Office by the 15th of the month following your date of hire. You are also eligible for optional medical coverage effective the first day of the second following month.

You must turn in your mandatory and optional medical enrollment forms in a manner which meets the deadline for coverage as of the date of your first eligibility for coverage. Failure to do so will cause your coverage for dental to default to the non-HMO Dental plan and coverage for only yourself in both vision & dental. You will then not be eligible to enroll in optional medical or to add your existing dependents until the next September open enrollment. Premiums are paid in advance (i.e.; September 30 payroll deductions pay for the month of October coverage).

If you waive enrollment into an optional medical plan because you are covered by another plan, you may be eligible for a special open enrollment period should you lose such coverage. The special open enrollment period would begin on the date of your loss and run for 30 days. If you miss the 30 day deadline you will not be eligible to enroll in a medical plan until the next September open enrollment period.

B. COVERAGE FOR DEPENDENTS

Many of the programs allow for your family members to participate as well. These include: medical, dental and vision. The following family members are considered eligible dependents:

- Your legal spouse;

- Unmarried dependent children under age 25 (age 19 or 25 if a full-time student for voluntary AD&D) who are primarily dependent upon you for support. This also includes your stepchildren and adopted children;
- Children who are physically or mentally unable to take care of themselves are also eligible beyond the limiting age. The insurers have the right to periodically ask for proof of incapacity.

C. ADDING NEW DEPENDENTS

September is Open Enrollment for the District's benefit plans. With few exceptions, this is the only time you may enroll yourself or eligible family members. The exceptions to this rule are detailed below. You may also want to discuss your situation with Personnel or Payroll.

- *You or your family members lose coverage under another group plan.* You have a special open enrollment period of 30 days beginning from the date the coverage is lost;
- *You become married during the year.* Again, you have a 30 day special open enrollment period;
- *You have a new child by birth, adoption or marriage.* This allows for a 60-day special open enrollment period beginning from the date you have the new child.

D. MAINTAINING DISTRICT PAID BENEFITS

In order to maintain District-paid benefits, you must work or be on paid leave for at least 50% of your normal assigned working days in any given month. In any month you fail to do so, your District-paid benefits will not be available for the following month and you will be responsible for their full cost. The premiums will automatically be taken as a payroll deduction. **You will receive NO notification.** Therefore, it is in your best interest to monitor your leave without pay. You must notify the Payroll Office, in writing, if you do not want to pay your own premiums and you choose to forfeit any or all coverages in that month. Please note - If a lapse in coverage should occur, you may be required to wait until the next open enrollment period to re-enroll and if your coverage should lapse for more than 63 calendar days, your coverage may be subject to the pre-existing conditions language of the particular plan in which you enroll.

For example, if during the month of May you have leave without pay for 10.5 of the 20 working days, you will be responsible for paying the premiums on the June payroll.

If terminating employment and you have completed your current school year assignment and request a total payoff of your remaining pay prior to August 31st, your District-paid benefits will end on the last day of the month following your payoff. The earliest you may request a payoff is July.

III. OPTIONS FOR CONTINUING COVERAGE AFTER ELIGIBILITY ENDS

There are certain conditions under which you may be allowed to continue in many of the plans after your eligibility would normally end. These are outlined below.

A. CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The federal law known as COBRA allows you and/or your family members to continue coverage for *medical/dental/vision* if coverage is lost for any of the following reasons:

- Termination of employment (see next page for temporary involuntary termination provisions)
- Reduction in hours
- Medicare Entitlement of a covered employee
- Divorce or legal separation, (Spouse & Children only)
- Death of the employee (Spouse & Children Only)
- When a child ceases to meet the criteria to be defined as a dependent

Coverage may be continued for up to 18 months when the loss of coverage is for termination of employment or a reduction in hours. When loss of coverage is caused by Medicare entitlement, divorce or legal separation, death of the employee or a child reaching the maximum age, coverage may be continued up to 36 months. For an employee who loses coverage because of termination or a reduction of hours and is disabled during the first 60 days of COBRA continuation coverage, the maximum coverage may be extended an additional 11 months for a total of 29 months. In order for this to apply, you must be disabled as determined by the Social Security Act and notify Planned Benefit Systems, Inc. within 60 days of receiving such notice of disability from Social Security.

Coverage is on a self-pay basis only. You must pay premiums within 30 days of the due date. Premiums are mailed directly to: Planned Benefit Systems, Inc. (see page 2 for the address and phone number). In some instances, the maximum coverage period can be reduced and coverage end. These are listed below:

- The District no longer provides benefit plans for active employees;
- You fail to pay your premiums on a timely basis;
- You become covered under another group health plan (unless you are subject to some limitation for pre-existing conditions under that new plan);
- You become entitled to Medicare;

- You are determined to no longer be disabled after receiving the 11 month disability extension under Social Security (i.e.: the determination occurs between the 19th and 29th month of coverage).

You must notify the Payroll Office within 30 days of a change in your marital status or when a dependent child loses eligibility (i.e.: turns the limiting age or under the limiting age and gets married or joins the military). Upon occurrence of a COBRA qualifying event, Planned Benefit Systems, Inc. will provide you or your affected family member with a written notice of your rights and responsibilities.

Special Temporary COBRA Provisions provided under the American Recovery and Reinvestment Act of 2009 – Read carefully!!!

Under the new American Recovery and Reinvestment Act of 2009, there are special temporary provisions which allow for employees who are involuntarily terminated by the District to be eligible for a 65% subsidy of health insurance premiums for up to nine months. Following is a summary of the new law and how it impacts you.

You are eligible for the subsidy if you were/are involuntarily terminated between September 1, 2008 and December 31, 2009. You are eligible even if you initially declined COBRA between September 1, 2008 and March 1, 2009. You are not eligible for the subsidy if your income is greater than \$125,000 (\$250,000 if filing jointly), eligible for Medicare or eligible for coverage under another group plan (such as a spouse's plan).

The subsidy may last up to nine months. The subsidy ends after nine months although you may continue coverage under COBRA for the balance of the 18 month extension at your own cost. The subsidy can end before nine months if you either become eligible for Medicare or for another group plan (such as a spouse's plan).

For additional information, please contact the District's COBRA administrator, Planned Benefit Systems at 1-800-800-0133 or our benefits consultants, DiMartino Associates, Inc. (John Wallen/Christina Buchholz) at 1-800-488-8277 or refer to:

www.dol.gov/COBRA

B. FAMILY MEDICAL LEAVE ACT (FMLA)

FMLA allows you to continue all of your benefits for up to 12 weeks in the event of a serious illness of yourself or family member. To be eligible for FMLA, you must have 12 months of employment with the District and worked a minimum of 1,250 hours during the preceding 12 months.

To qualify as a serious illness, at least one of the following criteria must be met:

- Requires continuing treatment from a health care provider;

- Requires absence from work or daily activities for more than 3 days;
- Treatment for pregnancy or chronic diseases (i.e., diabetes) even if treatment requirements are less than 3 days;
- Medical treatments that are not usually incapacitating on a day-to-day basis such as dialysis, chemotherapy, radiation and chronic arthritis;
- Mental illness/conditions may qualify.

For maternity leave, you are allowed to use sick leave for the full disability period. The 12 weeks of FMLA will begin at the end of the disability period or the day you run out of sick leave, whichever occurs first.

It is important to notify the District within 30 days or as soon as practical of any foreseeable leaves for births, adoptions or planned medical treatment.

You must continue to pay your portion of any contributions to the plans you would have been required to make should you have continued active employment. Finally, should you decide not to return to work after FMLA leave ends, the District is allowed to recover the costs of health premiums paid on your behalf during the leave.

If you have additional questions about FMLA, please contact the Personnel Office.

C. CONTINUATION OF COVERAGE UNDER *USERRA*

If you leave employment with the District for uniformed service, you may elect to continue medical coverage under the Plan, in accordance with the Uniformed Services Employment and Reemployment Act (*USERRA*). You are responsible for giving the Payroll or Personnel Office notice when you leave for uniformed services and you must elect and provide payment to continue medical coverage under *USERRA*. If you fail to elect or make payments as described below, your eligibility for coverage will end as it normally would under the terms of District policy.

You must notify the Payroll Office if electing to continue coverage under the provisions of *USERRA* within 60 days of your departure. The District will provide you an election form once we have been notified. You will have 60 days from the latter of your loss of coverage or the date election information is sent to you to elect coverage. You have 45 days from the date you elect coverage to pay all currently due premiums. After that initial payment, premiums must be received within 30 days from the beginning of the month to be covered.

You may continue coverage until one of the following occurs:

- You complete 24 months of active coverage,
- The last day of the month following in which you fail to return to employment or apply for a position of reemployment as required under *USERRA*,

- The last day of the month in which you fail to make the required premium payments.

You have the right to elect COBRA coverage in lieu of USERRA. The length of coverage may be different with COBRA so review carefully before making a choice.

You should contact Payroll if you have questions about USERRA continuation of coverage.

D. DISTRICT APPROVED LEAVES OF ABSENCE

Under certain conditions, you are allowed to take a District-approved leave of absence of up to 12 months. During that leave you may continue many of your benefits on a self-pay basis.

Checks must be received in the Payroll office by the 20th of the month prior to the month of coverage. You will receive notification from the Payroll office detailing premium payment amounts and payable information. Failure to make timely payment will result in coverage being cancelled back to the last day of the month for which you made timely payment.

While on a leave of absence you may choose to continue coverage for medical, dental, vision, life and disability. In addition, you may also continue coverage for voluntary life, voluntary accidental death and dismemberment and voluntary short-term disability.

Should you elect not to continue coverage during your leave of absence, you may need to complete re-enrollment forms when you return to work. Also, some plans may require a new waiting period or may institute a pre-existing condition clause.

Finally, while on a leave of absence you retain the right to add or drop dependents and change plans during Open Enrollment.

Contact the Personnel Office if you have specific questions related to requesting a leave of absence.

E. RETIREE COVERAGE

The following plans are available to you for a lifetime as opposed to the COBRA plans which are available for only 18 (or 29) months:

1. Washington State Public Employees Benefit Board (PEBB)

PEBB offers medical only or medical and dental plans to employees who have been approved to draw a retirement benefit from the Washington State Department of Retirement. You may choose to elect coverage with the PEBB immediately upon retirement or, if you can be covered under a spouse's plan or want to continue your District coverage under the COBRA laws, you may defer your coverage with the PEBB until a later date. You may also reject your lifetime benefit with the PEBB. Whatever your choice, you need to inform the PEBB

within 60 days of your last date of active employment. Failure to communicate timely with the PEBB will be deemed as a rejection and loss of your lifetime benefit. To obtain the retiree information packet and forms, please contact The Health Care Authority at (800) 200-1004.

2. WEA Select Retiree Dental Plan

A PPO Dental plan is available to any retiring school district employee. The plan is administered by Washington Dental Service (WDS). To be eligible, a retiree and any eligible dependents must transfer directly from an active school district plan or COBRA coverage with no break in coverage. Your enrollment application must be submitted a minimum of eight (8) weeks prior to the termination of your active coverage. If you choose to not enroll in one of the PEBB medical plans, or if you elect a PEBB medical and decline the PEBB dental plan, you can still enroll in the WEA Select Retiree Dental Plan immediately following termination of active coverage. Enrollment materials can be requested from WDS at (800) 554-1907. If you have any questions, contact WDS at the above number or AON Consulting at (206) 467-4646.

F. COVERAGE DURING A LABOR DISPUTE

Washington state law allows for the continuation of benefits on a self-pay basis during a labor dispute. Checks are turned into the Payroll Office. The maximum extension is six months; however, this is also a "qualifying event" under COBRA which provides a continuation option that may be longer.

IV. PAYROLL PROCESSING AND POOLING

This section includes descriptions of how payroll is processed, the Payroll processing schedule and how pooling works.

A. PAYROLL PROCESSING SCHEDULE

Time sheets are due on the 10th of each month. Paydays are always the last banking day of the month. Please note that contract pay is spread over 12 months. Feel free to contact the Payroll Office with any questions.

TIME SHEET PERIOD*	TIME SHEETS DUE	PAY DAY**
August 1 st – 31 st	September 10	September 30
September 1 st – 30 th	October 10	October 31
October 1 st – 31 st	November 10	November 30
November 1 st – 30 th	December 10	December 31
December 1 st – 31 st	January 10	January 31
January 1 st – 31 st	February 10	February 28
February 1 st – 28 th	March 10	March 31
March 1 st – 31 st	April 10	April 30
April 1 st – 30 th	May 10	May 31
May 1 st – 31 st	June 10	June 30
June 1 st – 30 th	July 10	July 31
July 1 st – 31 st	August 10	August 31
* For Time sheet pay and leave purposes only		
** Contract pay is spread evenly over 12 months beginning September 30		

B. DIRECT DEPOSIT

Bremerton School District has Mandatory Direct Deposit. Washington state law allows employers of our size to make this decision. This is a convenient system providing automatic deposit of your net pay into your checking or savings account each payday. You gain because direct deposit lessens the chance of your pay warrant being lost or stolen. It will save you time and the trouble of a trip to the bank. You can have access to your pay on payday, even when you may be out of town. In addition, direct deposit of employees' pay increases financial and time efficiencies for the District.

With Direct Deposit, you authorize the Bremerton School District to deposit your net pay to your checking or savings account. Authorization consists of an enrollment form and a voided check (a deposit slip, if it is a savings account). Depending on when the payroll office receives your authorization; enrollment can take two payrolls to process. In the event this happens, the first month, a "check" will be mailed to your home, while the Payroll Office processes a test run of your direct deposit. The second month, the Payroll Office will process your pay and will ensure your pay is deposited and available to you at the opening of business on payday.

