Kiona-Benton City School District Employee Benefits Handbook

Effective October 1

2011/2012

~ PLAN YEAR ~

Open Enrollment
August 22 – September 2, 2011

Dear Kiona-Benton City School District Employees:

Please take the time to carefully review the enclosed materials to help you make important decisions regarding your employee benefits. Benefits are extremely important to you and your family, therefore careful analysis and decisions are critical.

The following pages briefly describe the medical, dental, vision, disability, life, and optional benefit coverages that are offered by the district. All employee bargaining units have been involved in the design and funding of the various employee benefit plans and will continue to participate in the decision process when changes are necessary to correspond with legislative revisions and budgetary needs.

It is important for you to inform payroll if you are experiencing any difficulty with your plan providers. In this way, we will be able to ensure you receive the high level of service you earn as an employee of Kiona-Benton City School District.

We are proud of the benefits that are available to you as an employee, and we again encourage your very serious study of this important information.

Sincerely,

Rom Castilleja
Superintendent

Table of Contents

Employee Benefits Program Directory 3
Health Care Reform Topics of Interest 4
Benefit Plan Changes 5
Basic Benefits – Guide to Funding & Pooling 8
Who is Eligible for Benefits? 9
Changing Your Benefit Choices 10
Medical Plans 11
Employee Requirements and Premium Rates 12
Monthly Medical Insurance Benefits and Rates 13
Dental Plans 16
Washington Dental Service (WDS) 18
Vision Plans 19
Voluntary Long Term Disability 20
Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance 21
Voluntary Short Term Disability 22
Identity Theft 23
Employee Assistance Plan (EAP) 23
Other Voluntary Benefits 23
Section 125 Premium Payment Plan Information 24
Notice of Automatic Enrollment and Salary Reduction Opt-out Form 26
Flexible Benefit Plan 27
Section 125 Enrollment Form 28
Section 125 Flexible Benefit Plan Expense Reimbursement Voucher 29
Dependent Day Care Reimbursement Form / Acknowledgement Form 30
Continuing Coverage under COBRA 31
Family and/or Medical Leave Act (FMLA) 33
Tax-Sheltered Annuities (TSAs) 34
Deferred Compensation Program (DCP) 35
VEBA Health Reimbursement Arrangement (HRA) 36
Workers' Compensation Self-insurance Program 36
Qualifications for Shared Sick Leave 37
ICMA Retirement Corporation 37
State of Washington Department of Retirement Systems 38
Direct Payroll Deposit 42
Automated Deposit Authorization Agreement 43
Attachments 44

Employee Benefits Program Directory

Payroll Department – Shelly Knight		(509) 588-2006
Personnel/AP Department – Louise Friedrichsen		(509) 588-2003
Enrollment and Claims Procedure		
COBRA Procedures (continuing medical & dental coverage)		
Retirement Plans (TRS, PERS & SERS)		
Supplemental Retirement Plans and Annuities (TSAs)		

Benefits Consultant

Copperleaf Consultants		
Rich Dickman		1-800-888-8322

Insurance Vendors

WEA Select Premera Blue Cross - Medical	*www.premera.com/wea*	1-800-932-9221
Group Health Cooperative	*www.ghc.org*	1-888-901-4636
Washington Dental Service	*www.deltadentalwa.com/wea*	1-800-554-1907
WEA Select Premera Blue Cross – Vision	*www.premera.com/wea*	1-800-932-9221
Lincoln Financial Insurance Company	*www.lfg.com*	1-800-423-2765
AFLAC	*www.aflac.com*	1-509-783-7400
American Fidelity Assurance Company	*www.afadvantage.com*	1-866-576-0201

Other District Programs

Department of Retirement Systems (DRS)	*www.drs.wa.gov*	1-800-547-6657
TRS, PERS & SERS – Active Member Services		
VEBA Service Group, LLC	*www.veba.org*	(509) 838-5571
Deferred Compensation Plans	*https://washington.gwrs.com*	1-888-327-5596
ICMA Retirement Corp.	*www.icmarc.org/plan3*	1-888-327-5596 option1

The following pages of this Employee Benefits Handbook describe the important plan provisions of employee benefits provided to and/or offered to employees of Kiona-Benton City School District. This Benefits Handbook is designed to be a short summary and is not designed to provide complete details of each benefit program.

In the event of any discrepancy with any of the materials, the master contracts control. The district reserves the right to change carriers and administrators as well as benefits. Before any such changes are made, the employee groups will be consulted. The material in this handbook was printed in August 2011. Any further information, revision by bargaining units, or by insurers after this date could change or modify the information contained herein.

If you have specific questions or need further information regarding your employee benefits, contact the Payroll Department, the district Benefits Consultant, or the Insurance Companies.

- Visit www.kibesd.org for an online version of this booklet**:**
  > click “Administration”
  > click “Human Resources”
  > click “Employee Retirement Health Plan Documents”
- Web-based benefit change/enrollment forms can be filled out online and printed for easier enrollment Remember to turn in the forms to the payroll office and keep a copy for yourself
- Enrollment/change forms for Group Health and WEA Select Plans are provided in this booklet

Due to PSE contracted scheduling dates, transportation employees ONLY will have until September 9, 2011 to turn in enrollment applications. All other employees have until September 2, 2011 to turn in enrollment forms.

Health Care Reform Topics of Interest

Patient Protection and Affordable Care Act (PPACA)

2011-2018

- Reporting health coverage cost on form W-2 requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage (note that this does not create a new tax)
- Eliminates annual limits (effort to prohibit all employer plans and new plans from imposing annual limits on the amount of coverage an individual may receive)
- The establishment of health insurance exchanges
    - Each state will create exchanges to allow individuals and small employers to purchase insurance
- Efforts to reduce avoidable hospital readmissions
- Limits health flexible saving account contributions
- Provides health care tax credits for lower income individuals
- Promotes individual responsibility
    - Requires most individuals to purchase acceptable health care coverage or pay a penalty
- Promotes employer responsibility
    - May require employers with 50 or more employees who do not offer coverage to their employees to pay an annual fee
- Excise tax on high cost employer provided health plans
- Cadillac Tax is an excise tax on high cost employer provided health plans (the tax threshold will be indexed to inflation)

The above list is not all-inclusive of the outcomes of the PPACA legislation.

Benefit Plan Changes

The following is a list of current revisions provided by Group Health Cooperative, Washington Education Association (WEA), and Select Premera Blue Cross. This is a brief summary of benefit modifications/enhancements and is subject to change at any time.

Refer to your plan booklets for a full description of benefits, limitations, and exclusions.

GROUP HEALTH COOPERATIVE – HMO PLANS

Contract or Plan Changes

BENEFIT CHANGE	*EXPLANATION*
Accessing Care	A clarification has been made throughout the document to replace references to "referral" with "authorization" for consistency in terminology. Terms such as self-referral and preauthorization have either been removed or replaced as well. A clarification has been added to enhance the description of a second opinion.
Allowances Schedule	A new provision has been added to state that newborn services are covered the same as for any other condition. Any applicable cost share for newborn services is separate from that of the mother. The optical services provision has been revised to state that eye examinations for eye pathology, including contact lens exams are covered. Lenses for eye pathology are now covered. A clarification has been added to the tobacco cessation provision to state that individual/group counseling is covered.
Enrollment and Eligibility	The special enrollment provision for eligibility for medical assistance has been revised in accordance with state regulations to reflect that the request for enrollment must be made within 60 days. An additional provision was added to address termination of coverage under Medicaid or CHIP, and the requirement for application within 60 days.
Medical and Surgical Care	Benefit provisions in Section IV have been clarified to include pertinent exclusions from Section V.
Miscellaneous Provisions	A provision on utilization management of covered services has been added for clarification purposes.
Definitions	A definition for authorization has been added to replace the definition for referral.

WASHINGTON EDUCATION ASSOCIATION (WEA) SELECT PREMERA BLUE CROSS PLANS

Benefit Change Summary

The following is a brief summary of benefit modifications/enhancements only for those plans with changes. Refer to plan booklets for a full description of benefits, limitations, and exclusions.

WEA Select Medical Plan—Premera Blue Cross (All Plans)

The WEA Select Medical Plan renewal includes a multi-faceted approach, which brings the plans more in line with their current costs relative to the benefit levels and current enrollment, while at the same time providing relief for family out-of-pocket costs. This approach will ensure that a wide variety of plan options remain available to meet the various needs of plan participants. WEA will be conducting dependent eligibility verification this year, and the projected savings applied to the dependent tiers further reduces the out-of-pocket costs for families. For employees enrolled in the two plans with a rate increase, they will have the ability to mitigate their rate increase and to significantly reduce the monthly premium by moving to a lower cost plan. As part of WEA's Rate Stabilization Fund (RSF) strategy, rates will be subsidized 1.5% out of the RSF. As a result, the needed rate increase varies by plan and by tier (e.g. employee only, employee + spouse, full family, and employee + children), as noted below:

- Plans 1 and 5: +8.9% to +12%, depending on tier
- Plans 2 and 3: -1.9% to -4.9%, depending on tier
- EasyChoice: -7.9% to -10.9%, depending on tier

Simplification of Out-of-Pocket Maximum (Plans 1, 2, and 3)

The General Benefits (coinsurance/deductible) out-of-pocket maximum calculation will be converted to a "you pay" methodology for Plans 1, 2, and 3 as noted below. The deductible will be included in the out-of-pocket maximum and a family maximum has been added. Amounts are calculated on a calendar year basis.

- Plan 1: $500 individual/$1,500 family
- Plan 2: $1,500 individual/$4,500 family
- Plan 3: $2,750 individual/$8,250 family

Nicotine Dependency — Healthcare Reform (All Plans)

- Nicotine dependency (smoking cessation) classes and programs will be covered at 100% when an in-network provider is used. The visit limitation will be removed.
- Services provided by an out-of-network provider will be covered subject to the applicable deductible and coinsurance.
- The prescription drug limitation will be removed.

Life Insurance Included with Medical

The employee only life insurance included with the medical plan will be converted from a decreasing schedule to a flat $12,500. Benefits will reduce to $8,125 for ages 65-69; and to $6,250 for ages 70 and older.

Health Management Program

The WEA Select Health Management Program is a voluntary and confidential program designed to assist people who, due to family history or lifestyle factors, are at risk for developing chronic diseases in the future. The overall goal is to improve the health status and quality of life for plan participants, which should in turn positively impact future health care trends. The program includes web-based tools and trackers and lifestyle centers to help guide enrollees toward improved health. For those who qualify, personal one-on-one telephone health coaching is available.

Dependent Eligibility Verification

WEA will be conducting dependent eligibility verification later this year. These verifications are done to ensure that the plan is only covering dependents that meet the plan's definition of an eligible dependent. Many large plan sponsors including the state of Washington have conducted eligibility verifications over the past several years, resulting in a positive financial impact to their plan. More specific information about the verification will be sent to WEA leaders and school districts later this summer.

WEA SELECT CORE DENTAL PLAN - WDS

Change in Benefit Year

Currently, the Plan Year (when rates and benefit changes become effective) is October 1 – September 30. However, the Benefit Year (when the annual benefit maximum renews) is September 1 – August 31. The Benefit Year will be adjusted to coincide with the Plan Year as follows:

- The current benefit year (2010-11) will be extended one month and all enrollees will receive an additional $170 for the month of September. Enrollees will then receive their full benefit effective October 1, 2011.
- This "extra" benefit will be available in addition to any remaining balance of an enrollee's 2010-11 benefit maximum.
- Going forward, the benefit maximum will renew on October of every year.

Alternate Identification Numbers

Effective June 13, 2011, WDS will use randomly selected identification (ID) numbers for plan participants in place of Social Security numbers. All Explanation of Benefits (EOB's) and other information will reflect the enrollee's new alternate ID number. Enrollees may use their alternate ID number or continue to use their Social Security number at their dental office, when they contact customer service, or when verifying benefits online at www.deltadentalwa.com/wea.

Basic Benefits – Guide to Funding & Pooling

The following information is to help each employee understand the basic benefits for the 2011-2012 school years and the state mandated pooling process.

STATE FUNDING & POOLING

The State allocation for benefits is $768.00 per month per 1.0 FTE.

The employee benefit allocation may be utilized to purchase basic benefits, which may include medical, dental, vision, group long term disability (LTD), and group term life insurance for each employee group and/or bargaining unit, *based on the benefits negotiated by each group*. In all groups, dollars are first applied to benefits requiring 100% participation such as dental and vision, and the balance is available for medical insurance. Any unused, remaining dollars are then "pooled," and reallocated among employees with payroll deductions. New benefit pooling rates are recalculated in September each year just prior to the completion of payroll. There is no guarantee that your employee group will have any available "pooled dollars" to reduce out-of-pocket deductions for basic benefits.

STEP ONE - BASIC BENEFITS

Each employee group chooses which basic benefits to offer their employees. The choices allowed under state law are:

- Medical
- Dental
- Vision
- Group Long Term Disability
- Group Term Life

Both the certificated and classified groups have chosen medical, dental, and vision. Some of the medical plans offer life insurance.

STEP TWO - ENROLLMENT

After the group has selected its basic benefits, individual employees need to enroll in the mandatory plans (if eligible) and may decide whether they want medical for themselves and/or their dependents. Employees may also elect no medical coverage.

Open enrollment is August 22 – September 2. To effective by September 1, your application must be received at the payroll office no later than 3:00 p.m., September 2, 2011.

Due to PSE contracted scheduling dates, transportation employees **only** will have until September 9, 2011 to turn in enrollment applications.

STEP THREE - POOLING

All employees' leftover (unused) benefit dollars go into a pool. This pool is then reallocated to all the employees with payroll deductions for basic benefits. These "pooled dollars" will help reduce their final payroll deduction. The amount available from the pool is calculated annually in September.

Who is Eligible for Benefits?

As an employee of the Kiona-Benton City School District, you may be eligible for benefits which may include medical, dental, vision, disability, or life insurance coverage. In addition, you may participate in some flexible benefit plans and other optional benefits.

This guide will be updated and distributed electronically to employees annually during the open enrollment period for the district's employee benefit program. Changes in your prior year's election are made during the open enrollment period which takes place during the month of September.

EMPLOYEE ELIGIBILITY

All employees who work at least three hours a day or more in a regular position may access various insurance plans.

If both you and your spouse are eligible district employees, you may enroll as subscribers in the same or different plans, and each may cover eligible dependent family members. A representative of the participating plans or the payroll office may request, at any time, verification of the dependency status of anyone enrolled under your employee benefit coverage.

DEPENDENT ELIGIBILITY

Generally, dependents are defined as an employee's legally married spouse, qualifying child, or qualifying relative (as defined by the IRS). Medical benefit plans may provide coverage for Domestic Partners. Verification of Domestic Partnership may be required. Affidavit of Domestic Partnership and Declaration of State Registered Domestic Partnership are available on pages 59 and 61 or in the district payroll office. Please review pertinent carriers' certificate for further dependent definitions or for further information contact the carriers' customer service.

Newly acquired dependents by marriage, birth, or adoption become eligible on the first day of the next month. Application must be made within sixty (60) days of marriage, birth, or adoption.

Generally, if both you and your spouse are eligible district employees, you may enroll as subscribers in the same or different plans and may each cover eligible dependent family members except for life and accidental death & dismemberment insurance options. See pertinent carriers' certificate for all eligibility, benefits, coverage dates, and termination issues regarding your insurance coverage.

Verification of the dependency status of anyone enrolled under your employee benefit coverage may be requested at any time by representatives of our insurance vendors.

Changing Your Benefit Choices

Each year the district holds an annual open enrollment period from August to September. At this time you may choose to continue your benefits with the carrier as they were the previous year, or you may choose to change health plans, life insurance coverage, or make other adjustments to better fit the benefits to your personal needs.

Certain qualifying events may allow you to make benefit changes outside the open enrollment period. Acceptance and approval of these "qualifying events" are subject to the terms and conditions of the official contract and plan description of the insurance carrier. To make a change, submit appropriate enrollment forms to the Kiona-Benton City School District Payroll Department within **thirty (30) calendar days** of the event.

QUALIFYING EVENTS

- Change in marital status, including marriage, divorce, death of spouse, legal separation, and annulment
- Change in number of dependents, including birth, adoption, placement for adoption, and death
- Change in employment status, including termination, change in hours, change in worksite, and unpaid leave
- Dependent ceases to be eligible due to age
- Residence change of employee, spouse, or dependent, affecting eligibility for coverage
- Medical child support orders
- The taking of Family Medical Leave by the employee or the employee's spouse
- A significant change in health coverage of a spouse or dependent under another employer's plan
- A significant change in cost of a benefit package option
- Entitlement to Medicare or Medicaid
- COBRA Qualifying event (see pages 31-32 in this handbook)
- HIPAA special enrollment right
    - Loss of COBRA coverage
    - A new dependent is acquired
    - Coverage under Medicaid or CHIP is terminated as a result of loss of eligibility
    - Eligibility is gained for a state premium assistance subsidy through Medicaid or CHIP

Benefit changes must be consistent with the qualifying event. Acceptance and approval of the changes made by an employee are subject to the terms and conditions of the official contract and plan description of the insurance carrier and federal and state law.

Medical Plans

Deciding which medical plan to join should be done carefully. It represents one of the biggest "fringe benefits" of your employment, and you will not be able to change plans until the next annual open enrollment period unless an IRS "qualifying event" occurs.

Kiona-Benton City School District is pleased to offer you and your dependents the choice of eight medical plans. Details regarding each plan are listed in the back of this booklet.

GROUP HEALTH COOPERATIVE PLANS

Group Health Cooperative (GHC) is a not-for-profit, consumer-governed health maintenance organization that features preventive health care, no annual deductibles, no claim forms, and worldwide emergency coverage. Group Health Cooperative focuses on integrated care that is coordinated by a specialist in primary care and uses three approaches for delivering care to members: 1) Staff physicians in GHC healthcare centers, 2) Community physician partners, and 3) Affiliated group practices, such as Rockwood Clinic of Spokane.

Group Health received Full Accreditation from the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization that evaluates managed-care plans across the United States. Full Accreditation is NCQA's highest rating and is valid for a 3-year period.

WEA SELECT PREMERA BLUE CROSS PLANS

The WEA Select Premera Plans are underwritten by Premera Blue Cross. The plans are designed specifically for Washington school employees and include thousands of in-network providers in all areas of the state. Plan 1, Plan 2, Plan 3, Plan 5, and EasyChoice A, B, and C are available, giving you the choice between higher benefit levels and lower premium costs, depending on the needs of your family. Term life insurance for employees is included in the plans.

MEDICAL NETWORKS

When deciding which health insurance plan to select it is important to take note of the differences in networks. The WEA plans use Premera Blue Cross Heritage and Foundation networks. Group Health has a separate HMO network.

Networks can differ in several categories. Ones to consider are:

- Hospitals
- Urgent Care
- Pharmacies
- Specialists
- Physicians

For the most accurate information on whether a facility or doctor is in a certain network, please search online at:

Premera – www.premera.com > click "Find A Doctor"

Group Health – www.ghc.org/provider > click "Provider and Facility Directory"
> choose a topic under "Search for"
> click "Group Health" from network drop down menu
> Enter requested information and click "Search" to find provider

Employee Requirements and Premium Rates

1. All employees must complete a W-4 form available in payroll.

2. All employees working over 70 hours per month need to complete a Department of Retirement Systems Employee's Permanent Record form.

3. Certificated employees must register a valid Washington State teaching certificate with the district office within 30 days of their hire date.

4. Mandatory insurance participation (as per employee group negotiated agreements):

Dental	Washington Dental Service	Certificated (Plan A) Classified (Plan A)	$126.75 per month $121.65 per month
Vision	WEA Select Vision Plan D	All employees	$ 23.30 per month

BALANCE OF STATE ALLOCATION (AFTER MANDATORY BENEFITS ARE PURCHASED):

	CERTIFICATED	CLASSIFIED
Funding:		
State Allocation (for 1.0 FTE)	$768.00	$768.00
Premiums for mandatory benefits:		
Dental	(126.75)	(121.65)
Vision	(23.30)	(23.30)
Balance Remaining	**$617.95**	**$623.05**

The balance remaining may be used to purchase additional benefits such as medical coverage.

Monthly Medical Insurance Benefits and Rates

2011 – 2012 School Year

GROUP HEALTH COOPERATIVE PLANS

Rates	Group Health HMO School Pool $20 Copay Plan
Employee	$624.40
Employee & Spouse	$1,211.34
Employee & Family	$1,461.10
Employee & Child(ren)	$874.16
Benefit	
Deductible (PCY)	$0
Office Visit	$20 copay
Coinsurance	0%
Out-of-Pocket Maximum (includes inpatient, outpatient, emergency, and ambulance services)	$2,000 p/person
Prescription Drugs Deductible	No
Retail (30-day supply)	$15 generic $25 brand name $45 non-formulary
Mail Order (90-day supply)	$30 generic $50 brand name $90 non-formulary
Hospitalization	$200/day (up to 3 days p/admit)

For more specific benefit information please refer to the Summary of Benefits at the end of the handbook, or contact the payroll department for these materials.

WEA SELECT PREMERA BLUE CROSS PLANS

Rates	WEA Select Premera Blue Cross Plan 1	WEA Select Premera Blue Cross Plan 2	WEA Select Premera Blue Cross Plan 3	WEA Select Premera Blue Cross Plan 5
NETWORK	**HERITAGE**	**HERITAGE**	**HERITAGE**	**FOUNDATION**
Employee	$806.15	$617.95	$552.80	$723.15
Employee & Spouse	$1,531.15	$1,166.15	$1,043.45	$1,432.70
Employee & Family	$1,838.10	$1,398.40	$1,251.40	$1,726.30
Employee & Child(ren)	$1,113.10	$850.20	$760.75	$1,016.75
Benefits				
Deductible (PCY)	$50 p/person $150 p/family; not subject to office visits, preventive care, or prescription drugs	$100 p/person $300 p/family; not subject to office visits, preventive care, or prescription drugs	$200 p/person $600 p/family; not subject to office visits, preventive care, or prescription drugs	$100 p/person $300 p/family; not subject to office visits, preventive care, or prescription drugs
Office Visit	$20 copay	$25 copay	$30 copay	$15 copay
Coinsurance	10%	20%	20%	0%
Out-of-Pocket Maximum (PCY) (includes deductible and coinsurance)	$500 p/person	$1,500 p/person	$2,750 p/person	$100 p/person
Prescription Drugs				
Deductible	No	No	No	No
Retail (30-day supply)	$10 generic $15 brand name $30 non-preferred	$10 generic $20 brand name $35 non-preferred	$15 generic $25 brand name $40 non-preferred	$10 generic $15 brand name $30 non-preferred
Mail Order (100-day supply)	$10 generic $15 brand name $30 non-preferred	$10 generic $20 brand name $35 non-preferred	$15 generic $25 brand name $40 non-preferred	$10 generic $30 brand name $60 non-preferred
Hospitalization	$100/day ($300 max/year) + Ded +10%	$150/day ($450 max/year) + Ded + 20%	$300/day ($900 max/year) + Ded +20%	$200/admit ($600 max/year) + Ded

For more specific benefit information please refer to the Summary of Benefits at the end of the handbook, or contact the payroll department for these materials.

Rates (same for all plans)	**WEA Select Premera EasyChoice A**	**WEA Select Premera EasyChoice B**	**WEA Select Premera EasyChoice C**
NETWORK	**HERITAGE**	**HERITAGE**	**FOUNDATION**
Employee	$421.55	$421.55	$421.55
Employee & Spouse	$793.85	$793.85	$793.85
Employee & Family	$951.55	$951.55	$951.55
Employee & Child(ren)	$579.25	$579.25	$579.25
Benefits			
Deductible (PCY)	$1,000 p/person $3,000 p/family; Not subject to office visits, preventive care, or prescription drugs	$750 p/person $2,250 p/family Not subject to office visits, preventive care, or prescription drugs	$0 p/person $0 p/family
Office Visit	$15 copay	$30 copay	$35 copay
Coinsurance	20%	25%	35%
Out-of-Pocket Maximum (PCY) (includes deductible and coinsurance)	$5,000 p/person	$4,000 p/person	$7,500 p/person
Prescription Drugs			
Deductible (waived for generics) (PCY)	$500 p/person	$250 p/person	$500 p/person
Retail (30-day supply)	$0 generic 30% brand name 30% non-preferred	$0 generic $30 brand name $45 non-preferred	$0 generic $30 brand name $45 non-preferred
Mail Order (90-day supply)	$0 generic 25% brand name 25% non-preferred	$0 generic $75 brand name $112 non-preferred	$0 generic $75 brand name $112 non-preferred
Hospitalization	Deductible + 20%	Deductible +25%	Deductible + 35%

For more specific benefit information please refer to the Summary of Benefits at the end of the handbook, or contact the payroll department for these materials.

Dental Plans

WEA SELECT DENTAL PLAN A - CERTIFICATED

Basis of Payment – Any Member Dentist	Filed Fees
Benefit Year	10/1-9/30
Benefit Year Maximum (PPO Network Provider)	$1,750 per person*
Benefit Year Deductible	No Deductible
Diagnostic & Preventive Care (Class I - Exams, Cleanings, Fluoride, X-rays & Sealants)	70/80/90/100% Incentive Level**
Routine Care (Class II - Fillings, Oral Surgery, Root Canals, Periodontics & Endodontics)	70/80/90/100% Incentive Level**
Onlays & Crowns (Class II)	70/80/90/100% Incentive Level**
Dentures, Bridges, Partials, & Implants (Class III)	50% Constant Level of Reimbursement
Orthodontia Plan A (covers adults and dependent child(ren) to age 26)	50% payable up to $1,000 Lifetime
Monthly Total Composite Rate for Dental & Orthodontia	**$126.75**

THIS IS A BRIEF SUMMARY OF BENEFITS ONLY AND DOES NOT CONSTITUTE A CONTRACT. PLEASE REFER TO YOUR PLAN BOOKLET FOR COMPLETE INFORMATION REGARDING BENEFITS AND ELIGIBILITY REQUIREMENTS.

*The annual maximum will increase to $2,000 if a Delta Dental PPO dentist is used.

**The Washington Dental Service Incentive plan is designed to promote regular dental care by increasing the amount paid for preventive care and regular visits from one 12-month benefit period to the next. During the first benefit period, the payment level for covered and allowable Class I and Class II benefits is 70%. This payment level will increase by 10% - up to a maximum of 100% - each successive benefit period in which benefits are used at least once by the eligible person(s). If the once-a-year visit is missed, the payment level will be decreased by 10% for each benefit period during which benefits are not used. In no event will the payment level be less than 70%. The incentive provision does not apply to Class III benefits, which are paid at 50%.

WASHINGTON DENTAL SERVICE
P.O. Box 75688
Seattle, WA 98125
Customer Service (206) 522-2300
Toll-free 1-800-554-1907

WEA SELECT DENTAL PLAN A - CLASSIFIED

Basis of Payment – Any Member Dentist	Filed Fees
Benefit Year	10/1-9/30
Benefit Year Maximum (PPO Network Provider)	$1,750 per person*
Benefit Year Deductible	No Deductible
Diagnostic & Preventive Care (Class I - Exams, Cleanings, Fluoride, X-rays & Sealants)	70/80/90/100% Incentive Level**
Routine Care (Class II - Fillings, Oral Surgery, Root Canals, Periodontics & Endodontics)	70/80/90/100% Incentive Level**
Onlays & Crowns (Class II)	70/80/90/100% Incentive Level**
Dentures, Bridges, Partials, & Implants (Class III)	50% Constant Level of Reimbursement
Orthodontia Plan B (covers dependent child(ren) to age 26)	50% payable to $1,000 Lifetime
Monthly Total Composite Rate for Dental & Orthodontia	**$121.65**

THIS IS A BRIEF SUMMARY OF BENEFITS ONLY AND DOES NOT CONSTITUTE A CONTRACT. PLEASE REFER TO YOUR PLAN BOOKLET FOR COMPLETE INFORMATION REGARDING BENEFITS AND ELIGIBILITY REQUIREMENTS.

*The annual maximum will increase to $2,000 if a Delta Dental PPO dentist is used.

**The Washington Dental Service Incentive plan is designed to promote regular dental care by increasing the amount paid for preventive care and regular visits from one 12-month benefit period to the next. During the first benefit period, the payment level for covered and allowable Class I and Class II benefits is 70%. This payment level will increase by 10% - up to a maximum of 100% - each successive benefit period in which benefits are used at least once by the eligible person(s). If the once-a-year visit is missed, the payment level will be decreased by 10% for each benefit period during which benefits are not used. In no event will the payment level be less than 70%. The incentive provision does not apply to Class III benefits, which are paid at 50%.

WASHINGTON DENTAL SERVICE
P.O. Box 75688
Seattle, WA 98125
Customer Service (206) 522-2300
Toll-free 1-800-554-1907

Washington Dental Service (WDS)

- Washington Dental Service (WDS) is the largest dental insurance carrier in the State of Washington. Over 85% (3,000+) of the licensed dentists in Washington State are members of WDS.

- You may select any licensed dentist. Tell your dentist you are covered by a WDS dental program and give your dentist your social security number, the program name, and your program number.

- If your dentist is a member dentist, the dentist will submit claim forms to WDS and receive payment based on the dentist's filed fee. You are responsible for any balance remaining.

- If you choose to use a non-member dentist, claim forms will be provided to you to submit to WDS. Payment will be made to you based on the average fees in Washington. Payment for enrollees using non-member dentists would be issued on a co-payee basis to the subscriber and dentist.