You will receive a detailed earnings statement on (or before) payday. The earnings statement also serves as your notification of deposit.

C. POOLING

Under Washington law, all K-12 employees who are eligible for benefits are funded at the rate of \$745.00 per full-time equivalent (FTE). The state benefit dollars are reduced by the portion designated as the Health Care Authority (HCA) Retiree "Carve Out". The amount of the "carve out" is set by the HCA but the funding formula is determined by agreement between the District and each pooled group. The current formula requires the District to pay the first \$45.50/month/FTE. Any required subsidy above the \$45.50/month/FTE will be paid one-half from the state benefit dollars and one-half by the District. The 2009/2010 Retiree Carve Out is \$59.59. Therefore, the benefits fund is reduced by \$7.04 ($\$59.59 - \$45.50 \times .50$) per 1.0 FTE. The net amount available to each 1.0 FTE employee is \$737.96 a month. If you are a .5 FTE you will receive \$368.98 ($\$737.96 \times .5$), a .75 FTE will receive \$553.47 ($\$737.96 \times .75$), etc. Each employee is required to first apply their monies to the District's mandatory benefits (i.e.: dental, vision, life, long-term disability). If he/she chooses an "optional" medical plan, the remaining monies can be applied to the medical premium. If an employee does not use all of his/her apportionment, the unused portion is put into a "pool." The amount in the pool is split evenly between the employees in the same pooling group whose medical premium exceeds the amount available to him/her.

The amount of pooling dollars available to a specific individual can vary by bargaining unit. Factors that can influence the value include the level of core benefits and costs by a collective bargaining unit, demographics of that group as well as the number of full-time equivalent (FTE) employees within that group.

Pooling is calculated in the months of September, October, January and April. Once the monies are distributed there are no changes until the next pooling period. As a new hire, your start date will determine when you are included in the pooling. If you add a new dependent outside of the pooling months, you will be responsible for the full increase in premiums until the next pooling month. Please be aware, as in all pooling periods, pooling dollars may not be enough to cover the increased premiums.

Please contact your pooled group or consult your particular CBA (collective bargaining agreement) for more precise information regarding the amount of your pool dollars. Currently, the pooled groups at Bremerton School District are:

- ABA
- BEA
- WSTSCEA
- BPEA
- SEIU
- Exempt Administrators
- Other non-represented Employees

See pages 38 through 41 for the 2009-2010 premium rates and a worksheet to estimate your out-of-pocket expenses.

D. EXPLANATION OF PAYROLL EARNINGS STATEMENT

Please contact the Payroll Office if you have any questions.

Employee Name	SSN	Tax Exemptions	Period End	Check Date	Location	Number
Doe, John Q.	XXX-XX-XXXX	FEDM-OWAM-0	7/31/2009	7/31/2009	102	45921

Payments	Rate	Current		YTD Amount	Contract	
		Hours	Amount		Amount	Balance
BASIC			5,407.25	5,407.25	64,887.00	5,407.25
PREP/TRAIN DAYS			267.40	267.40	3,208.70	267.39
CLASRM OVERLOAD			100.00	100.00		
REGULAR PAY			0.00	34,307.35		
Totals		0.00	5,774.65	40,082.00	68,095.70	5,674.64

Deductions	Current Amount	YTD Amount	PreTax
FED INC TAX	542.11	3,877.55	
125/KPS-KPS HEA	360.43	360.43	
FICA	335.68	2,328.62	
TRS PLAN 2	246.01	1,715.29	
LIFE EE-STANDAR	102.00	102.00	
BEA DUE-.76-1.0	89.92	89.92	
MEDICARE	78.51	544.60	
STD SAL-WEA/APA	51.70	51.70	
WORKERS' COMP	5.07	35.44	
MISC DEDUCTIONS	6.00	3,666.78	NA
Totals	1,817.43	12,772.33	

Benefits	Current Amount	YTD Amount
125/KPS-KPS HEA	703.32	703.32
TRS PLAN 2	488.52	488.52
FICA	335.68	2,328.62
125 WDS-WEA/APA	111.20	111.20
MEDICARE	78.51	544.60
HCA-HEALTH CARE	60.40	60.40
WORKERS' COMP	45.90	321.36
LTD 1/4-STANDAR	27.20	27.20
125 VSP-VISION	23.29	23.29
LIFE 1/-STANDAR	11.34	11.34
Totals	1,885.36	4,619.85

Time Off Info	Beg. Bal.	Added	Used	Current	Unit
SICK LEAVE	0.00	345.00	0.00	345.00	Hours

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	Current Amount	YTD Amount
Gross Pay	5,774.65	40,082.00
Pre-Tax Deductions	- 606.44	4,238.78
Taxable Wages	5,168.21	35,843.22
Federal Tax	- 542.11	3,877.55
State Tax	- 0.00	0.00
FICA/Medicare	- 414.19	2,873.22
Other Deductions	- 254.69	1,782.78
Reimbursed	+ 0.00	0.00
Net Pay	3,957.22	27,309.67

V. MEDICAL PLAN INFORMATION

In this section is a brief description of the medical plans available to you and your eligible family members through Bremerton School District. At the back of this section is a benefit comparison of the plans for your use.

A. KPS HEALTH PLANS (*KPS*)

The Basic Plan has a deductible of \$200 per person/\$600 per family. After the deductible, benefits are paid at 80% of the next \$12,500 (\$2,500 out-of-pocket) and 100% thereafter. Therefore, your maximum out-of-pocket expense is the deductible plus \$2,500 per person (limited to \$7,500 per family). Coverage includes physicians, hospital, alternative care providers, and prescription drugs (subject to co-pays).

The Enhanced Plan has no deductible. Benefits are paid at 80% of the first \$6,000 (\$1,200 out-of-pocket) and 100% thereafter. Therefore, your maximum out-of-pocket expense is \$1,200 per person (\$3,600 per family). Coverage includes: physicians, hospital, alternative care providers, and prescription drugs (subject to co-pays).

Plan 4 is a scaled down version of the above offerings and is intended for those employees who are willing to share an increased cost-sharing risk with claims expenses in exchange for lower premium contributions. The plan has a \$500 per person deductible along with higher out-of-pocket expenses, higher office visit co-pays, a separate prescription drug deductible and adds co-pays to hospital stays. Please refer to the Benefit Comparison on pages 18 through 23 for details.

All three plans encourage the use of participating providers. It is a broad list which may be obtained from KPS or by accessing their web site at www.kpshealthplans.com. Claims are paid at the local KPS Bremerton office.

B. GROUP HEALTH COOPERATIVE (*GHC*)

Group Health Cooperative (GHC) offers employees a staff-model health maintenance organization (HMO). All care must be provided by or arranged through a GHC provider. The plan has no deductibles and most benefits are provided in full after applicable co-pays. The out-of-pocket maximum is \$2,000 per person, \$4,000 per family. Office visits are subject to \$10 co-pays. Prescriptions are also subject to a \$10 co-pay.

GHC is principally located in Seattle, WA. It serves members through a variety of clinics and hospitals. Locally, GHC contracts with Harrison Hospital and a few local physicians. They also maintain their own clinics in Poulsbo, Silverdale and Port Orchard.

C. *WEA/PRENERA BLUE CROSS (PBC)*

The WEA sponsors two plans (PPO 1 and PPO 2) that are underwritten by Premera Blue Cross (PBC). You can also access your benefits online at www.premera.com/wea.

The PPO 1 plan has a deductible of \$50 per person/\$150 per family. Office visits for preferred physicians are paid at 100% after a \$20 co-pay (a \$25 co-pay for non-preferred). Most other services from preferred physicians are paid at 90% and non-preferred at 70%. Prescriptions are subject to co-pays with discounts for using the PBC mail order program through Paid Prescriptions, Inc. Payment defaults to 100% once the plan has paid \$4,000 in benefits.

The PPO 2 plan has a deductible of \$100 per person/\$300 per family. Office visits for preferred physicians are paid at 100% after a \$25 co-pay (a \$30 co-pay for non-preferred). Most other services from preferred physicians are paid at 80% and non-preferred at 60%. Prescriptions are subject to co-pays with discounts for using the PBC mail order program through Paid Prescriptions, Inc. Payment defaults to 100% once the plan pays \$5,500 in benefits.

Premera Blue Cross uses a broad network of preferred and participating providers in its Heritage +1 network. Approximately 85% of the state's physicians participate. A provider listing may be obtained directly from Blue Cross or by accessing www.bluecares.com and linking to Premera Blue Cross. Claims are paid in Seattle.

D. OPEN ENROLLMENT EXCEPTIONS FOR PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

Under a new insurance law enacted in Washington, when the Washington State Department of Social and Health Services (DSHS) determines it is more cost-effective for an employee and/or dependents who are eligible for state medical assistance to enroll on an available group-sponsored plan, a notice of eligibility will be issued to the employee to take to Bremerton School District.

If such an employee and/or dependent is eligible to enroll on this plan (for example, the employee has met the probationary period and works the hours required for employee coverage), the employee and/or dependent must be enrolled outside of the normal September open enrollment period. Coverage for these members will begin the first of the month following receipt of the enrollment application.

BREMERTON SCHOOL DISTRICT
COMPARISON OF MEDICAL PLAN BENEFITS 2009-2010 School Year

	KPS Basic	KPS Enhanced	KPS Plan 4	GROUP HEALTH	PREMERA BLUE CROSS PLAN 1	PREMERA BLUE CROSS PLAN 2
<u>Provider Choice</u>	Full contract benefits apply from participating providers with KPS. Non-participating providers are paid at 75% of the amount paid to participating providers.	Full contract benefits apply from participating providers with KPS. Non-participating providers are paid at 75% of the amount paid to participating providers.	Full contract benefits apply from participating providers with KPS. Non-participating providers are paid at 75% of the amount paid to participating providers.	Unless noted or indicated, all must be provided by GHC staff to be covered.	Any licensed provider worldwide (except as stated). Only Preferred and Participating Providers agree not to bill for amounts over the allowable charge.	Any licensed provider worldwide (except as stated). Only Preferred and Participating Providers agree not to bill for amounts over the allowable charge.
<u>Lifetime Maximum</u>	\$5,000,000	\$5,000,000	\$2,000,000	N/A	\$5,000,000 (revolving each 5 years)	\$5,000,000 (revolving each 5 years)
<u>Deductible</u>	\$200 per person \$600 per family	None	\$500 per person \$1,500 per family	None	\$50 per person \$150 per family	\$100 per person \$300 per family
<u>Dependent Limiting Age</u>	Age 25	Age 25	Age 25	Age 25	Age 25	Age 25
<u>Benefit Year</u>	Oct - Sept	Oct - Sept	Oct - Sept	Jan - Dec	Jan - Dec	Jan - Dec
<u>Payment Level</u>	80% of \$12,500, 100% thereafter	80% of \$6,000, 100% thereafter	In Network: 80% of the first \$25,000 Out of Network: 80% of the first \$50,000 and 100% thereafter	Most services provided in full after \$10 co-pay.	Preferred: 90% Non-Preferred: 70% to \$4,000 in plan payments then 100% thereafter All payments subject to allowable charges.	Preferred: 80% Non-Preferred: 60% to \$5,500 in plan payments then 100% of allowable thereafter. All payments subject to allowable charges.
<u>Out-of-pocket</u>	Deductible plus \$2,500 per person \$7,500 per family	\$1,200 per person \$3,600 per family	In Network: \$5,000 per person/\$15,000 per family. Out of Network: \$10,000 per person/\$30,000 per family	\$2,000 per person/\$4,000 per family	The out-of-pocket can vary depending on the use of preferred and non-preferred providers. (see payment level)	The out-of-pocket can vary depending on the use of preferred and non-preferred providers. (see payment level)
<u>Physician Services</u>						
<u>Office Calls</u>	\$20 co-pay, then 100%	\$15 co-pay, then 100%	\$30 co-pay, then 100%	\$10 co-pay, then provided in full	100% of Allowable after \$20 co-pay Preferred/\$25 Non-Preferred	100% of Allowable after \$25 co-pay Preferred/\$30 Non-Preferred

BREMERTON SCHOOL DISTRICT
COMPARISON OF MEDICAL PLAN BENEFITS 2009-2010 School Year (continued)

	KPS Basic	KPS Enhanced	KPS Plan 4	GROUP HEALTH	PREMERA BLUE CROSS PLAN 1	PREMERA BLUE CROSS PLAN 2
Surgical	Deductible, then 80%	80%	Deductible, then 80%	Provided in Full	Preferred: 90% Non Preferred: 70%	Preferred: 80% Non Preferred: 60%
Hospital	Deductible, then 80%	80%	Deductible, then \$350/day co-pay (5 day max /admit) then 80%	Provided in Full	Preferred: 90% Non Preferred: 70%	Preferred: 80% Non-Preferred: 60%
Maternity	Deductible, then 80%	80%	Same as any other care	Provided in Full	Preferred: 90% Non Preferred: 70%	Preferred: 80% Non-Preferred: 60%
Hospital Room & Board	Deductible, then 80%	80%	Deductible, then \$350/day co-pay (5 day max /admit) then 80%	Provided in Full	\$100 per day co-pay (\$300 max per person per calendar year), then 90% Preferred 70% Non-Preferred	\$150/day co-pay (\$450 max per person per calendar year) then 80% Preferred Or 60% Non-Preferred
Ancillary Charges	Deductible, then 80%	80%	Deductible, then \$350/day co-pay (5 day max /admit) then 80%	Provided in Full	Included Above	Included above
Emergency Room	\$75 co-pay, then 100%	\$75 co-pay, then 100%	80% after \$150 co-pay	Provided in Full after \$75 co-pay, \$125 co-pay at non-GHC facility	See "Payment Level" (subject to a \$75 co-pay)	See Payment Level (subject to \$75 co-pay)
Outpatient Surgery	Deductible, then 80%	80%	80% after \$350 co-pay	\$10 co-pay then provided in Full	\$50 co-pay then 90% Preferred 60% Non-Preferred	\$100 co-pay then 80% Preferred or 60% Non-Preferred
Other Benefits						
Ambulance	Ground Ambulance to \$2,000 per year Air Ambulance to \$5,000 per trip.	Ground Ambulance to \$2,000 per year Air Ambulance to \$5,000 per trip.	Paid at 80%; Ground Ambulance to \$2,000 per year Air Ambulance to \$5,000 per trip	Paid at 80%	Paid at 80%	Paid at 70%
Accident	Deductible waived, then same as any other care	Same as any other care	Deductible waived, then same as any other care	\$75 co-pay at GHC facility; \$125 co-pay non-GHC facility (waived if admitted to hospital)	100% after \$75 co-pay (waived if admitted to the hospital within 72 hours) for 1 st 7 days following accident	100% after \$75 co-pay (waived if admitted to the hospital within 72 hours) for 1 st 7 days following accident