- If you receive dental treatment outside Washington State, you are responsible for paying the dentist's bill and submitting the claim to WDS for reimbursement. Payment will be based on the dentist's charge or the amount that would have been payable if treatment had been provided by a WDS member dentist, whichever is less. If the dentist is a member of their state Delta Dental Plan, payment is based on the dentist's filed fees with that state.

- If your dental care will be extensive, ask your dentist to complete and submit a standard WDS claim form for an estimate. This will allow you to know in advance exactly what procedures are covered, the amount WDS will pay toward the treatment, and your financial responsibility. You will receive a copy of the results of the pre-determination of benefits.

Vision Plans

WEA SELECT VISION PLAN D

BENEFITS	PREMERA BLUE CROSS PARTICIPATING PROVIDERS
EXAMINATION	
Once every calendar year	$5 copay
Exam once every calendar year after copay	Paid in full
LENSES	
Once every calendar year	
Single Vision	Paid in full
Bifocal	Paid in full
Trifocal	Paid in full
Lenticular	Paid in full
Continuous blend	Paid in full
Oversize Lenses	Not covered
Lens Tinting, coating, light sensitive lenses, sunglasses when benefits provided for lenses under this program	$15
FRAMES	
Once every 2 calendar years	$65
CONTACTS	
Medical necessary contact lenses once every calendar year in lieu of eyeglass lenses (following cataract surgery or to improve vision to 20/70 or better)	Paid in full
Once every 2 calendar years (in lieu of frames and eyeglass lenses)	$200
Monthly Composite Rate	**$23.30**

The rate is a “composite rate.” This means that the amount shown above is paid monthly for each eligible employee, regardless of marital status or number of dependents, and covers the employee and all eligible dependents.

All full-time employees, as defined by the group, must participate in the plan.

The benefits are subject to Premera Blue Cross allowable charges. Premera Blue Cross network providers agree not to bill for amounts over the allowable charge.

Contacts

WEA Select Customer Service Team
1-800-932-9221
Hearing impaired TDD 1-800-842-5357

www.premera.com/wea
- Benefit book and summary of benefits
- Claims information*

*Select “Login/Register” in the left column. First time users will need their Premera ID card member number.

This summary is a brief outline of the main features of your plan. For details of benefit limitations and exclusions, please see the WEA Select Vision Care Plan D benefit booklet, available online or by calling the WEA Select Customer Service Team.

Voluntary Long Term Disability

LINCOLN FINANCIAL INSURANCE COMPANY

Eligible Members:	All full time employees (minimum .5 FTE)
What is LTD?	Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.
LTD Benefit:	60% of salary
Maximum benefit:	$6,000 per month
Minimum benefit:	$100 per month
Elimination Period:	90 days (The number of days you must be disabled prior to collecting disability benefits.)
Total disability definition:	You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your own occupation. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training.
Maximum Benefit Duration and Rates:	Benefit duration and rates are subject to age at time of Total Disability and the benefit level you select. Contact the payroll department for premium and benefit information.

This is a brief summary of benefits only and does not constitute a contract. Please refer to your plan booklet for complete information regarding benefits and eligibility requirements. The District does not endorse any voluntary product. Products offered are benefit enhancements.

Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance

LINCOLN FINANCIAL INSURANCE COMPANY

Eligible Members: All full time employees (minimum .5 FTE)

	Employee	Spouse	Dependent
Benefit:	Choice of $10,000 increments Not to exceed 5 times your salary.	Choice of $5,000 increments Employee must elect coverage for spouse to be eligible. Not to exceed 50% of employee elected amount.	$10,000 Child: Six months to age 19 (to age 25 if full-time student) *See note below
Maximum Amount	$300,000	$150,000	Not applicable
Minimum Amount	$10,000	$5,000	Not applicable
Guarantee Issue	The lesser of $50,000 or 300% of salary under age 70	$20,000 under age 60 No Guarantee Issue age 60 and older	Not applicable
Benefits will reduce:	The amount of Life and Accidental Death & Dismemberment Insurance benefits shall reduce to 65% at age 65, to 40% at age 70, to 25% at age 75 or over, and terminate at age 80 or retirement.		Not applicable

Monthly Rates:

Age	Monthly Rate per $1,000	$25,000	$50,000	$100,000	$200,000	$300,000
< 30	$0.06	$1.50	$3.00	$6.00	$12.00	$18.00
30 - 34	$0.08	$2.00	$4.00	$8.00	$16.00	$24.00
35 - 39	$0.09	$2.25	$4.50	$9.00	$18.00	$27.00
40 - 44	$0.10	$2.50	$5.00	$10.00	$20.00	$30.00
45 - 49	$0.15	$3.75	$7.50	$15.00	$30.00	$45.00
50 - 54	$0.23	$5.75	$11.50	$23.00	$46.00	$69.00
55 - 59	$0.39	$9.75	$19.50	$39.00	$78.00	$117.00
60 - 64	$0.57	$14.25	$28.50	$57.00	$114.00	$171.00
65 - 69	$0.95	$23.75	$47.50	$95.00	$190.00	$285.00
70 - 74	$1.55	$38.75	$77.50	$155.00	$310.00	$465.00
75 - 79	$1.55	$38.75	$77.50	$155.00	$310.00	$465.00

Dependent Children: $2.00/month.

*Note: If you purchased life insurance for your dependent child(ren) before 1/8/2010 the coverage and rate was grandfathered at .30$ per month for a $2,000 benefit. Dependent child(ren) coverage purchased after 1/8/2010 is at $2 per month for a $10,000 benefit.

This is a brief summary of benefits only and does not constitute a contract. Please refer to your plan booklet for complete information regarding benefits and eligibility requirements. The District does not endorse any voluntary product. Products offered are benefit enhancements.

Voluntary Short Term Disability

LINCOLN FINANCIAL INSURANCE COMPANY

Eligible Members:	All full time employees (minimum .5 FTE)
What is STD?	Short-term disability is intended to protect your income for a short duration in case you become ill or injured.
STD Benefit:	66.67% of salary
Maximum benefit:	$1,500 per week
Minimum benefit:	$100 per week
Elimination Period:	Benefits begin on: 15 days for an accident 15 days for an illness
Total disability definition:	You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.
Maximum Benefit Duration and Rates:	11 weeks
Monthly Rates:	Rates are subject to annual income and the benefit level you select. Contact the payroll department for premium and benefit information

This is a brief summary of benefits only and does not constitute a contract. Please refer to your plan booklet for complete information regarding benefits and eligibility requirements. The District does not endorse any voluntary product. Products offered are benefit enhancements.

Identity Theft

LINCOLN FINANCIAL INSURANCE COMPANY

Insurance and resolution services are provided at no cost to all eligible employees. The coverage protects all the members of employee's household. If not participating in the short-term or long-term disability plan, there is $5 monthly fee for participation in the program.

Employee Assistance Plan (EAP)

LINCOLN FINANCIAL INSURANCE COMPANY

Employee Connect

Your EAP provides no-cost, confidential assistance for you and your family members. By calling EAP, you can identify solutions to assist with life, work, and family concerns. Information you discuss with EAP is kept confidential in accordance with federal and state laws. EAP services can help you with:

- Depression – stress management
- Anxiety
- Family conflict
- Relationship problems
- Financial or legal concerns
- Alcohol or drug addictions
- Gambling problems
- Parenting concerns
- Child or elder care

Employee Connect

1-877-757-7587

www.eapadvantage.com

(password – **connect**)

Employee Connect is available 24 hours a day, 7 days a week with support, guidance, and resources. Talk with a specialist at **1-877-757-7587** or visit them online at www.eapadvantage.com (password = **connect**).

A professionally trained clinician is available to assist you with problem identification, analysis, and short-term problem resolution. Your EAP counselor can provide a referral for services within your health insurance benefits or to community resources / self-help groups. Services provided by Bensinger, DuPont & Associates.

Other Voluntary Benefits

AFLAC offers employees a variety of insurance policies such as Income Protection, Cancer Protection, Accident, and Hospital Care Protection. Monthly premiums are paid through a payroll deduction. Employees may sign up for coverage during open enrollment by contacting AFLAC at (509) 783-7400.

All benefits received from these policies are paid in addition to your medical insurance benefits. For more detailed information, contact Shelly Knight, (509) 588-2006 or e-mail sknight@kibesd.org .

This is a brief summary of benefits only and does not constitute a contract. Please refer to your plan booklet for complete information regarding benefits and eligibility requirements. The District does not endorse any voluntary product. Products offered are benefit enhancements.

Section 125 Premium Payment Plan Information

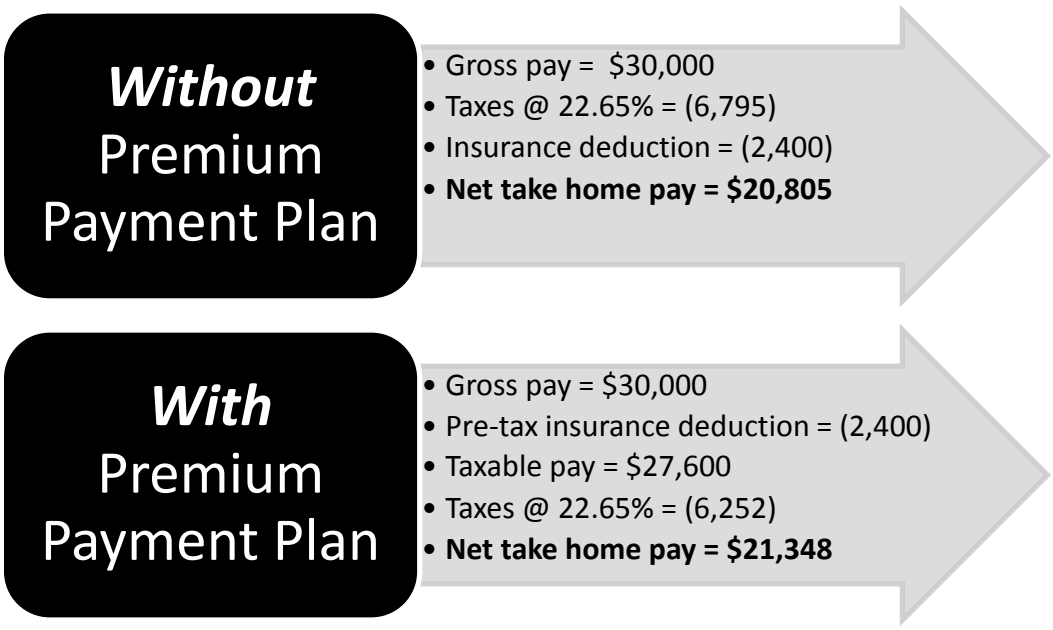
This is the plan that allows you to convert after tax payroll deductions for qualified fringe benefits to pre-tax salary reduction contributions.

What is a Premium Payment Plan?

A Premium Payment Plan under Section 125 allows you to avoid social security and federal income tax withholding on your share of group insurance premiums. By signing up for the District's Premium Payment Plan, an employee will be converting an after-tax payroll deduction for qualified fringe benefits to pre-tax salary reduction contributions. Income taxes and social security taxes will be applied to your salary only after your contributions for qualified benefits have been deducted (see the example). However, Washington State retirement contributions and benefits will continue to be based on your gross salary.

Example:

Mark has taxable income (i.e. gross income less deductions and exemptions) of $30,000 per year. His employer deducts $200 per month ($2,400 per year) from his pay warrant to pay the premiums for covering his spouse and children under the District's group insurance plan. Mark is in the 15% Federal Income Tax bracket and subject to FICA taxes of 7.65% for total tax withholding of 22.65%.



Mark has *increased* his take home pay by *$543 per year ($45.25 per month)* by participating in the District's Section 125 Premium Payment Plan.

How does it work?

If you elect to participate, your monthly deduction for qualified benefits will be adjusted from an "after-tax" basis to a "pre-tax" basis. If currently enrolled in the Premium Payment Plan, a new enrollment form must be submitted to participate in the plan this year.

This is the plan that allows you to convert after tax payroll deductions for qualified fringe benefits to pre-tax salary reduction contributions.

What insurance premiums qualify?

- Premiums for group medical, dental, vision, accident, and/or disability insurance
- Premiums for optional group term life insurance policies with a face value of $50,000 or less

Why should I participate?

Your withholding taxes will decrease and your net take-home pay (spendable income) will increase.

Are there any negatives?

Because Social Security tax will not be deducted from the amount used to pay for qualifying insurance premiums, your Social Security benefits may be reduced.

You cannot revoke your premium conversion election mid-year unless you experience a qualifying event.

Can I revoke my premium conversion amount?

Only if you have a change in family status for such "qualifying events" as marriage, divorce, birth, adoption of a child, or change in employment status or your spouse's employment status during the plan year. You must change your election within 30 calendar days of the event. If your group medical premiums change, your deduction will be adjusted automatically.

How do I elect to participate?

Should you choose to pay your insurance premiums pre-tax, complete the annual form for the premium payment plan and return the completed form to the payroll department. Unless you are a newly eligible employee, YOU MAY ONLY ENROLL IN THE PLAN DURING THE OPEN ENROLLMENT PERIOD.

Once you are enrolled in the premium payment plan, it is not necessary to complete another annual enrollment form UNLESS YOU NO LONGER WANT TO PARTICIPATE IN THE PLAN.

Notice of Automatic Enrollment and Salary Reduction Opt-out Form

KIONA-BENTON CITY SCHOOL DISTRICT
NOTICE OF AUTOMATIC ENROLLMENT AND SALARY REDUCTION OPT-OUT FORM

Kiona-Benton City School District utilizes a Section 125 plan automatic enrollment process for group health coverage and other qualifying benefits through a cafeteria plan, which includes salary reduction amounts. However, employees have the right to decline participation and have no salary reduction amounts taken on their behalf.

Under the automatic salary reduction procedure, each employee is automatically enrolled and his or her salary is reduced pre-tax to pay for part of the coverage cost. Elections carry over to the next plan year unless changed in writing. For a description of or to confirm your existing employee benefit/insurance coverage, if any, contact the payroll office.

The salary reduction amounts for employee-only coverage and family coverage for the period October 1, 2011 through September 30, 2012 are as follows:

Plan Name	Employee-only	Employee & Spouse	Employee & Children	Full Family
WEA Premera Blue Cross	X	X	X	X
Group Health	X	X	X	X

NOTE: Your specific salary reduction amounts may differ.

If you would like to exercise your right to decline participation, you may do so by completing the bottom portion of this form and returning it to Kiona-Benton City School District Payroll Office on or before September 2, 2011. If you decline to participate, your election will remain in force beginning October 1, 2011 and ending on September 30, 2012 unless you complete a Change in Election Event which would make you eligible to change your election.

OPT-OUT FORM
Waiver of Pre-tax Benefits Form

- ❑ I elect to decline participation in the Section 125 plan and not have salary reduction for my share of any benefit plan in which I participate. Except for a Change in Election Event for the applicable benefit period, I understand that I cannot elect to participate until the next Open Enrollment Period.