***BREMERTON SCHOOL DISTRICT
COMPARISON OF MEDICAL PLAN BENEFITS 2009-2010 School Year (continued)***

	KPS Basic	KPS Enhanced	KPS Plan 4	GROUP HEALTH	PREMERA BLUE CROSS PLAN 1	PREMERA BLUE CROSS PLAN 2
<u>Alternative Care Providers</u>						
Acupuncturists	\$20 co-pay, then 100% 12 visits/year	\$15 co-pay, then 100% 12 visits/year	100% after \$30 co-pay 12 treatments/year	Referral required \$10 co-pay then 100%	100% of allowable after \$20 co-pay Preferred \$25 co-pay Non-Preferred Limited to 12 visits/year	100% of allowable after \$25 co-pay Preferred \$30 co-pay Non-Preferred Limited to 12 visits/year
Naturopaths	\$20 co-pay, then 100%	\$15 co-pay, then 100%	\$100 after \$30 co-pay	Must meet GHC protocol for medical necessity, \$10 co-pay	100% of allowable after: \$20 co-pay Preferred	100% of allowable after: \$25 co-pay Preferred
Massage Therapist	See Rehab	See Rehab	See Rehab	Must meet the GHC protocol for medical necessity	100% of allowable after: \$20 co-pay Preferred \$25 co-pay Non-Preferred Limited to 12 hours/year	100% of allowable after: \$25 co-pay Preferred \$30 co-pay Non-Preferred Limited to 12 hours/year
<u>Audiology</u>	Not provided	Not provided	Deductible, then 80%, up to \$125 per year	Diagnostic exams to determine hearing loss provided in full after \$10 co-pay	80% allowable to \$400 paid every 3 consecutive years	80% allowable to \$400 paid every 3 consecutive years
<u>Chemical Dependency</u>	Limited to \$14,500 in any 24 month period	Limited to \$14,500 in any 24 month period	Limited to \$14,500 in any 24 month period	Limited to \$14,500 in any 24 month period	Limited to \$14,500 in any 24 month period	Limited to \$14,500 in any 24 month period

***BREMERTON SCHOOL DISTRICT
COMPARISON OF MEDICAL PLAN BENEFITS 2009-2010 School Year (continued)***

	KPS Basic	KPS Enhanced	KPS Plan 4	GROUP HEALTH	PREMERA BLUE CROSS PLAN 1	PREMERA BLUE CROSS PLAN 2
<u>Chiropractic</u>	\$20 co-pay, then 100% up to 12 manipulations per year	\$15 co-pay, then 100% up to 20 visits per year	\$30 co-pay, then 100% up to 24 visits per year	\$10 co-pay, up to 10 visits per year Must meet GHC protocol for medical necessity (may self refer)	See "Office Calls"	See "Office Calls"
<u>Diagnostic X-ray & Lab</u>	Outpatient X-ray/lab 100% Inpatient same as any other benefit	Outpatient X-ray/lab 100% Inpatient same as any other benefit	Deductible, then 80%	Provided in full	Preferred: 90% Non-Preferred: 70%	Preferred: 80% Non-Preferred: 60%
<u>Durable Medical Equipment</u>	Deductible, then 80% to \$2,500 per year	Deductible, then 80% to \$2,500 per year	Deductible, then 80% to \$2,500 per year	Covered at 100% if pre-approved and listed in the DME formulary	Preferred: 90% Non-Preferred: 70%	Preferred: 80% Non-Preferred: 60%
<u>Eye Exam (Annual)</u>	Routine vision exams not covered	Routine vision exams not covered	Routine vision exams not covered	\$10 co-pay then provided in full	Routine vision exams not covered	Routine vision exams not covered
<u>Home Health Care</u>	\$20 co-pay up to 130 visits per year	\$15 co-pay up to 130 visits per year	Deductible, then 80% up to 130 visits per year	Provided in full	Skilled care paid in full (custodial care not covered)	Paid in full after a \$50 annual co-pay (custodial care not covered)
<u>Hospice</u>	80%, up to 6 month maximum	80%, up to 6 month maximum	80% after \$50 co-pay, up to 6 month maximum	Provided in full	Paid in full up to lifetime maximum	Paid in full after a \$50 annual co-pay
<u>Orthotic Inserts</u>	Paid in full to \$150 per pair once each 24 months	Paid in full to \$150 per pair once every 24 months	Not provided	One pair per calendar year. Paid at 90% preferred, 70% non-preferred.	One pair per calendar year. Paid at 80% preferred, 60% non-preferred.	One pair per calendar year. Paid at 80% preferred, 60% non-preferred.

***BREMERTON SCHOOL DISTRICT
COMPARISON OF MEDICAL PLAN BENEFITS 2009-2010 School Year (continued)***

	KPS Basic	KPS Enhanced	KPS Plan 4	GROUP HEALTH	PREMERA BLUE CROSS PLAN 1	PREMERA BLUE CROSS PLAN 2
<u>Organ Transplants</u>	Same as any other care paid at 80% to lifetime maximum of \$250,000	Same as any other care paid at 80% to lifetime maximum of \$250,000	12-month waiting period applies. \$200,000 lifetime maximum for Participating Providers	6-month waiting period applies – see contract for details. Limited to \$250,000 lifetime benefit, \$50,000 for organ acquisition	12-month waiting period applies – see contract for details. \$250,000 lifetime maximum	12-month waiting period applies – see contract for details. \$250,000 lifetime maximum
<u>Mental Health</u>						
<u>Inpatient</u>	All care must be pre-authorized. Paid at constant 80% after deductible Limited to 14 days per year	All care must be pre-authorized. Paid at constant 80% Limited to 14 days per year	All care must be pre-authorized. Paid at 80% after \$350 co-pay per day, 5 co-pay maximum per admit. Limited to 10 days per year	80% to 12 day max per calendar year	Constant 90% of allowable, subject to inpatient co-pay	Constant 80% of allowable, subject to inpatient co-pay
<u>Outpatient</u>	All care must be pre-authorized \$20 co-pay per visit Limited to 20 visits per year	All care must be pre-authorized \$15 co-pay per visit Limited to 20 visits per year	All care must be pre-authorized 100% after \$30 co-pay, up to 20 visit per year	20 visits per year; \$10 co-pay then 100%	Limited to fifty (50) 1 hour visits per year; Preferred: \$20 co-pay then 100% Non Preferred: \$25 co-pay then 100%	Limited to fifty (50) 1 hour visits per year; Preferred: \$25 co-pay then 100% Non Preferred: \$30 co-pay then 100%
<u>Podiatry</u>	Same as any other benefit	Same as any other benefit	Same as any other benefit	\$10 co-pay then 100%	Same as any other provider	Same as any other provider
<u>Prescription Drugs</u>	\$10 Generic \$25 Brand 50% Non-Preferred and limited to 31 day supply (\$35 Minimum) 2 co-pays per 90-day supply for maintenance medications.	\$5 Generic \$15 Brand 50% Non-Preferred and limited to 31 day supply (\$35 Minimum) 2 co-pays per 90-day supply for maintenance medications.	\$150 deductible per person, then \$7 Generic \$30 Brand Non-Preferred Brand 50% and subject to a \$50 minimum co-pay	\$10 co-pay per 30 day supply	\$10 Generic \$15 Preferred Brand \$30 Non-Preferred Mail Order: \$10 Generic \$15 Preferred Brand \$30 Non-Preferred (up to 100 day supply)	\$10 Generic \$20 Preferred Brand \$35 Non-Preferred Mail Order: \$10 Generic \$20 Preferred Brand \$35 Non-Preferred (up to 100 day supply)

BREMERTON SCHOOL DISTRICT
Comparison of Medical Plan Benefits 2009-2010 School Year (continued)

	KPS Basic	KPS Enhanced	KPS Plan 4	Group Health	PREMERA BLUE CROSS PLAN 1	PREMERA BLUE CROSS PLAN 2
<u>Radiation Therapy</u>	Same as any other benefit	Same as any other benefit	Same as any other benefit	Provided in full	Preferred: 90% Non-Preferred: 70%	Preferred: 80% Non-Preferred: 60%
<u>Rehabilitation</u>	\$1,000/year, (outpatient only)	\$1,500/year, (outpatient only)	IP: Up to 30 days per year. Subject to other hospital stay requirements OP: \$30 co-pay then 100% up to 45 visits per year	IP: Up to 60 days per calendar year OP: \$10 co-pay to 60 visits per calendar year	120 inpatient days and subject to inpatient co-pay; 45 outpatient visits to \$60 per visit	120 inpatient days and subject to inpatient co-pay; 45 outpatient visits to \$60 per visit
<u>Smoking Cessation</u>	The services of a licensed provider will be paid to \$500/lifetime. Approved medications are payable under the prescription drug benefit	The services of a licensed provider will be paid to \$500/lifetime. Approved medications are payable under the prescription drug benefit	Deductible waived, covered at 50% up to \$250 lifetime maximum for professional services	Nicotine Replacement therapy for a 30-day supply or refill when prescribed by a GHC provider. Subject to \$10 prescription drug co-pay	50% to \$250 lifetime maximum	50% to \$250 lifetime maximum
<u>TMJ</u>	Deductible, then 80% to \$1,000 per year and \$5,000 lifetime	80% to \$1,000 per year and \$5,000 lifetime	Deductible, then 80% up to \$1,000 per year; \$5,000 lifetime	\$1,000 per calendar year/\$5,000 lifetime	50% to \$1,000 lifetime (non-surgical)	50% to \$1,000 lifetime (non-surgical)
<u>Well Care</u>	Routine Exams; 100% after \$20 co-pay to \$200 per contract year Well Baby Care to 36 months and \$500/year max	Routine Exams; 100% after \$15 co-pay to \$200 per contract year Well Baby Care to 36 months and \$500/year max	Routine exams 100% after \$30 co-pay up to \$500. Well Baby Care to 36 months 100% up to \$500/year max	Provided in full after a \$10 co-pay	Age 0-3: \$600 per calendar year All others: \$300 per calendar year; 100% Preferred; 80% Non-Preferred	Age 0-3: \$600 per calendar year All others: \$300 per calendar year; 100% Preferred; 80% Non-Preferred

VI. DENTAL PROGRAMS

There are four dental programs available in Bremerton School District. The pooling group in which you belong determines the basic plan in which you participate or you may chose to participate in an HMO plan.

A. WEA/WASHINGTON DENTAL SERVICE (*WDS*)

This dental plan is available for all employees except members of BPEA* and SEIU. The plan has no deductible. Preventive and basic services are paid on an incentive basis. Initially, these services are paid at 70%. The benefit level increases 10% each year that you visit a dentist at least one time. The level decreases 10% in any year you do not see a dentist. The maximum benefit level is 100% and the minimum benefit level is 70%.

Bridges and dentures are paid at a constant 50%. The annual maximum is \$1,750 (October – September) per person. Orthodontia is not a covered benefit.

WDS encourages the use of its participating dentist network which numbers approximately 85% of the state's licensed dentists. Claims are paid in Seattle.

*260-day BPEA members have a choice between WDS or Standard.

B. STANDARD – *BPEA*

Members of BPEA have a dental contract with Standard Insurance Company. The plan has a deductible of \$25 per person with a maximum of three deductibles per family. The deductible is waived for preventive/diagnostic services. The maximum benefit is \$1,500 per person per calendar year.

Preventive/Diagnostic services are paid at 100%, Basic Restorative services at 80% and Major Restorative at 50%. All benefit levels are based on the usual, customary and reasonable charges for our area. Orthodontia is not a covered benefit.

Standard permits the use of any licensed dentist. Claims are paid in Portland, OR.

C. STANDARD – *SEIU*

Members of SEIU have a dental contract with Standard Insurance Company. The plan has a deductible of \$25 per person with a maximum of three deductibles per family. The deductible is waived for preventive/diagnostic services. The maximum benefit is \$1,500 per person per calendar year.

Preventive/Diagnostic services are paid at 100%, Basic Restorative services at 80% and Major Restorative at 50%. Adult and Child Orthodontia benefits are paid at 50% to a lifetime maximum of \$1,000/person.

Standard permits the use of any licensed dentist. Claims are paid in Portland, OR.