Additional Terms

I understand that I cannot change or revoke this election as of any date prior to September 1, 2012, unless a Change in Election Event occurs as defined in the Plan (e.g. termination of employment, divorce, marriage, etc.). By signing below, I hereby certify that I have read and agree to the terms set forth in this document. Any previous agreements under the Plan relating to the benefits described above, including any prior elections, are hereby revoked.

_____ _____
Employee Signature Date

_____ _____
Plan Administrator Signature Date

Flexible Benefit Plan

This is the program that allows you to withhold money from your paycheck on a pre-tax basis to later reimburse yourself for qualified medical expenses such as prescriptions; braces; vision care; etc., or for dependent day care expenses.

PLAN ADMINISTRATOR

American Fidelity

Open Enrollment Period: September 1 to October 1

Plan Year: October 1 to September 30

GENERAL INFORMATION

- You may allocate specific amounts of monthly salary or wages for the reimbursement of medical care expenses, dependent day care expenses, or both
- You may file a claim voucher for reimbursement of the eligible medical care or dependent day care expenses that you have incurred
- No reimbursements will be made until the first account deposit is received from your employer
- Because your money goes into your reimbursement accounts before federal or Social Security taxes are withheld, you pay less in taxes, and ultimately have more disposable income

IMPORTANT RESTRICTIONS

- You must elect to participate prior to the beginning of each plan year - there is no allowance for late enrollment
- The amounts that you designate for medical reimbursement may not subsequently be used for reimbursement of dependent care expenses and vice versa
- If you do not file sufficient claims for reimbursement, you will lose the unused amounts - this is often referred to as the “use it or lose it” rule

Additional information is available in the plan brochure available in the District office. The plan brochures include the following information:

- Election changes
- Options at employment/termination
- Filing claims for reimbursement
- List of eligible and ineligible medical expenses
- Dependent care work requirements
- Eligible dependent day care expenses
- Qualifying dependents
- Qualifications of children of divorced or separated parents
- Payments available to relatives
- Earned income limitations
- Student, spouse, or disabled spouse eligibility
- Tax credit alternatives
- Important tax information

The above is a summary only and if you are interested in learning more about the plan, you should review the plan brochures available in the District office, or call the plan administrator.

Section 125 Enrollment Form

SECTION 125 PLAN
BENEFIT ELECTION AGREEMENT

AMERICAN FIDELITY ASSURANCE COMPANY

Name of Employer: **Kiona-Benton School District**

Employee Name: _____

Social Security Number: _____

Employee Address:_____

City, State, Zip: _____

Employee phone: _____ Work: _____

Plan Year Beginning: 10/01/2011 Ending: 09/30/2012

I have elected to participate in the following plan(s):

[ ] Medical Expense Reimbursement
(DO NOT include medical insurance or any other insurance premiums in this section.)

$_____ per pay period x 12 = Total plan year election $_____ *($**2,400.00** per calendar year maximum)*

[ ] Dependent Day Care Expense Reimbursement

$_____ per pay period x 12 = Total plan year election $_____ ***($5,000 per** calendar year maximum)*

If I am participating in a Flexible Spending Account, I HAVE READ THE FLEXIBLE SPENDING ACCOUNT RULES AND I UNDERSTAND THE RULES FOR PARTICIPATION IN THE EXPENSE REIMBURSEMENT PORTION OF THE SECTION 125 PLAN.

I understand that if I do not complete a new election form that my benefit election for the current plan year will remain in effect for the next plan year and cannot be revoked or changed unless the change of revocation is due to a change in family status (e.g. marriage, divorce, death of a spouse or child, birth or adoption of a child, change of spouse's employment, or change of employee's employment status). Any changes in benefits elections must be consistent with and due to the family status change. Financial hardship does not qualify as a change in family status. A new election form MUST be completed each year for participation in the Flexible Spending Accounts. NO changes are allowed in the Medical Expense Reimbursement Account except for termination of employee's employment.

Signature _____ Date_____

PLEASE COMPLETE THIS FORM AND RETURN TO KIONA-BENTON PAYROLL DEPARTMENT.
PLEASE RETURN TO THE DISTRICT OFFICE BY OCTOBER 7, 2011.

THANK YOU!

Section 125 Flexible Benefit Plan Expense Reimbursement Voucher

AFES SECTION 125 FLEXIBLE BENEFIT PLAN EXPENSE REIMBURSEMENT VOUCHER

Name of Employee (Last, First, MI)	Social Security #
Mailing Address ☐ *Check here if this is a new address*	**E-mail address**
Name of Employer	**Daytime Phone #**

Date of Expense	Name of Person for Whom the Expense Was Incurred	State Tax Law Eligible (If Incurred for a Dependent)*		Amount of Medical Expense
		Yes	No	
				Expense Total: (must be completed)

ALL DOCUMENTATION ATTACHED MUST HAVE A DETAILED EXPLANATION OF THE DATE, TYPE, AND AMOUNT OF EACH SERVICE RENDERED. REIMBURSEMENTS CANNOT BE MADE UNTIL THE FIRST DEPOSIT OF EACH PLAN YEAR HAS BEEN RECEIVED FROM YOUR EMPLOYER.

Acceptable Documentation to accompany the reimbursement voucher:

- √ Professional bill or receipt that includes:
  - • Provider of service • Type of service rendered
  - • Charges for the service • Original date of service
  - **NOTE:** the date of service, not the date of payment must fall within the dates of the plan year for which you are enrolled)
- √ Insurance Company Explanation of Benefits
- √ Pharmacy Statement that includes Rx number and name of prescription
- √ ***Over-the-counter drugs and medicine - medical practitioner's prescription and receipt required.***

Unacceptable Documentation includes:

- √ Cancelled checks or credit card receipts
- √ Bill or receipt that only shows a balance forward/ previous balance or payment due

I authorize the above expenses to be reimbursed from my Health FSA (Unreimbursed Medical Expense) account. To the best of my knowledge my statements on this form are true and complete. I certify that either I, my spouse, or my dependent (qualifying child or qualifying relative as defined in Code Section 152) or qualifying adult child (as amended in Code Section 105 to be included as a dependent with respect to benefits provided after March 30, 2010) has received the services described above on the dates indicated and that the expenses qualify as valid medical care expenses under Code Section 213 (d). I certify that these expenses have not been reimbursed, nor will I seek reimbursement, under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan, a Health Savings Account, or Health Reimbursement Arrangement. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I further understand that I may be asked to provide further documentation or further detail relating to an expense.

* *You only need to complete this box if you live in one of the following states: HI, MN, VT, WI.* As a general rule, employees pay no FICA, federal, or state income taxes on employer or employee Health FSA contributions or reimbursements. However some state tax rules do not allow the tax-free treatment that applies under federal law and, therefore, Health FSA reimbursements may need to be included in my income for state tax purposes. I have verified and appropriately indicated, to the best of my knowledge, whether each dependent for whom an expense was incurred is a state tax-qualified dependent in the state where I reside.

Signature of Employee **Date Signed**

Mailing Address: American Fidelity Assurance Company, AFES Flex Account Administration, PO Box 25510, Oklahoma City, OK 73125-0510 **PHONE NUMBER:** 1-800-325-0654 **FAX NUMBER:** 1-800-543-3539

American Fidelity will not be responsible for faxes not received. Average processing time is 5 to 7 working days from receipt of a completed voucher. Additional Forms and Account Information are available on our website at: www.afadvantage.com – forms for **Education Employees**.

INCOMPLETE VOUCHERS MAY DELAY PROCESSING OR RESULT IN A DENIED CLAIM

AFES rev0611

KEEP A COPY OF ALL CLAIMS SUBMITTED FOR YOUR RECORDS

Dependent Day Care Reimbursement Form / Acknowledgement Form

DEPENDENT DAY CARE REIMBURSEMENT FORM / ACKNOWLEDGMENT FORM

******THIS FORM CANNOT BE USED FOR MEDICAL EXPENSE REIMBURSEMENT REQUESTS******

Name of Employer:		Daytime Phone (with area code):
Name of Employee (Last, First, M.I.):		Social Security #:
Mailing Address (where reimbursement is to be sent):	City & State:	Zip Code:
Is this a New Address? Yes ☐ No ☐		
*E-mail Address (please print clearly):		

*** You will receive notification by e-mail when your claim is received and another when a payment is sent. You will also receive e-mail notification of direct deposits. Please be sure your e-mail address is legible.***

It is hereby acknowledged by _____ ("Dependent Day Care Provider") that it is in compliance with any and all applicable federal, state and local regulations governing dependent day care centers. The Dependent Day Care Provider further acknowledges that it has billed or received $_____ from _____ (Employee's Name/ "Participant") for dependent day care services rendered for the period of _____ through _____ for the following eligible individuals:

Name of dependent	Age

Please provide the following required information for Dependent Day Care Reimbursement:

Name of Dependent Day Care Center or Individual Provider	Tax ID number of Dependent Day Care Center or Social Security Number of Individual Provider
Address of Dependent Day Care Center or Individual Provider	Signature of Dependent Care Center Representative or Individual Provider Date: _____

I authorize the above expenses to be reimbursed from my Dependent Day Care Account. To the best of my knowledge and belief, my statements on this form are complete and true. I certify that my dependent as defined in Code Section 152 has received the services described above on the dates indicated and that the expenses are valid dependent care expenses under the Plan; that the reimbursement requested will not exceed the applicable earned income limit; and that the expense reimbursement requested meets all other rules and regulations of Code Sections 129 and 21. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit and that the expense has not been reimbursed, nor will be sought, under insurance or any other plan. I understand that the day care provider's name, address and tax ID must be included on my annual tax return by completing Schedule 2 of Form 1040A or Form 2441.

Signature of Employee	Date Signed

Who is a Qualifying Dependent for Dependent Day Care Plans?

- **Your qualifying child,** who is either 1) under the age of 13 and who has the same principal place of abode as the taxpayer for more than half of the taxable year, **or** 2) is physically or mentally incapable of self-care, who has the same principal place of abode as the taxpayer for more than half of the taxable year, and who routinely spends at least 8 hours per day in the taxpayer's home (age restriction does **not** apply).
- **Your qualifying relative,** who is physically or mentally incapable of self-care, who has the same principal place of abode as the taxpayer for more than half of the taxable year, who routinely spends at least 8 hours per day in the taxpayer's home.
- **Your spouse,** who is physically or mentally incapable of self-care, who has the same principal place of abode as the taxpayer for more than half of the taxable year, and who routinely spends at least 8 hours per day in the taxpayer's home.

Visit www.afadvantage.com for more details on qualifying dependents and to access additional claim forms. You may also sign up for an account activation code to view your flexible spending account information. Visit our site for details!

Mailing Address: American Fidelity Assurance, Flex Account Administration, P. O. Box 25510, Oklahoma City, OK 73125

Fax Number: (800) 543-3539. **Average processing time is 5 to 7 working days from receipt of a completed voucher**. **Processing times may vary throughout the year**. American Fidelity will not be responsible for faxes not received.

FlexConnection® Interactive Phone Response Number: (800) 325-0654

AFES DDC/ACK Rev. 0308

Continuing Coverage under COBRA

The Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that most employer-sponsored health plans* offer covered employees and their dependents the opportunity to continue health coverage in some instances where it would otherwise normally end.

* Medical, vision, dental insurance, the VEBA health reimbursement arrangement, and Section 125 Flexible Spending Arrangements (FSA's) are health plans. Each must offer the COBRA continuing coverage options.

You and/or your enrolled dependents may elect and **self-pay** for continued coverage or extended coverage in the following circumstances (these may change, please contact your employer if you or any of your eligible family members lose coverage):

1. If employment ends (except for gross misconduct), or if your hours are reduced and you lose benefits
2. If the covered employee dies
3. If the employee and spouse become legally separated or divorced
4. If a dependent child no longer qualifies as a dependent under the District plan
5. If the employee becomes entitled to Medicare

To be eligible for COBRA continuation coverage, you or a family member must inform payroll within 60 days of the date of legal separation or divorce, or a child losing eligibility, or the date coverage is lost due to such event - whichever is later. You will then receive a form explaining your rights and the premium cost to continue coverage. The District will notify you and/or your dependents in the other circumstances. You must decide whether or not you want to purchase continued coverage within 60 days after the date you are notified of your eligibility for continued coverage, or the date coverage would otherwise terminate (whichever is later).

COBRA continued coverage or extended coverage may be available for up to 18, 29, or 36 months depending on the event. The events which allow you and/or family members to continue coverage, and the maximum coverage period applicable to each event, are summarized in the following chart.

EVENT	COVERAGE ON THE DAY BEFORE EVENT	MAXIMUM COVERAGE PERIOD FOR ENROLLED INDIVIDUALS
Termination of employment due to retirement	Any District sponsored health plan	18 months for employee and/or family members
Termination of employment due to disability	Any District sponsored health plan	18 months for employee and/or family members **
Termination of employment for retirement or disability	Any District sponsored health plan	18 months for employee and/or family members **
Termination for any other reason (except gross misconduct)	Any District sponsored health plan	18 months for employee and/or family members **
Work hours are reduced and you lose coverage	Any District sponsored health plan	18 months for employee and/or family members **
Employee dies	Any District sponsored health plan	36 months for spouse and/or dependents
Employee becomes legally separated or divorced from spouse	Any District sponsored health plan	36 months for spouse and/or dependents
Dependent children no longer meet eligibility requirements	Any District sponsored health plan	36 months for dependent child
Employee becomes entitled to Medicare benefits	Any District sponsored health plan	36 months for spouse and/or dependent

** Additionally, if the employee or a family member is determined by the Social Security Administration to have been disabled at the time the employee terminates employment or reduces hours, the disabled individual may be eligible to continue coverage for up to twenty-nine (29) months.

Continued coverage may end earlier than the 18, 29, or 36 months if:

1. The premium is not paid on time
2. The District terminates all group health plans for all employees
3. The person continuing coverage becomes entitled to Medicare
4. The person continuing coverage is covered by another group health plan, unless the new plan has limitations on pre-existing conditions
5. In the case of a disability extension (from 18 to 29 months), the disabled individual recovers

Various retiree medical and dental programs are also available upon retirement. Most retirees choose the option to purchase coverage from the Public Employees Benefit Board (PEBB) plans administered by the State Health Care Authority (HCA). For further information, call the HCA at 1-800-200-1004.

COBRA CONTINUED COVERAGE AND OTHER EXTENDED COVERAGE IS PROVIDED ONLY AS REQUIRED BY LAW, APPLICABLE BARGAINING AGREEMENTS, BOARD POLICY, AND/OR CARRIER LIMITATIONS. IF THE LAW, BARGAINING AGREEMENTS, AND/OR CARRIER LIMITATIONS CHANGE, YOUR RIGHTS WILL CHANGE ACCORDINGLY.

A group health plan must provide a written certification “at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision” as required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (“HIPAA”). The written certification must state the period of an individual’s coverage under the plan and “the waiting period imposed with respect to the individual for any coverage under such plan.”