D. WILLAMETTE DENTAL – HMO – AVAILABLE TO ALL GROUPS

For SEIU, coverage will include orthodontia with a \$1,500 co-pay. Orthodontia is not covered for any other group. However, Willamette Dental will provide discounts for orthodontia to District employees not covered by the SEIU agreement regardless of which dental plan they are enrolled in. If you are an SEIU employee enrolled in Standard dental, the discounted orthodontia benefit is not available to you. This dental HMO requires participants to use only Willamette's dental offices for all services. A list of participating Willamette Dental dentists/offices is included in the enrollment package or can be accessed via their website www.willamettedental.com.

Preventive/Diagnostic and Basic Restorative services are paid at 100% after a \$15 office visit co-pay, Major Restorative services are also paid at 100% after a \$50 office visit co-pay. There is no deductible or annual maximum.

E. DENTAL PLAN BENEFIT SUMMARY

The following page contains a summary and comparison of the 2009-2010 dental plans.

	WEA / WDS	STANDARD SEIU 114	STANDARD BPEA	WILLAMETTE DENTAL
<u>Preventive/Diagnostic</u>				<u>\$15 office visit co-pay</u>
Routine Exams	70% - 100%	100%	100%	100%
Cleanings	70% - 100%	100%	100%	100%
Fluoride Treatment	70% - 100%	100%	100%	100%
Sealants	70% - 100%	100%	100%	100%
X Rays – Bitewing	70% - 100%	100%	100%	100%
X Rays – Panorex	70% - 100%	100%	100%	100%
<u>Basic Restorative</u>		<u>After deductible</u>	<u>After deductible</u>	<u>\$15 office visit co-pay</u>
Fillings	70% - 100%	80%	80%	100%
Basic Periodontal	70% - 100%	80%	80%	100%
Major Periodontal	70% - 100%	80%	80%	100%
Oral Surgery	70% - 100%	80%	80%	100%
Root Canal Therapy	70% - 100%	80%	80%	100%
<u>Major Restorative</u>				<u>\$50 office visit co-pay</u>
Crowns	70% - 100%	50%	50%	100%
Onlays/Inlays	70% - 100%	50%	50%	100%
Bridges	50%	50%	50%	100%
Dentures	50%	50%	50%	100%
<u>Deductible</u>	No Deductible	Waived for preventive / diagnostic \$25 per person (no more than 3 deductibles per family)	Waived for preventive / diagnostic \$25 per person (no more than 3 deductibles per family)	No Deductible, \$15 office visit co-pay applies to each Preventive Diagnostic visit; \$50 office visit co-pay applies to each Major Restorative visit
<u>Annual Maximum Benefit Year</u>	\$1,750 Oct - Sept	\$1,500 Jan - Dec	\$1,500 Jan - Dec	No maximum No benefit year
<u>Dependent Limiting Age to:</u>	Age 25	Age 25	Age 25	Age 25
<u>Orthodontia</u> (adult and child)	Not Provided	Paid at 50%	Not Provided	Provided to SEIU members only, \$1,500 co-pay applies N/A
Deductible	N/A	None	N/A	
Lifetime Maximum	N/A	\$1,000	N/A	

VII. VISION COVERAGE

All eligible employees and their dependents are covered for vision by Vision Service Plan (VSP). The plan provides for periodic exams and materials on the following basis. The benefit period begins with:

- Exam – Once each 12-month benefit period
- Lenses – Once each 12-month benefit period (including contact lenses)
- Frames - Once each 24-month benefit period

Exams are subject to a co-pay of \$10 and lenses/frames a co-pay of \$20. The co-pays apply each benefit period. When services are received from VSP providers, benefits are often, but not always, covered in full. Services received from non-VSP providers are paid according to the schedule which can be found in the Vision Plan Benefit Summary at the end of this section.

Locating Your VSP Doctor

When you obtain services from a VSP doctor, you get the most value from your VSP benefit. VSP offers two convenient ways to locate a VSP doctor near your home or office, or to verify your doctor is a VSP doctor:

- Visit us at www.vsp.com
- Call Member Services at 1-800 877-7195

Using Your VSP Benefit

No cards, no claim forms, no hassles. To access your benefits, simply:

- Make an appointment with a VSP doctor
- Tell the doctor you are a VSP member when making the appointment
- Provide the doctor with the covered member's ID

Your doctor and VSP will handle the rest by verifying your benefits and eligibility for services.

Out-of-Network Providers

Although more than 90% of VSP members receive care from VSP doctors, you have the option of seeing an out-of-network provider. If you see an out-of-network provider, be aware your out-of-network benefits do not guarantee full payment. For out-of-network reimbursement, pay the entire bill when you receive services. Then send your itemized receipt to VSP within six months from your date of service. Included with your receipt should be the covered member's name, phone number, address, member ID, the name of the group, the patient's name, date of birth, phone number and address, the patient's relationship to the covered member (such as spouse, child, etc.).

Please keep a copy of the information for your records and send the originals to the following address:

VSP
PO Box 997105
Sacramento, CA 95899-7105

Vision Plan Benefit Summary

Benefit	Frequency (Based on service year)	Co- payment	Coverage from a VSP doctor	Out-of-Network Reimbursement
Eye Care Wellness – Regular exams are essential for protecting your visual wellness.				
Exam	12 months	\$10	Covered in full.	Up to \$45 allowance
Prescription Eyewear – You may choose between glasses or contacts. Remember if you choose contacts, you will not be eligible to receive glasses (lenses and frame) in the same service period.				
Lenses	12 months	\$20 (applied to lenses & frame)	Single vision, lined bifocal and lined trifocal lenses, progressive lenses, tints, and anti- reflective coatings are covered in full. ¹	Single vision up to \$45 allowance Lined bifocal up to \$65 allowance Lined trifocal up to \$85 allowance
Frame	24 months		Covered up to \$120 allowance ²	Up to \$47 allowance
Contact Lenses	12 months	None	Covered up to \$120 allowance	Up to \$105 allowance
Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15 percent savings off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.				
Value Added Discounts				
Laser VisionCareSM - VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers. Visit VSP's Web site at www.vsp.com to learn more about this exciting program.				
Contact Lenses – VSP also offers valuable savings on annual supplies of certain brands of contacts. You can receive these VSP member preferred prices, even if you use your coverage for glasses. Visit vsp.com or ask your doctor for details.				
Prescription Glasses – Receive a 20 percent savings when you purchase non-covered pairs of prescription glasses, including prescription sunglasses from the same VSP doctor within 12 months of your last eye exam.				
1 Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at VSP's member preferred pricing. Ask your doctor for details.				
2 If you choose a frame valued at more than your allowance, you'll save 20 percent on your out-of-pocket costs for frames.				
DEPENDENT LIMITING AGE - Age 25				

VIII. BASIC LIFE/AD&D COVERAGE

All eligible employees are covered for Basic Life/AD&D coverage through Standard Insurance Company. Each pooling group determines the level of coverage for its own participants. However, all other terms and conditions are the same. The coverage levels are summarized below.

A. AMOUNT OF COVERAGE

- BEA	\$ 50,000
- WSTSC	50,000
- BPEA	25,000
- SEIU	25,000
- ABA	100,000
- Exempt Administrators	100,000
- Other Non-Represented Employees	25,000

B. WHEN COVERAGE REDUCES

Coverage reduces as you attain certain ages and ends completely when you retire or terminate. Coverage reduces to a certain percentage of the original benefit at the following ages:

65 but less than 70	65%
70 but less than 75	45%
75 but less than 80	30%
80 or older	20%

C. COVERAGE DURING DISABILITY

If you become eligible for long-term disability (LTD) benefits, then your coverage will continue without further premium payment provided that:

- Your disability began prior to your 60th birthday, and
- You continue to receive disability benefits

Your life insurance will cease under this provision once you are:

- No longer disabled
- Age 65

D. ACCELERATED BENEFITS

If you are seriously ill and have a reasonable life expectancy of less than 24 months, you may be eligible to receive a portion of your life benefits prior to death.

You are eligible for up to 75% of your life insurance amount if you apply before you are 63 years old and have met the other requirements outlined in the Standard booklet.

E. ACCIDENTAL DEATH AND DISMEMBERMENT

If your death is caused by an accident, an additional amount equal to your principal sum is payable to your beneficiary. In addition, the following amounts are payable if you are dismembered:

- Loss of hand	50%
- Loss of foot	50%
- Sight of one eye	50%
- Any combination of above	100%
- Quadriplegia	100%
- Paraplegia/Hemiplegia	50%

Also included in the coverage is MEDEX, a travel assistance service, for you and your dependents. These services are available whenever you travel – whether for business or pleasure – domestic or international as long as you are 100 miles or more from home. Some of the services include:

- 24-hour pre-departure information
- Lost luggage and document assistance
- Emergency cash/bail assistance
- Physician/hospital/dentist referrals
- Prescription transfer
- Evacuation and repatriation

Before you travel, contact Gerrylee Garrett in the Personnel Office to obtain the Medex travel assistance service brochure and ID card.

IX. LONG TERM DISABILITY

Each pooled group has elected Long Term Disability coverage as a core benefit. The contracts are underwritten by Standard Insurance Company. The plan features are the same among all participants although the maximum monthly benefit varies depending on what the individual group negotiated with the District and Standard.

The basic contract provisions are summarized below. Please refer to the Standard plan booklet you received in your new hire orientation for a more detailed explanation of specific benefits and provisions.

A. WAITING PERIOD FOR BENEFITS

You must be disabled for 90 days before benefits are payable.

B. DEFINITION OF DISABILITY

During the first 36 months in which you receive a disability check, you are considered disabled if you are unable to earn at least 80% of your normal earnings at your normal occupation because of injury, illness or pregnancy. After that time, you will be considered disabled if you are unable to earn at least 60% of your normal earnings at any occupation for which you are qualified because of experience or education. You do not need to be totally disabled to qualify for benefits.

C. MAXIMUM BENEFIT PERIOD

Benefits are not payable should the following occur:

- You are no longer disabled or die;
- You reach Social Security Normal Retirement Age (SSNRA);
- You refuse to provide or cooperate with Standard in determining the extent of your disability.

<u>Age Disability Starts</u>	<u>Maximum Benefit Duration</u>
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

D. MAXIMUM MONTHLY BENEFIT

The maximum monthly benefit is limited to the lesser of 60% of your pre-disability earnings or \$5,000. That benefit may be further reduced by income from other sources. Please refer to the Standard contract for details.

E. LIMITATIONS

Benefits are limited to 24 months for mental or nervous disorders unless the disability is the result of schizophrenia, bipolar disorder, dementia or organic disease. There is also a 24-month limitation on benefit for disabilities due to alcohol/substance abuse.

F. EXCLUSIONS

No benefits are payable for disabilities caused by: war, insurrection, active participation in a riot, intentionally self-inflicted injuries, attempted suicide, or participation in a felony.

G. OTHER FEATURES

This contract also includes the following benefits:

- Benefits are adjusted after three years of disability by up to 3.0% annually, depending on the CPI (Consumer Price Index).
- If disability is expected to last greater than 90 days you may be eligible for the Assisted Living Benefit (see contract), benefits will be increased to 80% of pre-disability earnings.

X. VOLUNTARY COVERAGES

Bremerton School District allows for its employees to supplement their benefit packages with a number of voluntary coverages. Many of these are summarized below.

A. VOLUNTARY LIFE INSURANCE

This coverage is underwritten by Standard Insurance Company and allows employees to buy life insurance in excess of the Basic Life/AD&D amounts described in Section VIII. You may also include coverage for your spouse and children. Below is a summary of the major features of the plan.

1. How much can an employee purchase?

An employee may purchase up to \$250,000 in \$10,000 increments not to exceed six times (6x) annual pay.

2. How much can a spouse purchase?

A spouse may be covered up to 50% of the employee amount, but not to exceed \$50,000.

3. How much can a dependent child(ren) purchase?

Each child may be covered for \$5,000. The premium is the same regardless of the number of children covered.

4. Is coverage guaranteed?

If application is made within 30 days of your employment date, the first \$80,000 is guaranteed issue for you. For a spouse, \$20,000 is guaranteed issue.

5. When is evidence of good health required?

You must provide "evidence of good health" when you do not apply when first eligible for this plan or when the amount you are requesting exceeds the guarantee issue amounts noted in No. 4. You must also complete the form should you choose to increase your coverage.

6. Is coverage portable?

The plan is designed so that you may keep the insurance at the same rates when your employment ends with the District. You may continue this coverage for up to 24 months.

7. Where to find applications and more information about Voluntary Life.

Contact Payroll or Personnel.

8. What about Monthly Premiums?

Coverage is purchased in \$10,000 increments and is based on the age of the person applying for insurance. Separate rates apply for employee and spouse. Rates are summarized on page 41.

9. Is there a Benefit Reduction for Age?

Benefit amounts under voluntary life will be reduced to 65% at age 60, 30% at age 70 and 20% at age 80.

B. VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT

This coverage is also underwritten by Standard. It provides for an employee to purchase accident protection for himself/herself and eligible family members. The plan provides for payment to a beneficiary in the event of your accidental death and a payment to you if you are dismembered.

1. How much can be purchased?

You may purchase up to the lesser of 10 times your annual pay or \$500,000. If you choose family coverage, your dependents receive the following benefits:

- Spouse Only will be covered at 50% of employee amount.
- Child Only will be covered at 15% of employee amount.
- Spouse/Child will be covered at 40% of employee amount for spouse and 10% of the employee amount for each child.

2. What is payable in the event of a Claim?

The amount paid is dependent on the type of injuries sustained. Below is a small sample. Please refer to the plan booklet or the enrollment packet from the Personnel Office.

<u>Covered Loss</u>	<u>Benefit Amount</u>
• Loss of life	Principal Amount
• Loss of foot, hand or eye	½ Principal Amount
• Any combination of the above	Principal Amount
• Quadriplegia	Principal Amount
• Paraplegia/Hemiplegic	½ Principal Amount

3. Are there any Special Additional Benefits?

The voluntary accident plan includes special additional benefits for the following:

- If you lose your life in an automobile accident while properly wearing your seat belt, an additional amount of up to \$25,000 or the principal amount is payable.
- Your spouse may be eligible for up to an additional benefit of 5% of the principal amount up to \$5,000 as a career adjustment benefit if you lose your life in an accident.
- Your children can qualify for an additional education benefit equal to 5% of the principal amount not to exceed \$5,000/year.

4. What are the Monthly Costs and where can I get more information?

Enrollment packets are available from Personnel. The cost is summarized below:

Employee Only	\$.25 / \$10,000 increment
Employee and Family	\$.40 / \$10,000 increment

C. VOLUNTARY SHORT TERM DISABILITY

There are two District approved short term disability products available. Both are summarized below.

1. American Fidelity (WEA Sponsored)

American Fidelity offers two programs. One is for certificated, administrative and clerical staff and the other for non-clerical staff. Rates vary between the plans.

Both offer a benefit duration of 90 days. The maximum income replacement permitted is 66-2/3% of monthly pay. The maximum monthly benefit is \$2,500/month for certificated, administrative and clerical employees. For non-clerical support personnel, the maximum benefit is \$1,500/month.

To qualify for the plan you must be working a minimum of 17.5 hours/week. For more information, the Personnel Office has brochures available upon request.

Starting July 1, 2007 these programs will have an annual open enrollment period from August 15th through November 30th. This open enrollment will apply to new enrollees and changes in coverage. Employees that wish to enroll outside this period (other than within 60 days of employment for new hires) will be required to submit evidence of insurability to American Fidelity.

2. AFLAC

AFLAC provides District employees a variety of disability options with benefit durations ranging from 90 days to two years. AFLAC also offers a number of other insurance products including: intensive care, accident and cancer insurance.

See Section I, page 3, for the name and contact information of the local AFLAC representative.

D. LONG TERM CARE

There are three different long term care plan designs available to District employees and their eligible family members. This voluntary coverage helps pay for costs associated with a broad range of medical, personal and social services provided to people who are unable to care for themselves over a relatively long period of time. Benefits are paid for services obtained by nursing homes, assisted living facilities, as well as services in the home provided by home health care workers, nurses and therapists.

Actively at work employees working at least 17.5 hours are eligible to participate, as well as their spouses, parents, parents-in-law, grandparents, grandparents-in-law, children age 18 and older and their spouses. Newly eligible employees may elect the coverage without providing evidence of insurability. Existing employees as well as eligible family members will need to submit evidence of insurability to Prudential for underwriting purposes.

The three plan designs are based on a daily maximum benefit for nursing home/assisted living (\$100, \$150 and \$200) and home and community based care (\$60, \$90 and \$120). For more detailed information regarding this long term care insurance, please contact the Personnel Office for an enrollment packet. Employees will enroll directly with Prudential Financial.

E. PRE-PAID LEGAL & IDENTITY THEFT SERVICES

These voluntary plans are designed to help District employees and their families have access to legal assistance and identity theft protection. Coverage is provided through Pre-Paid Legal Services.

The legal services portion provides help for:

- Will preparation
- Contract and document review
- Moving traffic violation assistance
- Auto related criminal charge representation

The identity theft portion provides help for:

- Experian Credit Report Review & Evaluation
- Continuous Credit Monitoring of Experian Activity
- Identity Restoration
- Fraud Alert & Investigations

Other legal services are provided at a 25% discount. The prepaid legal program also gives you access to unlimited phone consultations on a number of legal matters. Contact the Payroll or Personnel Office for a flyer with additional details. To enroll, contact the Prepaid Legal Services Representative listed in Section I. Important District and Vendor Information, page 4.

F. CANCER INSURANCE

This coverage is designed to cover the medical costs of certain kinds of cancers. There are two carriers that provide this voluntary insurance.

1. American Fidelity

American Fidelity offers two programs, a basic and an enhanced plan. Both provide a benefit for screening, treatment and procedures for cancer. Optional benefits can be added for heart attack and stroke.

2. AFLAC

AFLAC also provides coverage in the event of a cancer diagnosis. Coverage includes benefits for hospital confinement, radiation and chemotherapy, as well as a National Cancer Institute evaluation and consultation.

XI. 2009-2010 RATE SCHEDULES

A. MEDICAL PLANS

WEA/Premera Plan 1	Rates through 9/30	Rates starting 10/1	Dollar Change
Employee	\$ 654.40	\$ 702.95	\$ 48.55
Emp/Spouse	1,244.75	1,337.20	92.45
Emp/Spouse/Child(ren)	1,536.05	1,650.15	114.10
Emp/Child(ren)	916.90	984.95	68.05
WEA/Premera Plan 2	Rates through 9/30	Rates starting 10/1	Dollar Change
Employee	\$ 572.35	\$ 614.75	\$ 42.40
Emp/Spouse	1,110.95	1,193.45	82.50
Emp/Spouse/Child(ren)	1,338.95	1,438.45	99.50
Emp/Child(ren)	800.35	859.75	59.40
KPS Enhanced	Rates through 9/30	Rates starting 10/1	Dollar Change
Employee	\$ 745.72	\$ 816.56	\$70.84
Emp/Spouse	1,495.56	1,637.64	142.08
Emp/Spouse/Child(ren)	1,845.90	2,021.26	175.36
Emp/Child(ren)	1,096.08	1,200.21	104.13
KPS Basic	Rates through 9/30	Rates starting 10/1	Dollar Change
Employee	\$ 531.02	\$ 581.47	\$50.45
Emp/Spouse	1,063.75	1,164.81	101.06
Emp/Spouse/Child(ren)	1,314.76	1,439.66	124.90
Emp/Child(ren)	783.73	858.18	74.45
KPS Plan 4	Rates through 9/30	Rates starting 10/1	Dollar Change
Employee	\$ 339.46	\$ 371.71	\$ 32.25
Emp/Spouse	680.02	744.62	64.60
Emp/Spouse/Child(ren)	840.46	920.30	79.84
Emp/Child(ren)	501.00	548.60	47.60

Group Health Cooperative	Rates through 9/30	Rates starting 10/1	Dollar Change
Employee	\$ 479.54	\$ 516.85	\$ 37.31
Emp/Spouse	959.02	1,033.63	74.61
Emp/Spouse/Child	1,225.55	1,320.90	95.35
Emp/Spouse/Children	1,440.62	1,552.70	112.08
Emp/Child	746.02	804.06	58.04
Emp/Children	961.12	1,035.90	74.78

B. DENTAL PLANS

WEA/WDS	Rate through 9/30	Rate starting 10/1	Dollar Change
Employee (composite)	\$111.20	\$117.45	\$6.25
BPEA/Standard of Oregon	Rates through 9/30	Rates starting 10/1	Dollar Change
Employee	\$49.34	\$49.34	\$0.00
Emp/Spouse	100.41	100.41	0.00
Emp/Sp/Child(ren)	158.34	158.34	0.00
Emp/Children	106.14	106.14	0.00
SEIU/Standard of Oregon	Rates through 9/30	Rates starting 10/1	Dollar Change
Employee	\$50.22	\$50.22	\$0.00
Emp/Spouse	102.17	102.17	0.00
Emp/Sp/Child(ren)	173.90	173.90	0.00
Emp/Children	120.82	120.82	0.00
Willamette Dental (SEIU)	Rates through 9/30	Rates starting 10/1	Dollar Change
Composite	\$82.45	\$83.95	\$1.50
Willamette Dental (All Other)	Rates through 9/30	Rates starting 10/1	Dollar Change
Composite	\$71.75	\$73.05	\$1.30

C. VISION PLAN

VSP	Rate through 9/30	Rate starting 10/1	Dollar Change
Composite	\$23.29	\$23.29	\$0.00

D. BASIC LIFE / AD&D

	Rates through 9/30	Rates starting 10/1	Dollar Change
BEA	\$11.34	\$11.34	\$0.00
WSTSC	11.34	11.34	0.00
ABA	31.10	31.10	0.00
Exempt Administrators	31.10	31.10	0.00
Other Non-Represented	10.51	10.51	0.00
BPEA	4.90	4.90	0.00
SEIU – Active	10.51	10.51	0.00
SEIU – Retiree	3.96	3.96	0.00

E. LONG TERM DISABILITY

	Rates through 9/30	Rates starting 10/1	Dollar Change
BEA	\$27.20	\$27.20	\$0.00
WSTSC	27.20	27.20	0.00
ABA	48.07	48.07	0.00
Exempt Administrators	48.07	48.07	0.00
Other Non-Represented	24.81	24.81	0.00
BPEA	7.59	7.59	0.00
SEIU	13.63	13.63	0.00

F. VOLUNTARY TERM LIFE

<u>Age Band</u>	<u>Monthly Cost/\$10,000 of Coverage</u>	
	<u>Employee</u>	<u>Spouse</u>
Less than 30	\$0.70	\$0.60
30 but less than 35	1.00	0.80
35 but less than 40	1.20	1.00
40 but less than 45	1.40	1.20
45 but less than 50	2.30	1.90
50 but less than 55	3.80	3.20
55 but less than 60	6.80	5.70
60 but less than 65	8.50	7.10
65 but less than 70	13.20	11.00
70+	20.60	16.90
Dependent Child(ren)	.68 (\$5,000 maximum)	

G. VOLUNTARY AD&D

	<u>Monthly Cost per \$10,000</u>
Employee	\$0.25
Employee and Family	\$0.40

H. PRE-PAID LEGAL & IDENTITY THEFT

	<u>Monthly Cost</u>
Prepaid Legal Services	\$15.95
Identity Theft (Only)	\$12.95
Identity Theft (along with Prepaid Legal Services)	\$ 9.95

I. ESTIMATE OF "OUT-OF-POCKET" EXPENSE

Out-of-pocket spreadsheet calculator is located on the following page.

THIS WORKSHEET IS FOR YOUR USE IN ESTIMATING YOUR OUT OF POCKET EXPENSE.

Benefit Dollars (see District Pooling on page 14)	\$ <u>745.00</u>
Less: Retiree Subsidy carve-out (59.59 – 45.50 * 50%)	\$ <u>7.04</u>
Net Benefit dollars available	\$ <u>737.96</u>
Times your FTE (must be .5 or greater)	<u>x</u>
Available Benefit Dollars	\$ _____

<u>Minus:</u>	
Dental	\$ _____
Vision	\$ _____
Life	\$ _____
LTD	\$ _____
Net Benefit Dollars available for Medical:	\$ _____
Minus: Medical	\$ _____
Your estimated Monthly "Out-of-Pocket" Expense*	\$ _____

*Your "Out-of-Pocket" expense will not be more than this, but may be less due to your bargaining unit's "pooled" dollars.

Benefit dollars may not be used for voluntary benefits.

Your total "out-of-pocket" expense will be equal to the estimate on the above work sheet plus the amount of any voluntary benefits for which you have enrolled.

XII. EMPLOYEE ASSISTANCE PROGRAM (EAP)

The District provides each employee with access to an Employee Assistance Program (EAP). The EAP is a confidential assessment and referral program. It allows you or a family member to receive short-term counseling, at no cost, for the purpose of discussing issues or problems that could disrupt your work or personal life. This service is delivered by First Choice Health EAP.

The EAP can help you address a wide variety of issues. These include: relationship, marital or family problems, substance abuse, addiction, problems with debt or credit, eldercare, work performance problems, mental health concerns, legal matters, and a wide range of other concerns that arise as a result of the conflicts and demands of contemporary life.

Using the EAP is straightforward. Contact the EAP at 1-800-777-4114 (TDD: 1-800-777-4969) or online at www.firstchoicееap.com. By phone or online, you can request an appointment with a licensed EAP counseling professional. First Choice Health EAP has an extensive network of effective counselors who, based on your preferences, will respond quickly to your needs and concerns. You can even take advantage of Online Assessment from the comfort and convenience of home.

For additional information, contact the EAP at 1-800-777-4114 or the Personnel Office for a First Choice Health EAP brochure.

XIII. FLEXIBLE SPENDING ACCOUNTS (FSA)

A. PREMIUM ONLY

The District's Premium Only Plan allows employees to avoid Social Security and Federal Income Tax on monthly amounts that are deducted for group insurance (Medical, Dental, Vision, and Cancer {health care type} Insurance) premiums. Payroll will automatically adjust your monthly deduction for qualifying insurance premiums from an "after-tax" to a "pre-tax" basis. There are no forms for you to fill out. Deduction is automatic unless you request, in writing, not to participate in the premium only plan. Contact the Payroll Office if you want to opt out of this tax deferred premium plan. We do not tax-defer Life, Disability or Cancer (life insurance type) Insurance because the benefit pay out would be taxable to the beneficiary.

B. UNREIMBURSED MEDICAL AND DEPENDENT DAY CARE SPENDING

Bremerton School District also makes available to all eligible employees the opportunity to participate in a Section 125 Flexible Spending Account administered by American Fidelity (AFA). The plan permits you to pre-fund up to \$5,000 per year to pay for qualified dependent care expenses and \$3,600 in qualified health care expenses you will incur during the year on a pre-tax basis. This includes any medical and dental expenses that are not covered by your health or dental plan (including deductibles and co-insurance amounts) as well as certain daycare expenses for your children. You may refer to IRS Publication 502 for additional guidelines.

1. How does the Plan Work?

When you choose to participate, any amounts which are part of the Section 125 plan are deducted from your paycheck before federal withholding and FICA taxes are withheld. Consequently, the net amount on which your tax deductions are based is reduced by the amount deferred through the Plan. This saves you the marginal income tax rate plus the 7.65% FICA tax. The following example may help to illustrate this savings.