HIPAA affects group health coverage as follows:

- Limits exclusions for pre-existing medical conditions
- Provides credit for prior health coverage and a process for providing certificates concerning prior coverage to a new group health plan or health insurance issuer
- Provides new rights that allow eligible individuals to enroll for health coverage when they involuntarily lose other health coverage or acquire a new dependent
- Prohibits discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors
- Guarantees renewability of health insurance coverage

For further information on available coverage, rates, and enrollment forms, contact the payroll department.

Family and/or Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) and Washington State Family Medical Leave Act (WFMLA) provide for up to twelve (12) weeks of job-protected leave during a twelve (12) month period, for the serious health condition of either an employee, or that of their immediate family member. Employees are eligible for family medical leave if he or she has worked at least twelve hundred and fifty (1,250) hours in the past twelve (12) months of employment, and has worked for the District for at least twelve (12) months, not necessarily consecutive. The following are reasons that eligible employees may take family medical leave:

1. To care for the employee's child after birth or placement for adoption or foster care;
2. To care for the employee's spouse, child, or parent with a serious health condition;
3. A serious health condition of the employee which makes the employee unable to perform the job;
4. A qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty, has been notified of an impending call, or order to active duty in support of a contingency operation; or
5. To care for a covered service member who is a spouse, son, daughter, parent, or next of kin with a serious injury or illness incurred in the line of duty.

Health conditions are considered serious if they require inpatient care, continued treatment or incapacity of three days or more, two or more treatments by a health care provider related to a subsequent recovery, or at least one treatment which results in a regimen of continuing treatment or incapacity due to pregnancy or chronic disease or permanent or long term disability. Occasional short term illnesses are not covered.

An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child, parent, or family member must submit a verifying medical certification from a physician within 15 days of the application for leave.

When an employee is able to return to work, he or she will be restored to the same or equivalent job with equivalent status, pay, benefits, and other employment terms. Employees taking leave for their own serious health condition must provide the employer with an appropriate fitness for duty certification prior to returning.

USE OF PAID TIME OFF

If an employee has accrued paid time off benefits that are otherwise permitted for use in such absences, they *may* be utilized by the employee concurrent with unpaid FMLA leave.

Tax-Sheltered Annuities (TSAs)

INTRODUCTION

Employees may save supplemental funds for retirement by participating in a 403(b) tax-sheltered annuity. Participation is voluntary and contributions are deducted monthly from an employee's salary on a tax-deferred basis. There are many investment options from which to choose. There are fixed insurance annuities, variable annuities, and 403(b)(7) mutual funds. You should invest wisely and seek professional advice when investing.

Contributions and investment earnings are tax-deferred. Some 403(b) investment companies offer loan provisions. If you are interested, please ask your co-workers for a referral to a TSA investment representative.

CURRENT TAX-SHELTERED ANNUITIES OFFERED BY KIONA-BENTON CITY SCHOOL DISTRICT

- American Funds Group
- New York Life
- Waddell and Reed, Inc.

CONTRIBUTION LIMITS

Contribution limits on elective deferrals to 403(b) plans are illustrated on the chart below:

2011	**2012**
$16,500*	**Indexed with inflation**

* Limits subject to annual review by IRS

- Plus, individuals who have attained at least age 50 at any time during the calendar year can increase their elective deferral by the amount set forth in the chart below:

2011	**2012**
$5,500*	**Indexed with inflation**

* Limits subject to annual review by IRS

Thereafter, the age 50+ catch up limit is indexed in $500 increments based on cost-of-living adjustments.

- Eligible employees with 15 or more years of service with the current employer may be able to contribute up to an additional $3,000
  - The employee must have 15 or more years of service with the current employer
  - The employee must not have contributed on average $5,000 or more for each of the years of service to any elective deferral plan of this employer
  - The employee must not have used up to $15,000 "aggregate extra amount" permitted under this option with the current employer

Deferred Compensation Program (DCP)

INTRODUCTION

Employees may save supplemental funds for retirement by participating in the State of Washington Deferred Compensation Program (DCP). Participation is voluntary and contributions are deducted monthly from employee's salary on a tax-deferred basis. Investment options are limited to funds selected by the Washington State Investment Board (WSIB). A minimum deferral of $30 per month is required to enroll in DCP.

In 2011, the maximum amount you may defer from your annual compensation is $16,500. This amount is separate from any 403(b) contributions you may contribute giving you an opportunity to defer a total of $33,000 in 2011 (or even more depending on your age) between the two plans.

CURRENT DEFERRED COMPENSATION PROGRAM INVESTMENT OPTIONS

- Savings Pool
- Washington State Bond Fund
- Socially Responsible Balanced Fund
- Active US Value Stock Fund
- US Stock Market Index Fund
- Active US Core Stock Fund
- Fidelity Growth Company Fund
- US Small Stock Index Fund
- International Stock Fund
- 2055 Retirement Strategy Fund
- 2050 Retirement Strategy Fund
- 2045 Retirement Strategy Fund
- 2040 Retirement Strategy Fund
- 2035 Retirement Strategy Fund
- 2030 Retirement Strategy Fund
- 2025 Retirement Strategy Fund
- 2020 Retirement Strategy Fund
- 2015 Retirement Strategy Fund
- 2010 Retirement Strategy Fund
- 2005 Retirement Strategy Fund
- 2000 Retirement Strategy Fund

Contribution limits on elective deferrals to the State of Washington DCP are illustrated on the chart below:

2011
$16,500*

* Limits subject to annual review by IRS

There are two catch up options for DCP participants, however, they may not be used concurrently. Participants must contact DCP to use the catch up. The age 50 and over catch up may be used by participants during the year they turn 50 or older. They may defer an additional $5,500 in 2011 beyond the maximum annual deferral limit. In subsequent years, the amount will be the current year maximum, plus cost of living adjustments, if any, established by the IRS.

Another catch up option for DCP participants may be used in one or more of the three calendar years before reaching normal retirement age. You may be eligible to defer an additional amount equal to twice the maximum deferral for the year (e.g. $33,000 for year 2011). Contact DCP for details.

Washington State Deferred Compensation Program phone number: 1-888-327-5596.

VEBA Health Reimbursement Arrangement (HRA)

FUNDED WITH LEAVE CASH-OUT FUNDS & MONTHLY CONTRIBUTIONS

The VEBA Plan enables employees to use funds that would otherwise be paid to you for unused leave cash-outs to instead be deposited tax-free into a VEBA Trust account on your behalf. Your bargaining unit can also negotiate to have monthly contributions deposited tax-free into a VEBA Trust account on your behalf. The funds accumulated in this VEBA Trust account can then be used to pay qualified medical, dental, or vision expenses for yourself, your spouse, and qualifying dependents both before and after you retire.

Employees can become a participant if their employee group has agreed with the District that, during the period of their annual employment contract, the District will use unused leave cash-out funds (either annually or at retirement/separation from service) to make a contribution to the VEBA plan completely tax-free. An employee group can also vote to contribute to the plan through a monthly salary-redirection (each member of an employee group contributes the same flat dollar amount to the plan). You will need to check with your employee group or the payroll department to verify whether your employee group has voted to participate in VEBA (each bargaining group votes annually on whether or not to participate as a group in VEBA).

By participating in the VEBA Plan, you avoid social security (FICA) taxes of 7.65% and federal income taxes (approximately 15% - 25% depending upon your tax bracket) on the unused leave cash-out funds or salary redirected funds you contribute. You can invest your account by choosing either one of two options: (1) Build your own asset allocation portfolio with funds from six individual asset classes; or (2) Select any one of four professionally designed pre-mixed asset allocation portfolios. Investment earnings are tax-free. Benefit withdrawals are also tax-free.

If you want a plan brochure or have a specific question, call the VEBA Service Group, LLC Regional Office at 838-5571 or visit the VEBA website at www.veba.org.

Workers' Compensation Self-insurance Program

The Kiona-Benton City School District belongs to a group self-insured trust, called ESD 112 Workers' Compensation Trust. Our self-insured program applies to any work-related injury or illness. The industrial insurance laws of the State of Washington allow employers to insure 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, Kiona-Benton City School District assumes the cost of the actual medical charges and compensation expenses and pays, from district funds, all benefits prescribed by workers' compensation laws associated with an on-the-job injury or illness. Under our self-insurance program, you will no longer pay the medical-aid premium; however, the Supplemental Pension and Asbestos premium deduction will appear on your payroll check at each pay period. The deduction amount is determined by the Department of Labor and Industries and is subject to change annually.

If you sustain a work-related injury, the following steps are to be followed:

- Report the injury immediately to your supervisor (whether or not medical attention is required).
- Your supervisor will log the injury on the district's **accident report form**.
- If you seek medical treatment, contact ESD 112 at 1-800-749-5861 immediately. ESD 112 will provide you with a claim number and send you a "Self-insured Accident Report" (Form SIF-2) to complete. Detailed informational packets are available at each of the buildings and in the district office with step-by-step instructions.

In the case of any emergency, your supervisor or other Kiona-Benton City School District official will ensure that the treating physician or emergency facility is informed that Kiona-Benton City School District is self-insured through the ESD 112 Workers' Compensation Trust cooperative so that your claim can be processed properly. The Workers' Compensation Trust makes time loss determinations using information provided from, but not limited to, the following:

- Doctor's certificate of disability
- Medical reports
- Release-for-work slips
- Medical progress report (SIF-2)
- Phone calls

Qualifications for Shared Sick Leave

Who may share their sick leave?

- Employees who have more than 22 days of sick leave accrued.

Can employees from one bargaining group share their sick leave with an employee from another bargaining group?

- Yes, as long as the employee who is sharing the sick leave maintains 22 days on the books.

What qualifications are required to receive shared sick leave?

- Employees (and/or a relative, defined per the collective bargaining agreement) who are requesting shared sick leave must have a condition(s) that is "extreme and/or extraordinary." An "extreme and/or extraordinary" condition(s) would include a medical condition(s), which, if not treated, may result in severe consequences (i.e. death, permanent disability, etc.).

Examples of "extreme and/or extraordinary" conditions include some of the following:

- Cancer (treatment of cancer)
- Some mental disorders
- Major life threatening surgery
- Medically necessary leaves due to injury and/or illness

Examples of conditions, which do not qualify for shared sick leave, include some of the following:

- Flu
- Maternity leave
- Broken bones
- Some mental disorders
- Surgery that is not 100% medically necessary

Each request for shared sick leave is determined on an individual basis. As stated above, you (and/or a relative, defined per the collective bargaining agreement) must have an "extreme and/or extraordinary" condition, which if not treated, may result in severe consequences (i.e. death, permanent disability, etc.).

ICMA Retirement Corporation

The defined contribution component is member financed and provides a tax-deferred investment program that you may access any time after you separate from SERS/TRS covered employment.

The amount of retirement income generated by the defined contribution component depends on how much you contribute and the investment performance. You choose how much you contribute, where your contributions are invested, and how and when you take payment.

The Defined Contribution Funds from Retirement Plan 3 are managed with the ICMA Retirement Corporation.

State of Washington Department of Retirement Systems (DRS)

<table>
<tr><th>DRS Contact Information</th><th colspan="2">Member's Questions</th></tr>
<tr><td rowspan="2">Department of Retirement Systems
P.O. Box 48380, Olympia, WA 98504-8380

6835 Capitol Boulevard
Tumwater, WA 98501

www.wa.gov/DRS
recap@drs.wa.gov (Please include your complete e-mail address in the body of your message.)</td><td colspan="2">The following information will help DRS route your questions:
- Your name
- Your retirement system (PERS, TRS, SERS)
- Social Security Number</td></tr>
<tr><td>DRS Reception Center Phone
(360) 664-7000
1-800-547-6657</td><td>TDD Line
(for the hearing impaired):
(360) 586-5450</td></tr>
</table>

PERS: PUBLIC EMPLOYEES' RETIREMENT SYSTEM

PERS members include: elected officials; employees of state, county, and local government; elected or appointed judges; certain employees of community colleges, technical colleges, and universities; non-certificated employees of school districts; and employees of various service and utility districts.

TRS: TEACHERS' RETIREMENT SYSTEM

TRS members include teachers and administrators who work in Washington State public schools, educational service districts, and state agencies.

SERS: SCHOOL EMPLOYEES' RETIREMENT SYSTEM

SERS members include eligible classified employees of school districts and educational service districts.

3 STEPS TO RETIREMENT PLAN SELECTION

1 **REVIEW DRS RETIREMENT BOOKLET AND EVALUATE YOUR PERSONAL SITUATION.**

(Visit online at www.drs.wa.gov)

2 **CHOOSE YOUR PLAN, CHOOSE YOUR BENEFIT**

- Plan 2 has a guaranteed lifetime benefit.
  - Plan 2 benefit formula 2% x service credit years x average final compensation
- Plan 3 has a guaranteed lifetime benefit plus an investment program you select and contribute to.
  - Plan 3 benefit formula 1% x service credit years x average final compensation
  - Your contributions and their investment returns

3 **COMPLETE FORMS TO FORMALIZE YOUR CHOICE**

Although your employer will begin making Plan 2 contributions, you will default to Plan 3 in 90 days if you do not formalize your choice.

PLAN 2	PLAN 3	PLAN 3
DEFINED BENEFIT	**DEFINED BENEFIT**	**DEFINED CONTRIBUTION**
PLAN STRUCTURE		
The benefit in Plan 2 is based on the length of time you've worked, your pay, and your age of retirement. You will receive a benefit for the rest of your life. The payments are guaranteed by the State of Washington. Both you and your employer contribute to your plan.	Part of the benefit in Plan 3 is based on the length of time you've worked, your pay, and your age of retirement. You will receive a benefit for the rest of your life. The payments are guaranteed by the State of Washington. Your employer contributes to this part of your plan.	The other part of the benefit is based on what you contribute to the plan and how the investments you select perform.
BENEFIT CALCULATION		
2% x service credit years x average final compensation = defined benefit	1% x service credit years x average final compensation = defined benefit	Your contributions and investment performance = defined contribution.
CONTRIBUTION RATES		
Public Employees: 4.59% School Employees: 4.08% Teachers: 4.68% The Pension Funding Council approved these rates as of July 2011 for Public Employees and Teachers. The rates may change if pension bills passed during the 2011 legislative season have a financial impact. The most current rates can always be found on our website at www.drs.wa.gov.	Your employer contributes to this part of your benefit, you do not.	You select your rate. You cannot change your rate unless you change employers. Option A: 5% all ages Option B: 5% up to age 35 6% ages 35 – 44 7.5% age 45 and over Option C: 6% up to age 35 7.5% ages 35 – 44 8.5% ages 45 and over Option D: 7% all ages Option E: 10% all ages Option F: 15% all ages
THE ROLE OF INVESTMENTS		
Your contributions are invested by the Washington State Investment Board. Your benefit is guaranteed and is not dependent on investment performance.	Your employer contributes to this part of your benefit. Those contributions are invested for you by the Washington State Investment Board. Your benefit is guaranteed and is not dependent on investment performance.	You choose how your contributions will be invested from a range of options provided by the Washington State Investment Board. The amount of your benefit depends on the amount you contribute and the performance of your investments.
VESTING		
You earn the right to a retirement benefit when you have 5 years of service credit.	After 10 years of service credit in most cases; or After five years of service credit depending on your age and when your service credit was earned.	Vesting does not apply to this part of your benefit. You may withdraw the account balance if you leave employment.