	<u>Without Section 125</u>	<u>Section 125</u>
Monthly Gross Pay	\$2,500	\$2,500
Less: Pre-Tax Deductions:		
• Premium Contributions	-	(125)
• Day Care Expense	-	(300)
• Unreimbursed Medical	-	<u>(100)</u>
Adjusted Gross Income	\$2,500	\$1,975
Federal Income Tax @ 15%	(375)	(296)
FICA Tax @ 7.65%	<u>(191)</u>	<u>(151)</u>
Net pay	\$1,934	\$1,528
Less: Premium Contribution	(125)	-
Day Care Expense	(300)	-
Unreimbursed Medical	<u>(100)</u>	<u>-</u>
Actual Take Home Pay	\$1,409	\$1,528
Increase in Take Home Pay		\$119

The actual amount you will save depends on your individual tax situation. This example is only an illustration.

Once enrolled in the Plan, you may seek reimbursement from American Fidelity for eligible dependent care and unreimbursed medical expenses. For Health Care Spending, you may be reimbursed up to 100% of the amount you elected for the year regardless of the amount you have contributed to date. For Dependent Care, you can receive reimbursement only up to the amount you have actually contributed. You must actually incur the expense in order to seek reimbursement. You may submit receipts along with a claim form directly to American Fidelity either by mail or fax at:

American Fidelity Educational Services
Flex Account Administration
PO Box 25510
Oklahoma City, OK 73125
1-800-325-0654
Fax: 1-800-543-3539

2. How do I Enroll?

In order to participate, you must enroll by completing the Section 125 enrollment/election form which can be found in the information packet available from American Fidelity or the Payroll Office. You must enroll by October 1st of each year for the benefit period of October through September.

The Health Care Spending account has a minimum annual election amount of \$60 and a maximum of \$3,600. The Dependent Care Spending account has a minimum annual election amount of \$300 and a maximum of \$5,000.

With few exceptions, you may not change your election amount for the year. Therefore, it is important that you carefully determine the amount you will spend. Any amounts not spent at the end of the Plan Year are forfeited to the Plan (This is an IRS regulation). By following the directions in the AFA Flex Plan information packet, you will be able to accurately predict your expenses.

C. OTHER INFORMATION – GENERAL QUESTIONS AND ANSWERS

Following are some commonly asked questions about Section 125 Flexible Spending Accounts. If you have additional questions or concerns, contact Personnel, Payroll or American Fidelity.

1. What is the Plan Year?

The plan year is October 1st through the following September 30th.

2. If I elect to redirect my compensation, how can this benefit me?

The biggest advantage is the tax savings. Since a Flexible Spending Account uses pre-tax dollars for reimbursement of qualifying expenses, you reduce your income taxes and social security tax by reducing your taxable salary.

3. If I redirect part of my pay, won't I take home less money?

No. Your net take home pay will increase by the amount of tax savings.

4. Why should I participate in the medical reimbursement plan if I already have medical insurance?

The medical reimbursement plan offers reimbursement of medical care expenses not reimbursed by insurance. For example, expenses for annual physicals, eye exams, glasses, orthodontics, prescribed medicine, hospital care, co-pays and deductibles.

5. Can I change or revoke my elections during the plan year?

In general, the answer is "no". However, there is an exception for a change in family status. This includes marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of a spouse's employment, and other events within IRS guidelines that the Administrator determines will permit a change or revocation of an election during a plan year. You may also change your election if your premiums or daycare expenses increase or decrease significantly.

6. What documentation do I need to provide the Administrator to be reimbursed for expenses I incur?

Reimbursement request forms can be obtained from the Payroll Office or from AFA's website. You will be required to attach a copy of the medical or dependent care billing or receipt to this form, and then return it to American Fidelity. Requests will be processed and checks issued twice per month.

Alternatively, you have the option to be reimbursed for medical or dependent care expenses via direct deposit into your bank account. To use this option, complete the direct deposit form which can be obtained from the Payroll Office or from AFA's website. You may either fax or mail this form back to American Fidelity.

7. What if I don't use all of the money I redirect into my Reimbursement Account?

Assistance will be available to help you accurately determine your allowable expenses for the plan year so you can avoid having unused benefits at the end

of the year. However, if you do have funds remaining in your account at the end of the year, that amount will be forfeited according to IRS regulations. Effective with the plan year ending September 30, 2005, IRS has approved a "Grace" period for the medical expense reimbursement account only.

8. What is a "GRACE" period and how does it affect me?

The grace period is an additional 70 days after the end of the plan year. During this period, you can incur claims and be reimbursed for these expenses from any forfeitures you may have suffered from the immediately preceding plan year. If you over-funded your medical reimbursement account, this will help you to recoup all or part of the excess.

9. What is the last day to submit my claims?

Claims must be submitted within 90 days of September 30th, each year (the Plan's year-end). Any claims submitted after that date, will be denied and you will forfeit any funds remaining in your account.

10. Are there any negatives that I should know about?

Yes, because you are not paying social security tax on that portion of your income that has been redirected, your social security benefits may be slightly reduced. Also, reimbursed medical expenses are not deductible for federal Income Tax purposes and reimbursed Dependent Day Care Expenses may not be used for Child Care Tax Credit purposes.

XIV. VEBA III – SICK LEAVE CONVERSION

The VEBA III plan is both a pre-retirement and post-retirement medical expense reimbursement account. VEBA III accounts are 100% tax-free and are funded with your sick leave cash-out dollars either:

- **ANNUALLY** (days in excess of 180, maximum 12 per year); or
- **AT RETIREMENT** (all days up to 180); or
- **AT RESIGNATION** (all days up to 180; see details below).

All VEBA III contributions, earnings accumulation and withdrawals are completely tax-free (typically 28% federal income tax and 7.65% FICA tax) and will not raise or lower your monthly pension benefit from the Department of Retirement Systems.

A. USE YOUR VEBA III ACCOUNT TO PAY HEALTH CARE COSTS

Out-of-pocket health care costs for yourself, your spouse and/or your IRS qualified dependents are eligible for tax-free reimbursement from your VEBA III account, pre and post retirement depending when the account is funded. Following are a few examples of qualified expenses:

- Medical, dental, vision and long-term care insurance premiums;
- Medicare Part B and Medicare Supplement Plan premiums;
- Out-of-pocket medical, dental or vision costs such as deductibles, co-payments, co-insurance, prescriptions and other non-covered expenses as outlined in IRS Publication 502.

B. INVESTMENT OPTIONS

VEBA participants may self-direct the investment of their VEBA account among six different investment funds or four different “pre-mixed” funds. More information may be obtained by reading the VEBA enrollment packet or by visiting the VEBA Trust website at www.veba.org.

C. CLAIMS PAYMENT

Claims payment is efficient and hassle free. Claims are paid daily by the VEBA Plan Administrator. You may submit a VEBA Medical Claim Form at any time for qualified expenses incurred after your VEBA III account is opened. You may also have your monthly insurance premiums paid automatically by using the VEBA Systematic Payment Form.

D. DEATH BENEFIT

Upon the employee/retiree’s death, the surviving spouse and/or qualified dependent(s) may continue to use any remaining account balance for their qualified health care expenses and insurance premiums. NOTE: [IRS Revenue Ruling 2006-36](#) does not permit the payment of benefits to non-dependent heirs in the event a deceased participant has no surviving spouse or dependent(s). Therefore, if you have no

surviving spouse or dependent(s), any remaining funds will be forfeited and redistributed pro rata among the remaining participants from your employer.

E. ELIGIBILITY AND ENROLLMENT

First, your employee group must adopt/renew the plan in writing each year and elect to contribute annual sick leave cash-out dollars, retirement sick leave cash-out dollars or both.

Second, to be eligible for *annual* sick leave cash-out contributions, you must have accumulated a minimum of 180 earned sick leave days as of the first day of your employee group's written VEBA agreement. To be eligible for *retirement* sick leave cash-out contributions, you need to be eligible for retirement by the Washington State Department of Retirement and determined eligible for a sick leave cash-out (there is no minimum balance requirement, but there is a 180-day maximum). At resignation, you may be eligible for a sick leave cash-out. In order to be eligible you must meet the following criteria:

- Attained at least 55 years of age, and
- Be a member of TRS or SERS Plan 3, and
- Accumulated 10 years of service.

You will also be eligible for a cash-out if you:

- Have attained at least 55 years of age, and
- Are a member of TRS or SERS Plan 2, and
- Have accumulated 15 years of service.

Third, you must sign the VEBA III Membership Enrollment Form available from the Payroll Office.

IMPORTANT NOTE: A more detailed description of the VEBA III plan is contained in the VEBA III Questions & Answers brochure available from the Payroll Department. You may also visit the VEBA Trust website at www.veba.org or contact the VEBA Service Group's Western Washington Regional Office at 1-800-422-4023.

XV. 403 (b) TAX SHELTERED ANNUITIES (TSA)

Tax Sheltered Annuities (TSA) are employee-funded retirement fund vehicles. All District employees are eligible to buy TSA's through one of the approved investment providers which are listed at the end of this section.

Note that the rules and participating investment providers have changed significantly in order to comply with new 403(b) Tax Sheltered Annuities (TSA) rules effective January 1, 2009. The new rules place new fiduciary obligations on the District for oversight of the plans. In order to comply, the District has contracted with PenServ Plan Services as the plan record keeper and administrator. Please read this revised section carefully as it describes in detail how these changes impact you and what you must do to participate.

A. TAX STATUS

All contributions to a TSA are made on a pre-tax basis which means your current taxable income is reduced. Both the principal and the interest grow tax deferred in the account until you begin taking distributions. At that time, only the amount you withdraw is included as income for that year.

B. MAXIMUM SALARY REDUCTION

Under current IRS Regulations, 403(b) participants may defer the lesser of \$16,500 in 2009 (\$16,500 in 2010) or 100% of adjusted gross compensation. Under certain circumstances, catch-up provisions may allow a participant to exceed the IRS regulated limit. When contributing to a TSA and a qualified retirement plan, your maximum limit may be decreased due to IRS regulations; please discuss this with your financial or tax representative. Internal Revenue Services Publication 571 contains the IRS guidelines for 403(b) contributions.

C. INVESTMENT OPTIONS

Under the new rules, only investment providers who have entered into information sharing agreements with the District (and administered by PenServ Plan Services may offer contracts to District employees. The list of those vendors who have agreed to this requirement are listed at the back of this section and are the only investment options open to you. Because all investment entail some degree of risk, you should research you choices carefully by reviewing prospectus information, consulting a financial professional or contacting one of the registered representatives of the available funds.

D. PLAN RECORD KEEPER (third party administrator)

The District has retained PenServ Plan Services as the record keeper and administrator of the 403(b) plans. They will provide a broad array of services to plan participants including: collection of proper data form investment firms, processing your contributions, providing periodic consolidating reporting on all of your accounts, maintaining confidentiality and assuring that your retirement accounts are maintained in strict compliance with the new IRS rules. You can contact PenServ at 1-800-849-4001 or email them at 403bservice@penserv.com.

E. WITHDRAWAL OF TSA MONEY

Money deferred into a TSA is meant to create retirement income. Because of this, the IRS has very specific rules regarding when and under what circumstances you can access your account.

Money may be withdrawn beginning at age 59-½ without IRS penalty; or if you separate from service in the calendar year in which you turn age 55. However, money must begin being withdrawn by age 70-½. All distributions are subject to federal income tax in the year money is withdrawn.

You may withdraw money prior to age 59-½ should you become disabled, die or if you incur a financial hardship as defined by the Internal Revenue Code. In some of these instances, the distribution may be subject to a 10% penalty. You should consult your agent or financial advisor for your specific situation. PenServ Plan Services administers all requests for hardship withdrawals.

Saving for retirement is an important undertaking. However, be certain to defer only that money you can afford from your current income.

F. PARTICIPATION

As noted above, you may only select from the list of approved investment managers on page 52. In order to participate, you must complete the following:

- Select an investment provider from the list and contact the agent or broker to assist you in setting up an account.
- Once the account is set up, complete an Annuity 403(b) Salary Reduction Agreement which is available on the District's website and submit to Payroll.
- Payroll will fax the completed agreement to PenServ. PenServ must receive the form at least 10 days before the first deduction is scheduled to be taken.

G. TO CHANGE/STOP A SALARY REDUCTION

To **stop** a TSA contribution, complete a new Annuity 403(b) Salary Reduction Agreement and specify \$0.00 as the deferral amount. To **change** your TSA contribution, you must also complete a new Annuity 403(b) Salary Reduction Agreement. Be sure to also write in the name of the investment provider on the agreement. ***Note, if your change includes using a new investment provider you must first contact the agent or broker to set up a new account.*** A new Annuity 403(b) Salary Reduction Agreement supersedes any previous agreements. Therefore, if you wish to continue the old contribution as well as start contributing to a new fund, you must include both Funds and the contribution amounts on the new agreement. The combined contributions may not exceed your legal limitation as determined by IRS guidelines.

H. TEMPORARY NON-DEFERRAL

If your net pay for a month is not large enough to withhold the entire amount of the salary reduction specified in your Salary Reduction Agreement, no deferral will be withheld for that month.

I. LISTING OF ELIGIBLE INVESTMENT PROVIDERS

The following investment providers have executed information-sharing agreements with the plan to provide compliance data and will remain an active vendor under our Plan:

Active Vendor Name	Investment Company Contact
American Funds - Penserv	Requires re-enrollment and additional paperwork, please contact Penserv for additional information
Ameriprise	Wain M. Miller 800-285-4488 Ext. 116 wain.m.miller@ampf.com
AXA	Michael P. Matheny 360-990-4855 Michael.matheny@axa-advisors.com
Commonwealth Annuity (Kemper)	(508) 460-2400
Great American Life Insurance Co.	Tom Stitak 1-800-695-1471 ext 11409
Oppenheimer	1-888-470-0862
Reliastar Life/ING/Aetna Life & Annuity	Michelle Bearden 253-380-7706 yesworks@aol.com
Security Benefit	Susan Cain 1-888-724-7526 Ext. 3423
Vanguard - Penserv	Requires re-enrollment and additional paperwork, please contact Penserv for additional information
Variable Annuity Life Insurance Company	J. Andrew Davidson 800-523-5332 Andy_Davidson@aigvalic.com
Waddell & Reed	Duane D. Cofer 360-692-0980

These are the only investment providers with whom you can invest. Please contact PenServ for additional information.

XVI. DEFERRED COMPENSATION PLAN ADMINISTERED THROUGH WASHINGTON STATE

In addition to 403(b) Tax Sheltered Annuities (TSA), you may also want to contribute to the Deferred Compensation Plan (DCP) through the State. This program is organized under Section 457 of the Internal Revenue Code and also provides for periodic deferrals into specified investment contracts.

Deferred Compensation allows you to make pre-tax contributions into a number of investment options including annuities and mutual funds. You may contribute up to 100% of your compensation not to exceed \$16,500 in 2009.

If you contribute to a 403(b) Tax Sheltered Annuity and to a 457 – Deferred Compensation account, the combined contribution cannot exceed your adjusted gross compensation as determined on the 457 Deferred Compensation, Maximum Deferred Calculation Worksheet (obtain the Worksheet from the Payroll Office).

To enroll you can either call 1-888-327-5596 or you can go to www.drs.wa.gov/dcp. Once you receive your enrollment confirmation from DCPA you must provide Payroll with a signed authorization before we can start your deductions. This authorization form should be included in the package you receive from DCP. Your 457 Deferred Compensation, Maximum Deferred Calculation Worksheet must be attached to the confirmation and submitted to the Payroll Office by the 10th of the month to begin a payroll deduction in that month.

Your deductions will continue until you make a change. You must make the change with DCP, either by telephone or on-line and then provide Payroll with the confirmation of that change. If you wish to stop contributing, you must first notify DCP and then complete a new enrollment form with the amount as zero and then provide a copy to Payroll.

Your Deferred Compensation account is available to you at the separation from service, for an unforeseen emergency or upon death. Early withdrawal is not permitted. When you begin taking distributions, you must declare that distribution as income in the year in which it was received. You must begin distributions no later than age 70½.

XVII. WORKERS COMPENSATION SELF INSURANCE PROGRAM

Bremerton School District is an approved self-insured employer under the Washington State Workers' Compensation Law. Our self-insured program applies to all work-related injuries or illnesses. The industrial insurance laws of Washington allow employers to insure their workers' compensation obligations through the State Fund or through self-insurance. The benefits and rights for injured workers are exactly the same under either system. By being self-insured, Bremerton School District assumes the cost of the actual medical charges and compensation expenses, as well as all benefits prescribed by Washington State Workers' Compensation law.

IF YOU SUSTAIN A WORK-RELATED INJURY:

Report the accident/injury immediately to your Supervisor - WHETHER OR NOT MEDICAL ATTENTION IS REQUIRED.

When an injury is an emergency - GO DIRECTLY TO YOUR DOCTOR OR TO THE HOSPITAL.

When medical attention IS REQUIRED:

1. Report the accident/incident to your Supervisor.
2. Complete the Employee Accident/Incident Report Form and return it to your supervisor.
3. Supervisor, complete your portion of the Employee Accident/Incident Report Form. Give a copy of the completed form to the Employee and send a copy to Diana Brandvold in the Business Office
4. Contact Diana Brandvold (473-1032) in the Business Office. Bring your copy of the Accident/Incident Report form with you.
5. You will fill out the Self Insurer Accident Report form (SIF-2) and will be given a Physicians Initial Report form (PIR) to take with you to the Doctor, or, back to the Doctor, if you required immediate medical attention. In case of an emergency, your Supervisor will make sure that the treating physician or emergency facility is informed that the Bremerton School District is self-insured, so that your claim can be properly processed. (Please do not separate the NCR form.)
6. Ask your building Office Coordinator for an L & I packet .

When medical attention IS NOT REQUIRED:

1. Report the accident/incident to your Supervisor.
2. Complete the Employee Accident/Incident Report Form and give to your Supervisor.
3. Supervisor will complete the Supervisor's portion of the Accident/Incident Report Form.
4. The Supervisor will send the Accident/Incident Report Form to Diana Brandvold in the Business Office.

IMPORTANT:

Your employer cannot deny you the right to file a claim, and your employer cannot penalize you or discriminate against you for filing a claim. Every worker is entitled to workers' compensation benefits for any injury or illness which results from his/her job. **Any false claim filed by a worker may be prosecuted to the full extent of the law.** If you have any questions or concerns, contact your employer's representative, Puget Sound Workers' Compensation Trust (877) 955-9675, or call the Department of Labor & Industries, Self-Insurance Section (360) 902-6901.

TIME LOSS BENEFITS:

A Sick Leave form must be completed for all time that you are off work or you may choose to take Leave Without Pay (*). After three (3) days off work due to an on-the-job injury, you could be entitled to time-loss benefits. The benefits are paid on a sliding scale that takes into consideration your family size, rate of pay and Washington State Labor & Industries benefit rates. **If you received a time-loss benefit check AND you chose to use your Sick Leave while you were on leave, the amount of the time-loss payment will be deducted from your next paycheck. You do not gain additional pay because of the injury.** The time-loss pay will be calculated to credit back an appropriate number of sick leave hours.

Only if you have exhausted your sick leave balance, may you choose to use your accrued vacation hours to extend your pay and benefits with the District.

(*) You must work or be on paid leave for a minimum of ½ of the working days each month in order to maintain District-paid benefits. The employee will be responsible for payment of 100% of his / her benefit premiums in any month the paid work days fall below this threshold.

INDEPENDENT MEDICAL EXAMINATION:

Should an Independent Medical Examination be required for your claim, District policy provides you with release time to attend the exam. Time is also included for your travel time to and from your appointment. You are expected to report to work at the normal time and to return to work for the balance of your normal work day.

XVIII. LEAVE PROVISIONS AND POLICIES

A. VACATION LEAVE PROVISIONS

Bremerton School District Personnel Policy #5411 governs the provisions for Vacation Leave and provides for the following:

1. **Maximum Annual Accrual**

An employee who is eligible to earn vacation may accrue and carry from one year to the next, a maximum of thirty (30) days. If the employee's accrual on September 1st, after all leave earned and used through August 31st has been recorded, is more than thirty (30) days, the employee will forfeit the excess and his/her vacation balance will be adjusted to the maximum thirty (30) day total.

2. **Maximum Cash-Out Upon Termination of Employment**

An employee who is eligible to earn vacation and who has provided the District with at least a two-week notice may receive remuneration for up to thirty (30) days of accrued vacation upon termination of employment.

B. SICK LEAVE PROVISIONS

A variety of RCW's (Revised Code of Washington; 28A.400.300, 28A.400.10, 41.35.010) govern the provisions for Sick Leave and provide for the following:

1. **Maximum Annual Accrual**

An employee who is eligible to earn sick leave may accrue and carry from one year to the next, a balance equal to the employee's contract hours for one year. If the employee's accrual on September 1st, after all leave earned and used through August 31st has been recorded, exceeds the employee's contract hours for the just completed school year, the employee's sick leave balance will be adjusted to the one year total.

2. **Transfer of Balance Upon Termination of Employment**

An employee's sick leave balance, after all leave earned and used through the date of termination has been recorded, may be transferred to another school district in the State of Washington. When you begin employment at the new district, request their personnel office to send us a Verification of Employment form.

3. **Maximum Cash-Out Upon Retirement or Resignation**

An employee who is eligible to earn sick leave, may receive remuneration for up to one hundred eighty (180) days of accrued sick leave. An employee who resigns and is a member of TRS or SERS Plan 3, age 55 or older, with 10 or more years of service credit with the Washington State Department of Retirement or who is a member of TRS or SERS Plan 2, age 55 or older, with 15 or more years of service credit with the Washington State Department of Retirement, may receive remuneration for up to one hundred eighty (180) days of accrued sick leave. The

rate of remuneration is four (4) days of sick leave for one (1) day of pay. Effectively, 25% of the accrued balance (maximum of forty-five (45) days) may be received as pay or contributed into a VEBA III account, depending on which option was adopted by your bargaining unit.

4. **Annual Sick Leave Buy Back**

An employee who is eligible to earn sick leave may be eligible in February to annually cash-out up to twelve (12) days of sick leave which were earned in the prior calendar year (January - December). The current earned days must be reduced by any sick leave taken during the same calendar year. The remaining days may be cashed out at the rate of four (4) days of leave in exchange for one (1) day of pay (effectively 25%). In order to be eligible for the cash-out, you must have sixty (60) days *(sixty-eight {68} days if your sick leave is front-loaded at the beginning of the school year)* remaining after the cash-out is processed.

C. JURY DUTY / CIVIC LEAVE PROVISIONS

If you are subpoenaed to serve on jury duty or to testify, you must complete a leave slip and attach a copy of the subpoena or the order to appear. Please review your respective collective bargaining agreement to determine the proper type of leave to be taken.

If you are called to jury duty, the District first suggests you request your jury duty to be postponed until the summer. The courts are prepared for this request from school district employees. However, if your request for postponement is denied, you must request a Juror Certificate from the Court Clerk at the end of your jury service. Upon return to work, submit the certificate to the Payroll Department.

Please note: On the rare occasion when you are asked to call in mid-morning for a potential, same day, afternoon service, you are expected to report to work at your normal time. You must notify your supervisor as soon as you receive direction from the court to call in mid-morning. Your supervisor will set up an alternative plan, should you actually be requested to appear that afternoon.

Any juror or witness compensation received by a staff member for services performed on the same day as a paid contract day is to be reimbursed to the District. Any expense reimbursement received by a staff member for jury duty performed on a contract day shall be retained by the staff member. Expense payments include up to \$25 per day for serving on a jury plus mileage. Any other compensation received while performing jury duty or serving as a witness will be transferred to the District through a tax-deferred payroll deduction. For full details, see District Policy 5408.

XIX. FINAL PAY UPON SEPARATION OF EMPLOYMENT

A. COMPLETED CONTRACT/ASSIGNMENT

If you complete your school year assignment, you will continue to receive your normal pay through August 31st and benefits will end on September 30th. If you are an Administrator, pay will end June 30th with benefits ending July 31st. If there is a chance you could use leave in August (because you are scheduled to work in August), your August pay will be split into two (2) payments: 50% will be paid on August 31st and 50% will be paid on September 15th. This procedure allows funds to be available in the event Leave Without Pay is needed during the last couple weeks of August.

B. MID YEAR SEPARATION

If you separate from employment prior to completing your school year assignment, the remainder of your pay is split over the next two pay periods. See page 7, Section II.D. – Maintaining District Benefits to determine when your benefits end.

D. VACATION & SICK LEAVE CASH-OUT

If eligible, vacation and/or sick leave cash-out is included in the “Final” paycheck and after ALL of your leave is recorded.

XX. NOTICES OF PARTICIPANT RIGHTS

A. YOUR CONTINUATION RIGHTS UNDER THE CONSOLIDATED OMNIBUS RECONCILIATION ACT (*COBRA*)

The following is meant to notify you and any covered dependents of your rights to continue your healthcare coverage after you are no longer eligible to participate.

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under the group health plan would otherwise end. Bremerton School District (the "Employer") maintains a group health plan that is subject to this Notice. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the premium for your continuation coverage.

This summary is intended only to summarize, as best possible, your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly. The COBRA statute is not clear on some points and is interpreted by Federal agencies and the courts. Congress often changes the law. Therefore, this summary is subject to change without notice as interpretations or changes of the law occur. Please refer to special temporary COBRA provisions found on page 9 of this handbook.

Both you (the employee) and your spouse should read this summary carefully and keep it with your records.

Qualifying Events

If you are an *employee* of the Employer covered by the Plan you have a right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Termination (for reasons other than your gross misconduct) of your employment; or
2. Reduction in the hours of your employment.

If you are the spouse of an employee covered by the Plan you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Employer;
3. Divorce or legal separation from your spouse. (Also, if the spouse reduces or eliminates your coverage in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a Qualifying Event even though you lost coverage earlier. If you notify the plan administrator within 60 days of divorce and

establish that the spouse reduced or eliminated your coverage in anticipation of the divorce, then you are entitled to COBRA for a limited period after the divorce. This provision will also apply to a legal separation if a legal separation would cause a loss of coverage under the group health plan); or

4. Your spouse becomes entitled to Medicare benefits.

In the case of a dependent child of an employee covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five “qualifying events”:

1. The death of the employee parent;
2. The termination of the employee parent’s employment (for reasons other than gross misconduct) or reduction in the employee parent’s hours of employment with the Employer;
3. Parent’s divorce or legal separation;
4. The employee parent becomes entitled to Medicare benefits; or
5. The dependent ceases to be a “**dependent child**” under the Plan.