PLAN 2	PLAN 3	PLAN 3
DEFINED BENEFIT	**DEFINED BENEFIT**	**DEFINED CONTRIBUTION**

ELIGIBILITY FOR NORMAL RETIREMENT

Age 65 or older with **at least 5 service credit years.**	Age 65 or older with **at least 10 service credit years**; or Age 65 or older with at least five service credit years if at least 12 of those months were earned after the age of 44. Transfer members have a different retirement eligibility rule.	There is no specific age requirement for this part of your benefit. You may access your money at any time after your leave employment.

ELIGIBILITY FOR EARLY RETIREMENT WITH A REDUCED BENEFIT

Age 55 or older with **at least 20 service credit years.** There is less of a reduction to your benefit if you have at least 30 service credit years.	Age 55 or older with **at least 10 service credit years**. There is less of a reduction to your benefit if you have at least 30 service credit years.	There is no specific age requirement for this part of your benefit. You may access your money at any time after your leave employment.

LEAVING EMPLOYMENT BEFORE YOU'RE ELIGIBLE TO RETIRE

Your money can remain in the plan or you can withdraw your contributions and the interest they've earned. However, if you withdraw, you give up your right to a future retirement benefit.	You don't contribute to the defined benefit part of your plan. Your employer makes those contributions and you cannot withdraw those funds.	Your money can remain in the plan or you can access your contributions and investment earnings. A variety of distribution options are available.

COST-OF-LIVING ADJUSTMENTS

On July 1 of every year after your first full year of retirement, your monthly benefit will be adjusted by the percentage change in the Consumer Price Index up to a maximum of 3 percent per year.	On July 1 of every year after your first full year of retirement, your monthly benefit will be adjusted by the percentage change in the Consumer Price Index up to a maximum of 3 percent per year.	There are no Cost-of-Living Adjustments for the defined contribution part of your benefit.

HEALTH CARE COVERAGE IN RETIREMENT

Health care coverage may be provided by the Public Employee Benefit Board (PEBB). For information contact PEBB at 360-412-4200 in Olympia, toll free at 800-200-1004 or www.pebb.hca.wa.gov, or contact your current employer.

To qualify you must elect coverage within 60 days of termination and begin receiving your retirement benefit as soon as you leave employment. If you delay receiving your retirement benefit, you will not be eligible for health care coverage under PEBB.	To qualify you must elect coverage within 60 days of termination. As long as you meet the age and service requirements of the plan (age 55 or older, with 10 or more years of service credit) you can delay receiving your retirement benefit and still be eligible for PEBB coverage.	Leaving your contributions in the plan or starting to draw them does not impact your eligibility for health care coverage under PEBB.

Direct Payroll Deposit

It is required to have your paycheck automatically deposited in your checking or savings account on payday as per district policy.

Direct deposit will help you in many ways.

- It saves trips to your financial institution
- It saves time in depositing checks – no long lines to wait in
- It eliminates the possibility of lost, stolen, or forged checks
- Your money is deposited faster – reduces the possibility of overdrafts
- It means you get your money deposited to your account even if you're on vacation, sick, or away on pay day

Here's how direct deposit works:

Your money will have already been deposited in your account. The amount of the deposit will appear on your bank statement. If you have not already, please complete a Direct Deposit form located on the shared server. **S:drive/forms/payroll forms** or visit the Payroll Department. Fully complete the Direct Deposit form and return it to the Payroll Department.

The district does not issue paper paychecks. To view your paycheck information you must visit the employee portal on the district website at www.kibesd.org and click on the **staff** button. You will be directed to enter in your username and password. Once you have logged in you will see the drop-down menu option on the left of your screen, **Home** and **Employee Resources**. Click on the **Employee Resources** and you will be able to view your paycheck information. NOTE: If you do not know your employee portal user name and password please contact the Payroll Department.

If you close your account, change banks, or change your existing account number, you must inform payroll immediately. Failure to do so will mean that your money will not be deposited and you will have to wait for payroll to process a hand warrant.

Automated Deposit Authorization Agreement

Kiona-Benton City School District No. 52 AUTOMATED DEPOSIT AUTHORIZATION FORM

AUTOMATED DEPOSIT AUTHORIZATION AGREEMENT

Employee Name: _____
(please print clearly)

I hereby authorize the Kiona- Benton School District, hereinafter called "School District" to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (select one):

❑ **Checking** ❑ **Savings**

account in the depository named below, hereinafter called "Depository." I authorize the depository named below to credit and/or debit the same to such account.

Depository Name: _____

Branch: _____

Address: _____

City: _____

State & Zip: _____

Transit/ABA No.: _____

Account Number: _____

This authority is to remain in full force and effect until the School District has received written notification from me **one (1) month** in advance of its termination to afford the School District Payroll Office and Depository a reasonable opportunity to act on it.

Changes/Revisions: The School District will allow only one (1) bank change per year.

_____ _____
Employee Signature Date

Please attach a voided CHECK (for deposits to checking account) or deposit slip (for deposits to savings account) solely for the purpose of verifying account number and financial institution's transit number.

Revised 7/2008

Attachments

- Group Health HMO School Pool $20 Copay Plan
- Group Health Personal Physician List
- Group Health Urgent Care Facilities
- Group Health Employee Enrollment and Change Form
- WEA Select 1, 2, 3, and 5 Plans
- WEA Select EasyChoice Plans
- WEA Select Enrollment & Change Form
- Washington Dental Service Delta Dental Enrollment/Change Form
- Lincoln Financial Enrollment & Change Form
- Premera Affidavit of Domestic Partnership
- State of WA Domestic Partnership Declaration

Benefit Summary

HMO School Pool $20 Copay Plan

GroupHealth.

Effective Date 10/1/2011	**Health Plan** Group Health	**Ref** RQ-44768

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: $2,000 Family out-of-pocket limit: $4,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Inpatient services, outpatient services, emergency services at a GHC or non-GHC facility, ambulance services.
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$20 copay
Hospital services	**Inpatient services:** $200 copay, per day for up to 3 days per admit **Outpatient surgery:** $20 copay
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand/non-formulary $15/$25/$45 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan $20 copay
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** $200 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months	Covered at 80%
• Ostomy supplies • Prosthetic devices	Covered at 80%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Covered in full High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$100 copay at a designated facility $100 copay at a non designated facility
Hearing exams (routine)	$20 copay
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Unlimited visits $20 copay
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** $200 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Mental Health	**Inpatient:** $200 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Naturopathy	Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan $20 copay
Newborn Services	Any applicable coinsurance applies to the newborn while both mother and baby are confined. Otherwise, all applicable inpatient cost shares apply. Office visits: See Outpatient Services; Routine well care: See Preventive care.
Obesity-related surgery (bariatric)	Not covered
Organ transplants Donor search & harvest applies to lifetime max	Unlimited, no waiting period **Inpatient:** $200 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full
Rehabilitation services (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under) Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 60 days per calendar year $200 copay, per day for up to 3 days per admit **Outpatient:**60 visits per calendar year $20 copay
Skilled nursing facility	Covered in full up to 60 days per calendar year
Sterilization (vasectomy, tubal ligation)	**Inpatient:** $200 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Temporomandibular Joint (TMJ) **services**	$1,000 per calendar year; $5,000 lifetime max **Inpatient:** $200 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Tobacco cessation counseling	Free & Clear Program - covered in full
Routine vision care (1 visit every 12 months)	$20 copay
Optical hardware Lenses, including contact lenses and frames	Not covered

GroupHealth

Personal Physician list: Tri-Cities Area

July 2011

Benton City

Benton City Clinic (509) 588-4075

Lewis, Loren MD	Family Medicine	Y

Connell

Lourdes Family Health Center (509) 234-3410

Waites, William PA-C	Family Medicine	Y

Kennewick

8AM to 8PM Family Medicine (509) 586-8986

Sjerven, Raymond DO	Family Medicine	Y

Ahart, Sharon, MD (509) 586-5109

Ahart, Sharon MD	Pediatrics	Y

Badger Canyon Family Health & (509) 783-4949

Dramis, Shannon DO	Family Medicine	Y

de los Reyes, Cynthia M, MD (509) 582-3571

De Los Reyes, Cynthia MD	Pediatrics	N
Raposas, Stella MD	Pediatrics	Y

Kadlec Clinic Kennewick Primary Care (509) 942-3125

Monie, Paul MD	Family Medicine	Y
Podhaisky, Gary MD	Pediatrics	Y
Torres, Noda MD	Internal Medicine	Y

KGH Columbia Family Medicine (509) 586-5196

Cain, Arthur MD	Family Medicine	N
Jones, David MD	Family Medicine	N
Kohan, Wayne MD	Family Medicine	N

KGH Cynergy Center (509) 222-2240

Ello, Glenn MD	Pediatrics	Y

KGH Family Medicine (509) 222-2240

Ello, Maria Aleli MD	Family Medicine	Y
Hipolito, Mary Grace MD	Family Medicine	Y

KGH Ivan Guevara Pediatrics (509) 586-5162

Guevara, Ivan Siri MD	Pediatrics	Y

KGH Kennewick Internal Medicine (509) 586-5113

Al-Hawamdeh, Mahmoud MD	Internal Medicine	Y
Pillai, Gnanaranjith MD	Internal Medicine	Y
Toshani, Nadia MD	Internal Medicine	Y

KGH Kid's Care (509) 735-9239

Gavino, Gwendolyn MD	Pediatrics	Y
Gavino, Roman MD	Pediatrics	Y

KGH Medical Mall (509) 585-5222

Abu Khieran, Emad MD	Internal Medicine	Y
Ang, Ellen MD	Internal Medicine	Y
Clar De Jesus, Teresita MD	Internal Medicine	Y
Guevara, Maria MD	Pediatrics	Y

KGH Pediatrics (509) 737-1880

Freedman, Marianne MD	Pediatrics	Y

KGH Qayyum Nazar MD (509) 586-5677

Chaudhry, Yasmin MD	Family Medicine	Y
Nazar, Qayyum MD	Pediatrics	Y

KGH Sean G's Pediatrics (509) 586-5771

Guevara, Sean MD	Pediatrics	Y

Lilagan, Meneleo, MD (509) 586-5538

Lilagan, Meneleo MD	Family Medicine	Y

Ling Medical Associates (509) 783-9848

Ling, Stanley MD	Internal Medicine	N
Smith, Jennifer MD	Internal Medicine	Y

Smith, H Matt, MD (509) 585-5500

Smith, H MD	Family Medicine	N

The Rod Coler Center for Senior Health (509) 735-2069

Sahai, Madhu MD	Internal Medicine	Y

Tri-Cities Community Health - (509) 783-4454

Flores Aceituno, Sergio MD	Family Medicine	Y
Iraee, Ziba MD	Pediatrics	Y
Stringer, Penney MD	Family Medicine	Y

Tri-Cities Obstetrics & Gynecology (509) 586-5644

Mayuga, Henrietta MD	Family Medicine	Y

Vista Family Health (509) 735-2325

Burrup, Byron DO	Family Medicine	N
Dunlop, Sheila DO	Family Medicine	N
Flesher, Mark MD	Family Medicine	N

Wannarachue, Nikom, MD (509) 586-1157

Baxter, Nancy MD	Pediatrics	Y
Cabasug, Michael MD	Family Medicine	Y
Gavino, Ma Hazel Lyn MD	Family Medicine	Y
Pabalan, Maria Janina MD	Pediatrics	Y
Wannarachue, Nikom MD	Pediatrics	Y

Pasco

Cayetano, Rolando, MD (509) 545-9012

Cayetano, Rolando MD	Pediatrics	Y

Chou, Henry H, MD - 14th Ave (509) 547-0686

Chou, Henry MD	Pediatrics	Y

Kadlec Clinic Pasco Primary Care (509) 942-3170

Bongar, Debbierey MD	Internal Medicine	Y
Nelson, Kelly DO	Family Medicine	Y
Tandon, Puneet MD	Internal Medicine	Y

Lourdes West Pasco (509) 545-6220

De Vera, Paolo Antoni MD	Pediatrics	Y
Kahirimbanyi, Peresi MD	Family Medicine	Y
Nettleton, Benjamin DO	Family Medicine	Y
Taylor, Kevin MD	Family Medicine	N

Y = Accepting new patients
N = Accepting Established patients only

Miramar Health Center (509) 543-9280
- Gonzales, Bernadeth MD — Family Medicine — Y
- Luanzon, Ronaldo MD — Family Medicine — Y

Najera, Alex B, MD (509) 544-2156
- Najera, Alex MD — Internal Medicine — Y

Riverview Medical Group (509) 545-6220
- Hernandez Umana, Juan MD — Family Medicine — Y
- Intravartolo, John MD — Internal Medicine — Y
- Westhusing, Thomas DO — Family Medicine — Y

Tri-Cities Community Health - Pasco (509) 547-2204
- Davis, Scott MD — Pediatrics — Y
- Flores Aceituno, Sergio MD — Family Medicine — Y
- Iraee, Ziba MD — Pediatrics — Y
- Stringer, Penney MD — Family Medicine — Y

Prosser

Valley Vista Medical Group (509) 786-2010
- Abacan, Gloria Crese MD — Internal Medicine — Y
- Christensen, Royden DO — Family Medicine — Y
- Field, Carl MD — Family Medicine — Y
- Lane, Edward MD — Family Medicine — Y
- Sonnichsen, Ben MD — Family Medicine — Y

Richland

Albertini, Michael, MD (509) 946-3576
- Albertini, Michael MD — Pediatrics — Y

Apple Family Medicine (509) 946-2340
- Krause, Charles MD — Family Medicine — N
- Rogers, Deborah ARNP — Family Medicine — Y

Atwood, Barbara L, MD (509) 946-0802
- Atwood, Barbara MD — Internal Medicine — Y

Badger Mountain Family Medicine (509) 628-1220
- Vaughn, James MD — Family Medicine — N

Batayola, Charles, DO (509) 628-1220
- Batayola, Charles DO — Family Medicine — N

Columbia Basin Pediatrics (509) 946-7332
- Khurana, Ekta MD — Pediatrics — Y

Datta, Sam, MD (509) 943-6800
- Datta, Saumyajit MD — Family Medicine — Y

Dernbach, Frances D, MD (509) 946-6565
- Dernbach, Frances MD — Pediatrics — N

Kadlec Clinic Richland Family Practice (509) 946-3700
- Lara, Yolanda ARNP — Family Medicine — Y

Kadlec Clinic Richland Primary Care (509) 943-8515
- Leedy, James MD — Family Medicine — Y

Kadlec Clinic Senior Health (509) 942-3135
- Ayee, Kyawt MD — Internal Medicine — N
- Deray, Arnulfo MD — Internal Medicine — N

KGH Pediatrics and Family Practice (509) 627-3722
- Gaba, Payal MD — Family Medicine — Y
- Pulido, Bernard Jose MD — Family Medicine — Y

Lourdes Columbia Point (509) 943-7997
- Oro, Joseph MD — Family Medicine — N

Pediatrics For You PLLC (509) 946-8188
- Matta, Shakti MD — Pediatrics — Y

Physicians Immediate Care & Medical (509) 946-1695
- Beck, James MD — Family Medicine — Y
- Coker, Martin MD — Family Medicine — Y
- Crawford, Douglas DO — Family Medicine — Y

Reliance Medical Clinics PLLC (509) 420-0423
- Marcelo, Jesus Norber MD — Internal Medicine — Y
- Singer, Reuben MD — Pediatrics — Y

Richland Family Medicine-GW Way (509) 946-9664
- Wong, Gene MD — Family Medicine — N

Sharma, Vimal C, MD PS (509) 943-5664
- Sharma, Vimal MD — Internal Medicine — Y

Three Rivers Family Medicine (509) 943-3196
- Benedict, Michael MD — Internal Medicine — N
- Britt, Amy MD — Family Medicine — N
- Isaacson, Erick MD — Family Medicine — N
- Lawrence, Matthew MD — Family Medicine — N
- Merkley, David MD — Family Medicine — N
- Pattillo, Michael MD — Internal Medicine — N
- Raekes, Julie MD — Internal Medicine — N

Whitson, Robert L, DO (509) 946-5233
- Whitson, Robert DO — Family Medicine — Y

West Richland

Kadlec Clinic West Richland Primary (509) 942-3130
- Fiedler, Albert MD — Family Medicine — Y
- Kiki, Jeffrey DO — Family Medicine — Y
- Matta, Tania MD — Pediatrics — Y
- Rubin, Evelyn MD — Internal Medicine — N

Inpatient Hospitals

Kadlec Medical Center
Kennewick General Hospital
Lourdes Medical Center
Prosser Medical Center

Y = Accepting new patients
N = Accepting Established patients only

Looking for a cost-effective alternative to the Emergency Room? You have choices…

Urgent Care

- No referral required
- Much lower cost alternative than the hospital Emergency Room
- Broad choice of Urgent Care facilities – *See list below*

Consulting Nurse Line

- 1-800-297-6877
- Available 24 hours a day, 7 days a week

GroupHealth

Urgent Cares Facilities Available to Group Health Members

Clinic Name	Address	Phone Number	Hours of Operation
Fifth Avenue Urgent Care	507 5th Ave Pasco, WA 99301	(509) 543-1975	Hours: Mon - Sat 8am - 8pm
KGH Urgent Care	7201 W Grandridge, Ste 100 Kennewick, WA 99336	(509) 783-2222	Hours: 8am - 8pm 7 days a week
KGH After Hours Pediatric Urgent Care	7201 W Grandridge, Ste 100 Kennewick, WA 99336	(509) 783-2222	Hours: Mon – Fri, 5:00 pm - 8pm Sat, 9:00 am - 12:00 pm
KGH Walk In Care-27th	4303 W 27th Ave, Ste H Kennewick, WA 99336	(509) 783-4673	Hours: Mon-Sat, 8am - 6pm
KGH Walk In Care-Keene	81 Keene Rd Richland, WA 99352	(509) 627-2213	Hours: Mon-Sat, 8am - 6pm
KGH Urgent Care	3000 W Kennewick Ave Kennewick, WA 99336	(509) 783-8700	Hours: 8am - 8pm 7 days a week
Lourdes Kania Clinic Urgent Care	5304 N Road 68 Pasco, WA 99301	(509) 543-9300	Hours: 8am - 8pm 7 days a week
Physician Immediate Care-Torbett	310 Torbett Richland, WA 99352	(509) 946-7646	Hours: 8am - 8pm 7 days a week
Physicians Immediate Care-Gage	550 Gage Richland, WA 99352	(509) 628-1362	Hours: 8am - 8pm 7 days a week
Yakima Ave Medical Clinic–Urgent Care	1111 W Yakima Ave Yakima, WA 98902	(509) 452-1403	Hours: Mon-Fri, 9am – 5:30pm
Yakima Medical Clinic Walk-in/Urgent Care Clinic	310 Holton Ave Yakima, WA 98902	509-452-2508	Hours: Mon-Fri, 5pm – 8pm

- **Please note: For life-threatening emergencies, go to the nearest emergency room or call 911.**
- **Refer to your plan summary for benefit information.**

GroupHealth®

12401 E. Marginal S., Tukwila, WA 98168
P.O. Box 34750, Seattle, WA 98124-9745

Employee enrollment and change form

EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage effective date _____

Group name _____

Group number _____

**Group number should match health plan choice, if selected by employee in section below.*

Choose one: ☐ **Group Health Cooperative** ☐ **Group Health Options, Inc.**

Original date of hire ____/___ /____

Date of rehire ____/___ /____

Date transferred from part (p/t) to full time (f/t) ____/___ /____

Hours worked per week _____

If retired, date of retirement ____/___ /____

Choose one:

☐ Open enrollment ☐ New employee

☐ Address/name change ☐ Add dependent(s)

☐ Remove coverage

___ Subscriber ___ Dependent(s)

Date processed _____ by _____

☐ **Transfer to COBRA**

Start date _____

☐ 18 months

☐ 36 months

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____ (Last name) (First name) (M.I.) Marital status: ☐ Single ☐ Married Date married____/____/____

Mailing address _____ Home phone ( )_____

Resident address _____ (Street) (City) (State) (Zip) Work phone ( )_____

Employee Medicare claim # _____ Former name of applicant or spouse _____

Health plan choice *If more than one health plan is offered, please write in your choice, including the group number.*

Health plan _____ *Group number _____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

FOR HEALTH PLAN INTERNAL USE ONLY	CHECK ONE		PLEASE PRINT LAST NAME FIRST NAME M.I.	SOCIAL SECURITY NUMBER	MALE/ FEMALE	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	ADD	REMOVE					
			SELF				
			DEPENDENT				
			DEPENDENT				
			DEPENDENT				
			DEPENDENT				

Please list names of any **dependents who are Medicare-eligible or disabled and their Medicare number:**

1. Spouse Medicare claim # _____ 2. Dependent name _____ 3. Medicare claim # _____

ADDITIONAL HEALTH BENEFITS INFORMATION

Other insurance (that is not Group Health Cooperative or Group Health Options, Inc.):_____

Who is the subscriber under this plan?_____

What is their social security or policy number with this plan?_____ Attach any certificate of creditable coverage letters to the back of this form.

_____

(Signature of employee) **(Date signed)**

Please retain a copy for your records

WEA Select Health Plans
October 1, 2011

Benefits that have changed are highlighted in gray Ded + Coin = Deductible + Coinsurance ——Applies to all plans as shown——
IN = In-network OUT = Out-of-network PCY = Per Calendar Year OT = Occupational therapy PT = Physical therapy

		Plan 5 Foundation		Plan 1 Heritage		Plan 2 Heritage		Plan 3 Heritage	
Provider Network		IN	OUT	IN	OUT	IN	OUT	IN	OUT
Copayments, Deductible & Coinsurance									
Copayments									
Office Visit		$15*	30%	$20*	$25*	$25*	$30*	$30*	$40*
Inpatient Copay	Individual	$200 per admission, $600 Max PCY		$100 per day, $300 Max PCY		$150 per day, $450 Max PCY		$300 per day, $900 Max PCY	
	Family	$1,000 PCY		N/A					
Outpatient Surgery Copay		None	None	$50	$50	$100	$100	$150	$150
ER Copay (waived if admitted)		$50	$50	$75	$75	$75	$75	$100	$100
Deductible									
Deductible PCY	Individual	$100	$250	$50 combined IN + OUT		$100 combined IN + OUT		$200 combined IN + OUT	
	Family	$300	$250 /family member	$150 combined IN + OUT		$300 combined IN + OUT		$600 combined IN + OUT	
Coinsurance									
Coinsurance		0%	30%	10%	30%	20%	40%	20%	40%
Out-of-Pocket Maximum PCY**	Individual	Ded + $0	None	$500 combined IN + OUT		$1,500 combined IN + OUT		$2,750 combined IN + OUT	
	Family	N/A		$1,500 combined IN + OUT		$4,500 combined IN + OUT		$8,250 combined IN + OUT	
Covered Services		IN	OUT	IN	OUT	IN	OUT	IN	OUT
Office Visits – Professional Care									
Medical and Naturopathic Office Visits unlimited		$15*	30%	$20*	$25*	$25*	$30*	$30*	$40*
Spinal and Other Manipulations unlimited visits (chiropractic)		$15*	30%	$20*	$25*	$25*	$30*	$30*	$40*
Acupuncture 12 visits PCY (Plan 5 unlimited visits)		$15*	30%	$20*	$25*	$25*	$30*	$30*	$40*
Preventive Care unlimited									
Exams/Immunizations		$0*	Not covered	IN: $0* OUT: 20%					
Preventive Screenings (includes mammography and colon health screenings)		$0*	30%	Same as above					
Diagnostic Services									
Diagnostic Imaging/Laboratory		Ded + Coin							
Hospital/Facility Care									
Outpatient		Outpatient Surgery Copay (Plans 1, 2 & 3) + Ded + Coin							
Inpatient		Inpatient Copay + Ded + Coin							
Maternity – Prenatal/Postnatal Care		Ded + Coin							
Maternity – Delivery		See Outpatient or Inpatient Hospital/Facility Care							
Emergency Care									
Professional/Facility		ER Copay + Ded + Coin							
Ambulance (air and ground)		Deductible +$50		Ded + Coin					
Mental Health Outpatient unlimited visits		$15*	30%	$20*	$25*	$25*	$30*	$30*	$40*
Mental Health Inpatient unlimited days		Inpatient Copay + Ded + Coin							
Rehab. Outpatient 45 visits PCY (PT, Massage, Speech, OT) (1, 2 & 3 PT unlimited)		$15*	30%	$20*	$25*	$25*	$30*	$30*	$40*
				PT Ded + Coin					
Rehab. Inpatient 5&3: 30 days PCY, 1&2: 120 days PCY		Inpatient Copay + Ded + Coin							
Prescription Drugs (participating pharmacies)		Generic / Preferred Brand Name / Non-preferred Brand Name							
Rx Deductible per person PCY		None							
Rx Out-of-Pocket Maximum per person PCY		N/A							
Retail Cost Share 34 day supply		$10 / $15 / $30 / **30 day supply**		$10 / $15 / $30		$10 / $20 / $35		$15 / $25 / $40	
Mail Order Cost Share 100 day supply		$10 / $30 / $60 / **90 day supply**		$10 / $15 / $30		$10 / $20 / $35		$15 / $25 / $40	
Specialty Drug Cost Share 30 day supply		Subject to applicable retail copay							
Unum (Life & AD&D insurance)†		$12,500 Term Life and AD&D for employee only							

*Not subject to the calendar year deductible

**Out-of-pocket maximums for Plans 1, 2 and 3 include coinsurance and deductible. Covered in-network services paid at 100% of allowable charges for remainder of calendar year once out-of-pocket maximum is met. Plans 1, 2 & 3 pay out-of-network on same basis. No out-of-pocket maximum for Plan 5 (Foundation) for out-of-network services.

† Unum is an independent provider of life insurance services that does not provide Premera Blue Cross products or services. Unum is solely responsible for its products and services.

NOTE: This summary is intended to assist you in decision making. Details of covered benefits, limitations, and exclusions are provided in the WEA Select Health Plan benefit booklets. This summary of benefits is not a contract.

020683 (07-2011)

WEA Select Health Plans
October 1, 2011

EasyChoice Plan

Benefits that have changed are highlighted in gray Ded + Coin = Deductible + Coinsurance ——Applies to all plans as shown——
IN = In-network OUT = Out-of-network PCY = Per Calendar Year OT = Occupational therapy PT = Physical therapy

	Provider Network	EasyChoice A Heritage IN	EasyChoice A Heritage OUT	EasyChoice B Heritage IN	EasyChoice B Heritage OUT	EasyChoice C Foundation IN	EasyChoice C Foundation OUT
Copayments, Deductible & Coinsurance							
Copayments							
Office Visit		$15*	50%	$30*	50%	$35*	50%
Inpatient Copay	Individual	None					
	Family	N/A					
Outpatient Surgery Copay		None					
ER Copay (waived if admitted)		$100	$100	$150	$150	$200	$200
Deductible							
Deductible PCY	Individual	$1,000	$2,000	$750	$1,500	$0	$250
	Family	$3,000	$6,000	$2,250	$4,500	$0	$750
Coinsurance							
Coinsurance		20%	50%	25%	50%	35%*	50%
Out-of-Pocket Maximum PCY**	Individual	$5,000	None	$4,000	None	$7,500	None
	Family	$15,000	None	$12,000	None	$22,500	None
Covered Services		**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Office Visits – Professional Care							
Medical and Naturopathic Office Visits unlimited		$15*	50%	$30*	50%	$35*	50%
Spinal and Other Manipulations 12 visits PCY (chiropractic)		$15*	50%	$30*	50%	$35*	50%
Acupuncture 12 visits PCY		$15*	50%	$30*	50%	$35*	50%
Preventive Care unlimited							
Exams/Immunizations		IN: $0* OUT: Not covered					
Preventive Screenings (includes mammography and colon health screenings)		IN: $0* OUT: 50%					
Diagnostic Services							
Diagnostic Imaging/Laboratory		Paid in full to $1,000 then Ded + Coin		Ded + Coin			
Hospital/Facility Care							
Outpatient		Ded + Coin					
Inpatient		Ded + Coin					
Maternity – Prenatal/Postnatal Care		Ded + Coin					
Maternity – Delivery		Ded + Coin					
Emergency Care							
Professional / Facility		ER Copay + Ded + Coin					
Ambulance (air and ground)		Ded + Coin					
Mental Health Outpatient unlimited visits		$15*	50%	$30*	50%	$35*	50%
Mental Health Inpatient unlimited days		Ded + Coin					
Rehabilitation Outpatient A:30 visits PCY, B&C: 45 visits PCY (PT, Massage, Speech, OT)		$15*	50%	$30*	50%	$35*	50%
Rehabilitation Inpatient A: 30 days PCY, B&C: 45 days PCY		Ded + Coin					
Prescription Drugs (participating pharmacies only)		Generic / Preferred Brand Name / Non-preferred Brand Name					
Rx Deductible (waived for generics) per person PCY		$500		$250		$500	
Rx Out-of-Pocket Maximum per person PCY; includes Rx deductible, coinsurance and/or copay		$5,000					
Retail Cost Share 30 day supply		$0 / 30% / 30%		$0 / $30 / $45			
Mail Order Cost Share 90 day supply		$0 / 25% / 25%		$0 / $75 / $112			
Specialty Drug Cost Share 30 day supply		30%					
Unum (Life & AD&D insurance)†		$12,500 Term Life and AD&D for employee only					

* Not subject to the calendar year deductible

** Out-of-pocket maximums include coinsurance and deductible. Covered in-network services paid at 100% of allowable charges for remainder of the calendar year once out-of-pocket maximum is met. No out-of-pocket maximum for out-of-network services.