Notices and Election

The Plan provides that your spouse’s coverage terminates (thus, is lost) as of the last day of the month in which a divorce or legal separation occurs. A dependent child’s coverage terminates when he or she no longer is an eligible dependent under the Plan (for example, after attainment of a certain age). Under the COBRA statute, you (the employee) or a family member has the responsibility to notify the Employer upon a divorce, legal separation, or a child losing dependent status. You or a family member must give this notice no later than 60 days after the last day of the month of the divorce, legal separation, or a child losing dependent status. If you or a family member fail to notify the Employer during the 60-day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member fail to notify the Employer, and contrary to Plan terms, any claims are paid for expenses incurred after the last day of the month of the divorce, legal separation, or a child losing dependent status, then you and your family members will be required to reimburse the Plan for any claims so paid.

If the Employer is timely notified that one of the above three events has happened, the Employer will notify the family member of the right to elect continuation coverage. You (the employee) and/or your family member will also be notified of the right to elect continuation coverage automatically (i.e. without any action required by you or a family member) upon the following events that result in a loss in coverage: the employee’s termination of employment (other than for gross misconduct), reduction in hours, or death, or the employee becoming entitled to Medicare.

You (the employee) or your family member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Employer sends you or your family member notice of the right to elect continuation coverage. If you or your family

member do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.

A covered employee or the spouse of the covered employee may elect continuation coverage for all family members. The covered employee, and his or her spouse and dependent children, however, each have an independent right to elect continuation coverage. Thus a spouse or dependent child may elect continuation coverage even if the covered employee does not elect it. In addition, you or your qualifying family member can elect continuation coverage even if you or they are covered by another employer sponsored group health plan or Medicare.

Type of Coverage / Premium Payments

If COBRA coverage is elected, the Employer must provide coverage that is identical to the coverage provided under the Plan to similarly situated employees or family members. For example, if you had coverage for yourself and family, we will offer you the same coverage under COBRA. You or qualified family members, however, continue to have independent election rights. If the coverage for similarly situated employees or family members is modified, COBRA coverage will be modified the same way.

COBRA rates are based on the full cost of providing coverage and may also include an administration fee of up to 2% (up to 50% for coverage during a disability extension following the first 18 months of coverage).

You (the employee) or a family member must pay the premium payments for the "initial premium months" by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period.

Maximum Coverage Periods

1. **36 Months.** If you (spouse or dependent child) lose group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lose your status as a dependent under the Plan, the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.
2. **18 Months.** If you (employee, spouse or dependent child) lose group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in hours, the maximum continuation coverage period (for the employee, spouse, and dependent child) is 18 months from the date of termination or reduction in hours. There are three exceptions:
 - If an employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must

formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided by the disabled individual to the Employer within the 18-month coverage period and within 60 days after the date of determination.

- If a second qualifying event occurs (for example, the employee dies or becomes divorced) within the 18 month or 29-month coverage period, the maximum coverage period becomes three years from the date of the initial termination or reduction in hours.
- If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, the maximum coverage period (for the spouse and dependent child) ends three years from the date the employee became entitled to Medicare.

Newborn Children of, or Children Placed for Adoption with, the Covered Employee after the Qualifying Event

If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the covered employee, the child is considered a qualified beneficiary. The covered employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered employee or a family member must notify the Employer within 60 days of the birth or placement to enroll the child on COBRA. (The 60-day period is the Plan's normal enrollment window for newborn or adopted children.) If the covered employee or family member fails to so notify the Employer in a timely fashion, the covered employee will NOT be offered the option to elect COBRA coverage for the newborn or adopted child.

Termination Before the End of Maximum Coverage Period

Continuation coverage of the employee, spouse or dependent child will automatically terminate (even before the end of the maximum coverage period) when any one of the following five events occurs:

1. The Employer no longer provides group health coverage to any of its employees;
2. The premium for COBRA coverage is not timely paid;
3. You (the employee, spouse, or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after the preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under a Federal law {the Health Insurance Portability and Accountability Act of 1996} that requires

portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.);

4. You (employee, spouse or dependent child) become entitled to Medicare benefits (applies only to the person who becomes entitled to Medicare);
5. If you (employee, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity to change their coverage option or add or drop dependents at open enrollment as similarly situated active employees. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add dependents if such person acquires a new dependent through marriage, birth, adoption or placement for adoption, or if an eligible dependent declines coverage because of alternative coverage and later loses such coverage due to certain qualifying reasons. Except for a child who is born to, adopted by or placed for adoption with a covered employee, dependents who are added under this paragraph do not become qualified beneficiaries-their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

Other Information

If you (the employee) or a family member has any questions about this notice or COBRA, please contact the Employer. Also, please contact the Employer if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

If your marital status changes, or a dependent ceases to be a dependent eligible for coverage under the Plan terms, or you or your spouse's address changes, you *must* immediately notify the Employer.

Employer: Bremerton School District is the Employer. All notices and other communications regarding the Plan and regarding COBRA should be directed to the following individual who is acting for the employer:

Payroll Office
Bremerton School District
134 Marion Ave N
Bremerton, WA 98312
(360) 473-1039

B. NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT (NMHPA)

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law (the Newborn's and Mother's Health Protection Act of 1996, NMHPA), restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

C. WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Group health plans are required by Federal law to notify you of a breast reconstruction benefit in your plan. This law requires that health plans, which include coverage for mastectomy, must also include coverage of the following:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and physical complications of all stages of mastectomy

Benefits for reconstructive surgery may be subject to annual deductibles, if any, and coinsurance consistent with those established for other benefits. Health plans and employers may not deny a member eligibility to enroll in or to renew coverage solely for the purposes of avoiding coverage of breast reconstruction following a mastectomy.

D. HIPAA MODEL PRIVACY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significantly new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
- Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.
- We have the obligation to provide and you have the right to obtain a paper copy of this notice from us at least every three years.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with regard to protected health information.

This notice is effective as of April 14, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change

the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request in writing a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
(202) 619-0257
Toll free: (877) 696-6775

E. OTHER INFORMATION

The following is a list of Supplemental information your medical plan must, by law, have available at your request.

1. Whether a point-of-service plan is available, and if so, how the plan works.
2. Any documents or other information referred to in the Certificate of Coverage, for example, the Provider Directory.
3. A full description of your health plan's referral program for consulting a provider other than the Primary Care Provider.
4. Information about policies for your health plan's providers prescribing drugs from a drug formulary or drug list, and whether or not the drugs must be dispensed as brand or generic, as well as information regarding drugs purchased at an out-of-area, non-participating pharmacy.
5. Procedures to follow for obtaining prior authorization for health care services.
6. A written description of any reimbursement or payment arrangements between your health plan and a contracted health care provider.
7. Circumstances under which your health plan may retrospectively deny coverage for emergency and non-emergency care that was prior authorized by your health plan.
8. A copy of all grievance procedures for claims or service denial and dissatisfaction with care.
9. Descriptions and justifications for provider compensation programs.

MEDICARE CREDITABLE COVERAGE NOTICE

This notice contains important information for you and your family members with Medicare coverage. This notice has information about your current prescription drug coverage with Bremerton School District medical insurers (KPS Health Plans, Premera Blue Cross or Group Health Cooperative) and the new prescription drug coverage available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

If you or no member of your family covered by our medical plans has Medicare, you can disregard this notice.

- Effective January 1, 2006, Medicare prescription drug coverage is available to everyone with Medicare.
- KPS Health Plans, Premera Blue Cross, and Group Health Cooperative have determined that the prescription drug coverages they offer to Bremerton School District employees is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
- Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

1. What if I wait to enroll in Medicare Part D Coverage?

Initially people with Medicare could enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later without incurring a penalty. Each year going forward, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th and December 31st.

2. What if I enroll in Medicare Part D Coverage?

If you drop your coverage with KPS Health Plans, Premera Blue Cross or Group Health Cooperative prescription drug plan and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You should also know that if you drop or lose your coverage with KPS Health Plans, Premera Blue Cross or Group Health Cooperative and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15,

2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

Contact DiMartino Associates, Inc. (1-800-488-8277) for further information if you have any questions. You may receive this notice at other times in the future such as before the next period you can enroll in the Medicare prescription drug coverage, and if this coverage changes. You may also request a copy.

3. Where can I get more information about Medicare Part D Coverage?

You can get more detailed information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook, which is mailed to you by Social Security within six months of becoming Medicare eligible, for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

XXI. RETIREMENT PLANNING

The following list of items is produced by the Washington State Department of Retirement Systems (DRS). It is intended to assist you in your retirement planning. You should contact DRS if you have any questions or want additional information.

Retirement Planning “To Do” List:

- If you are within 10 to 15 years of retiring, plan to attend a retirement planning seminar every five years or so.
- If you have ever withdrawn your contributions, check with DRS to see if you can restore the contributions, and if so, what the benefit would be to you (this must be done in writing).
- Check your beneficiary listed with DRS, and if needed, update (this must be done in writing).
- PERS members who established membership prior to 6-30-95, check on “buying” six-month probation period (this must be done in writing).
- PERS Plan 1 members, submit a copy of your DD214 at any time to see if your military service is creditable, and if so, submit your DD214.
- Two years prior to retirement, make sure your birth evidence, your spouse’s birth evidence, and (if appropriate) your marriage evidence is in order.
- Within two years of retirement attend a DRS Rights and Benefits presentation. Check with your employer on setting up a presentation for yourself and your co-workers.
- Within two years of retirement, attend a Washington Health Care Authority seminar regarding your rights and responsibilities for lifetime insurance coverage upon retirement. Call 1-800-200-1004 for more information.
- At age 61-½, check on your Social Security Benefits.
- During the year before your retirement, visit DRS and consult with a Retirement Benefits Specialist to make sure your file is in order. Call to make an appointment.
- The last year before your retirement, check on your medical insurance as a retiree. Those under the Washington Health Care Authority program will get the forms from DRS. All others should check with their employer for insurance information.

The following checklist was developed by the Bremerton School District Payroll Office. We hope it will assist you in achieving a smooth transition from active employment into retirement.

Date completed

_____ Enroll in a Retirement workshop 2 years prior to your intended retirement date and notify the Business and Personnel Offices of your intended date, so the cost of cash-outs and rehiring can be factored into the budget process.

_____ Contact the Department of Retirement (DRS) at 1-800-547-6657. Obtain the Membership Handbook specific to your plan and request a verification of your total years of service credit – this will provide the opportunity to correct any problems well in advance of retirement.

_____ Review your Membership Handbook. Note: you may be eligible to trade up to 45 days of your sick leave balance for additional retirement service credit.

_____ Enroll in a Retirement workshop during the year you expect to retire to get updates.

_____ Gather your final six years of W-2's from your copies of your federal income tax returns.

_____ Notify your supervisor and Personnel, in writing, of your intent to retire.

_____ If you intend to request a lump sum payment (cash-out) from DRS prior to September 15th, you must notify Personnel of the date you are requesting your cash-out. Please be aware, in order to accommodate a cash-out prior to September 15th, your contract must be paid in full by the last day of the month prior to the month of the cash-out. Also, you will forfeit your District-paid benefits beginning 30 calendar days after your working contract payoff.

_____ Personnel presents the letter of intent to the School Board.

_____ Contact DRS at 1-800-547-6657 to request retirement.

_____ Retirement packet received from DRS.

_____ Make photocopies of all forms before beginning to fill them out – **DRS will not accept any forms that have been corrected by white-out or cross-outs.**

Complete the DRS retirement application and send it to DRS **NO MORE THAN 90 DAYS OR LESS THAN 30 DAYS PRIOR TO YOUR INTENDED RETIREMENT DATE.**

Provide DRS with birth evidence – either a birth certificate or US Passport.

Provide DRS with a W-4P Optional form – if not, DRS is required to calculate benefits based on a status of married with 3 allowances.

Provide DRS with a W-9 – required by the IRS to verify your Social Security Number.

Provide DRS with a Direct Deposit Form (optional – but highly suggested).

Provide DRS with a TRS Plan 1 Application to Transfer Contributions completed by the receiving financial group or bank (applicable to Plan 1 employees only).

Personnel will mail you a copy of the Payroll Authorization (PA) and the Sick Leave Cash-out letter (Payroll receives a copy of the PA at the same time and begins the Retiring Employee check off list).

You will receive a Retiree letter from Payroll – this letter will tell you what your last date of employment is, when you will receive your final payroll warrant, when you will receive your vacation or sick leave cash-outs, if any, when your benefits from the District end, what your estimated sick leave cash-out will be, whether or not your bargaining unit has voted in VEBA enrollment, when your last date to contact the Health Care Authority (HCA) is, what your COBRA rights are and finally, you will be asked to sign and return the letter to Payroll acknowledging that you have received the letter and information.

Complete and return the sick leave cash-out letter to Personnel.

Sign the Retiree letter (**note the date you sign and return it on your personal copy**) and return the original to Payroll.

If required, return the VEBA enrollment form to Payroll along with the Retiree letter. If you are required to receive cash for your cash-out, you may want to submit a new W-4 form to change your Federal income tax withholding – if you have access to the internet, go to www.irs.gov and follow the prompts to get the printable W-4 form, which you can fill out, on-line and then print – or you may consider an increase to your Tax Sheltered Annuity salary reduction agreement – Consult a tax or financial advisor, as the District cannot advise you.

_____ Respond to your COBRA enrollment opportunity within **60 days** of notification from COBRA Compliance Inc. – this coverage is only good for 18 months. Use your COBRA coverage, then after 18 months, switch to the PEBB coverage. However, you **MUST** notify the Health Care Authority of your intent to defer your right until a later date (as directed in the next step).

_____ Contact the Health Care Authority (HCA) at 1-800-200-1004 within **60 days** of your last active day of employment – they will need you to declare your intent, in writing, to refuse, waive/defer your right until a later date or use the PEBB Plan.

_____ Contact the Social Security Administration, if age 62 or older, to access your Social Security benefit.

XXII. NOTES