† Unum is an independent provider of life insurance services that does not provide Premera Blue Cross products or services. Unum is solely responsible for its products and services.

NOTE: This summary is intended to assist you in decision making. Details of covered benefits, limitations, and exclusions are provided in the WEA Select Health Plan benefit booklets. This summary of benefits is not a contract.

020684 (07-2011)

WEA SELECT ENROLLMENT AND CHANGE APPLICATION

School District Name: ☐ New Enrollment ☐ Change Enrollment

Employee Information

Employee Name (Last)	(First)	(MI)	Home Phone ( )	Work Phone ( )
Home Address—Street and Number			Social Security No.	Birth Date (MM/DD/YYYY)
Mailing Address (if different from home address)		City	State	ZIP -

Will you or your dependent(s) enrolled on your WEA Select Plan have any other active medical, vision, or Medicare coverage when this coverage begins?
☐ **No** ☐ **Yes**, please complete and attach an **Other Coverage Questionnaire** form.

Is any child over the dependent age limit applying for coverage due to a disability? ☐ **No** ☐ **Yes**, please complete and attach the **Request for Certification of Disabled Dependent** form.

Medical and Vision Plan Selection and Enrollment (Not all districts or employer groups offer all plans. PLEASE See Enrollment Notes on the reverse side)

☐ Waive WEA Medical ☐ WEA Plan 1 ☐ WEA Plan 2 ☐ WEA Plan 3 ☐ WEA Plan 5 ☐ WEA EC-A ☐ WEA EC-B ☐ WEA EC-C

☐ No WEA Vision ☐ Vision Plan A ☐ Vision Plan B ☐ Vision Plan C ☐ Vision Plan D ☐ Vision Plan E ☐ Vision Plan F

Relationship to Employee	**Please list ALL enrollees to be covered, added or dropped on your plan** Note: Names on ID cards are limited to 26 characters and spaces		Gender	Birth Date	**Please check applicable boxes**							
	Name (26 characters maximum, including spaces). **Last, First, Middle Initial** Example: *Harrison Michelle T*	Social Security No.	M / F	(Mo., Day, Yr.)	**WEA Medical**	Keep	Add	Drop	**WEA Vision**	Keep	Add	Drop
	— S E L F —	(same as above)	☐ M ☐ F	(same as above)	☐	☐	☐	☐	☐	☐	☐	☐
Spouse/DP:			☐ M ☐ F		☐	☐	☐	☐	☐	☐	☐	☐
Child:			☐ M ☐ F		☐	☐	☐	☐	☐	☐	☐	☐
Child:			☐ M ☐ F		☐	☐	☐	☐	☐	☐	☐	☐
Child:			☐ M ☐ F		☐	☐	☐	☐	☐	☐	☐	☐

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

If filling out the **online** form, please print two copies of the application—one for your records and one for the school district. If filling out the **4-part form**, keep goldenrod copy and return the others to the district. **Be sure to sign your application before turning it in.**

Employee Signature: X _____ **Date Signed:** _____

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of Insurance benefits.

To be completed by School District

Please print a copy for your records if using the online form. Or, send white & yellow copies to Premera; retain pink copy for your records.

Check Appropriate Enrollment Box and Provide Date:
☐ New Employee ☐ Insurance Eligible ☐ Open Enrollment ☐ Dependent Change

Date Eligible For Insurance / /

Effective Date of Insurance / /

☐ **Discount rate** ☐ **Full rate**

Change of Status: ☐ Marriage/Domestic Partnership ☐ Divorce ☐ Death ☐ Surviving Dependents ☐ Birth ☐ Special Enrollment

Legal documentation is attached for: ☐ Adoption ☐ Medical Child Support Order ☐ Legal Guardianship/Non-parental Custody

Date of Qualifying Event: / / **Loss of Other Coverage—Reason:** _____ **Date Prior Coverage Ended:** / /

Premera Blue Cross Use Only	ID Number:	ID Card:	Date: / /	Initials:

PREMERA PRIVACY POLICY PRACTICES

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other healthcare plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at www.premera.com/wea. To have forms mailed to you, please call the WEA Select Service Team at 1-800-932-9221.

ENROLLMENT NOTES

- Complete all sections of the WEA Select Enrollment and Change Application except the portion that is reserved for use by your school district and Premera Blue Cross.
- List ALL eligible family members to be covered, added or dropped on your plan and check the appropriate box to the right of each name.
- Please indicate each dependents name on the enrollment application as you would like it to appear on the ID card.
  Note: ID card names are limited to a maximum of 26 characters and spaces.
- If you have dependents that are to be enrolled on a WEA Select Vision plan but are not covered on your WEA Select Medical plan, please indicate that by checking the appropriate vision box to the right of each dependents name.

Medical plan selection and enrollment (Underwritten by Premera Blue Cross, PO Box 327, Seattle, WA 98111)
Please choose only from the plans made available to you by your school district or employer group. Not all school districts offer all six WEA Select sponsored medical plans. Contact your payroll office or benefits administrator for more information. If you are enrolling only on a WEA Vision plan, check the **Waive WEA Medical** box under **Medical and Vision Plan Selection and Enrollment.**

Vision plan selection and enrollment (Underwritten by Premera Blue Cross. Plans B, C, E & F administered by VSP, PO Box 997105, Sacramento, CA 95899)
Not all school districts and employer groups offer WEA Select Vision Plans. Contact your payroll office or benefits administrator for more information. Please check the appropriate box for the vision plan offered to you by your district or employer group under **Medical and Vision Plan Selection and Enrollment**. If a WEA Select vision plan is not available, please check **No WEA Vision**.

Vision subscription rates
The employee and all eligible dependents are covered for one monthly charge regardless of the number of dependents covered. Please list ALL eligible family members to be enrolled on your WEA Select Vision Plan on the enrollment application.

For additional information on dependent eligibility, refer to your benefit booklet or go to www.premera.com/wea.

DELTA DENTAL®
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association

WEA WASHINGTON EDUCATION ASSOCIATION

Enrollment Form

Washington Education Association

☐ New Hire ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Reinstate ☐ Other (Check One)

Employer complete this section:

Group Number _____ Subgroup _____

Please indicate current dental rate $_____ and your WEA Dental Plan #_____ and Ortho if applicable _____

School District			Hire Date	Effective Date	
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Address		City	State	Zip	
Phone Number		Email Address			

Dependents

Please list all dependents to be covered:

First Name	Middle Initial	Last Name	Birthdate	Gender	Add/ Remove	Dependent Over Limiting Age Verification**
Spouse or Domestic Partner*				M ☐ F ☐	Add ☐ Remove ☐	
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐

Incentive Level Transfer Information

WEA Select Dental Plan? Yes ☐ No ☐

WDS: _____; Willamette: _____; # of Years:_____; Former District:_____

Coordination of Benefits

Do you or any of your dependents have other dental coverage? Yes ☐ No ☐ If yes, please complete the section below.

Employer Group Number and Name			Effective Date		
Name and Address of Other Insurance Carrier					
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Other Insurance Covers ☐ Insured Only ☐ Insured & Spouse ☐ Insured & Dependents ☐ Insured & Children					

COBRA Enrollment Only

Indicate Qualifying Date
Indicate Qualifying Event ☐ Termination ☐ Reduction in Hours ☐ Divorce ☐ Widowed/Surviving Dependent ☐ Dependent Child No Longer Eligible ☐ Other

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits (R.C.W. 48.135.080).

* The WEA Select Plans cover registered domestic partners of any state or unregistered domestic partners who complete a domestic partner affidavit.

** Documentation is required (pursuant to R.C.W. 48.44.210). To download the proof of incapacity and dependency form, visit the Washington Dental Service Web site at **www.DeltaDentalWA.com/forms.**

Underwritten by Washington Dental Service, 9706 4th Ave NE, Seattle, WA 98115-2157.

Please send completed for to: Washington Dental Service
Attn: Group Administration — WEA Team
P.O. Box 75983 — Seattle, WA 98175-0983

_____
Signature Date

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **KIONAB**	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Kiona-Benton City School District			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ $	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Short Term Disability ☐Yes ☐No	$	$
		Long Term Disability ☐Yes ☐No	$	$

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life/AD&D Insurance ☐Yes ☐No	$	$
Voluntary Spouse Life/AD&D Insurance ☐Yes ☐No	$	$
Voluntary Dependent Child Benefit ☐Yes ☐No	☐ 10000	$

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name First MI	Relationship Beneficiary	Social Security Number
Street Address	City	State Zip
Contingent Beneficiary's Last Name First MI	Relationship Beneficiary	Social Security Number
Street Address	City	State Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

E. Request for Coverages
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
❑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
❑ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
❑ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____

P.O. Box 91059
Seattle, WA 98111-9159

PREMERA | BLUE CROSS

Affidavit of Domestic Partnership

1. Domestic Partners

A. Only domestic partnerships not documented in a state registry must complete this affidavit.

B. I, _____ certify that I, and _____
Print Name of Employee — Print Name of Domestic Partner

are domestic partners, and we:

1. currently share the same regular and permanent residence, and
2. have a close personal relationship, and
3. are jointly responsible for "basic living expenses" as defined below, and
4. are not married to anyone, and
5. are each eighteen (18) years of age or older, and
6. are not related by blood closer than would bar marriage in Washington state, and
7. were mentally competent to consent to contract when our domestic partnership began, and
8. are each other's sole domestic partner and are responsible for each other's common welfare.

C. "Basic living expenses" means the cost of basic food, shelter, and any other expenses of a domestic partner. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

2. Employee

A. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change in the circumstance attested to in this Affidavit.

B. I agree to notify the Business Office if there is any change in circumstances attested to in this Affidavit within thirty (30) days of the change.

C. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed within _____ as determined by the Group, but in no case less than 90 days, after a request for termination of domestic partnership has been filed with the Business Office.

3. Agreement

A. We understand that this information will be held confidential and will be subject to disclosure only to Premera Blue Cross for purposes of confirming our eligibility or upon our written authorization or as required by law.

B. We understand that this declaration of responsibility for our common welfare may have legal implications under Washington law.

C. We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, because of a false statement contained in this Affidavit of Domestic Partnership.

D. We also certify under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

E. I, the undersigned Employee, understand that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

_____ _____
Signature of Employee — Signature of Domestic Partner

_____/_____/_____ _____/_____/_____
Date Signed (MM/DD/YYYY) — Date Signed (MM/DD/YYYY)

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance coverage.

Note to Group: Keep original for your file and only submit a copy of the updated enrollment application to Premera Blue Cross.

STATE OF WASHINGTON
SECRETARY OF STATE

Declaration of State Registered Domestic Partnership

See attached detailed instructions

This Box For Office Use Only

Registration #

☐ **Filing Fee $50.00**

☐ **Filing Fee with Expedited Service $100.00**

DOMESTIC PARTNERSHIP DECLARATION

Chapter 26.60 RCW

PARTNER 1

Name: _____
First **Middle** **Last**

Place of Birth: _____
City **State** **Country**

Date of Birth: _____

PARTNER 2

Name: _____
First **Middle** **Last**

Place of Birth: _____
City **State** **Country**

Date of Birth: _____

ADDRESS

Mailing or **Postal** Address ***(optional)****:*

_____

City _____ State _____ Zip Code _____

Street Address: _____

City _____ State _____ Zip Code _____

Declaration of State Registered Domestic Partnership

Important information:
Registration of a domestic partnership may affect property and inheritance rights and is not a substitute for a will, deed, or partnership agreement. Any rights conferred by this registration may be superseded by a will, deed, or other instrument signed by either party to this domestic partnership registration.

Records of State Registered Domestic Partnerships are public and will be disclosed on request. Information about State Registered Domestic Partnerships will be shared with the Washington State Department of Health.

Partner 1 Name (Print)	Partner 2 Name (Print)

We declare that we meet the requirements for registration of a domestic partnership pursuant to Chapter 26.60 RCW, and that:

- We share a common residence;
- We are both at least eighteen (18) years of age;
- Neither partner is married to anyone else, or in a state registered domestic partnership with any other person;
- We are both capable of consenting to this domestic partnership;
- We are not of any relation to each other nearer than second cousin and neither partner is a sibling, child, grandchild, aunt, uncle, niece or nephew to the other;
- **We are <u>either</u> both of the same sex <u>or</u> one of us is at least 62 years of age**

These representations are true and correct, and contain no material omissions of fact to the best of our knowledge and belief.

X_____	X_____
Partner 1 (Signature)	**Partner 2 (Signature)**
State of Washington	State of Washington
County of _____	County of _____
Signed and affirmed before me on_____	Signed and affirmed before me on_____
By Partner 1 (print name)_____	By Partner 2 (print name)_____
_____	_____
Notary Public Signature	Notary Public Signature
My Commission Expires:_____	My Commission Expires:_____
Notary seal	Notary seal

INSTRUCTIONS - Declaration of State Registered Domestic Partnership

Complete all sections. **USE DARK INK ONLY**

Partner 1
Complete the name, place of birth, and date of birth portion of the Declaration of State Registered Domestic Partnership.

Partner 2
Complete the name, place of birth, and date of birth portion of the Declaration of State Registered Domestic Partnership.

Address
Complete the street address portion of the form. You may also provide an additional mailing or postal address if different than your street address.

Declaration
Both partners must sign this section. A notary is **required** for each partner's signature. The form provides space for a separate notarization allowing partners to sign at different times or places.

Additional Information
At the time of filing, the Corporations Division will provide each partner with one original certificate of State Registered Domestic Partnership and one wallet card showing registration of the State registered Domestic Partnership. After the date of filing, additional certificates are available from the Corporations Division for a fee of $5.00 each. Replacement wallet cards are available for a fee of $10.00 each.

Fees: The filing fee for Declaration of State Registered Domestic Partnership is $50.00. Make the checks or money orders payable to "Secretary of State." If expedited service is requested then include an additional $50.00 and write "EXPEDITE" on the outside of the envelope. ***(ALL fees are non-refundable)***

Mail completed forms and payment to:
Secretary of State
Corporation Division
801 Capitol Way S
PO Box 40234
Olympia WA 98504-0234

If you have questions, need assistance, or would like to provide feedback please visit the Corporations Division website at www.sos.wa.gov/corps or call 360-725-0377.

Print Form

Prepared for Kiona-Benton City School District

by

Rich Dickman

800.888.8322

Spokane Office | 906 W 2nd Avenue, Suite 400, Spokane, WA 99201

Kennewick Office | 3311 West Clearwater Avenue, Suite C200-E, Kennewick, WA 99336