Classified

CASCADE CHRISTIAN SCHOOLS

EMPLOYEE BENEFIT GUIDE

January 1, 2023 through December 31, 2023

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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WHO IS ELIGIBLE

Full time employees are eligible to participate in benefit plans on the first day of the month following or coinciding with their date of hire. Full time employment is defined as working a minimum of 30 hours per week. Your eligible dependents include your spouse, domestic partner, and dependent children. Dependent children are eligible to age 26.

HOW TO ENROLL

Eligible employees will receive information from their HR Department with detailed instructions for how to enroll for benefits.

If you do not complete your enrollment during your designated window, you may not be able to enroll or make changes unless you experience a qualifying event, or until the next open enrollment period.

MID-YEAR CHANGES

Unless you have a qualifying event, you cannot make changes to the benefits you elect until the next open enrollment period. If you experience a qualified "change in status," you must make any associated enrollment or benefit changes within 30 days of the event except for a Medicare or Medicaid entitlement event, in which case you must make changes within 60 days of the event.

Qualified changes in status include:

- Change in legal marital status (marriage, death of spouse, divorce, legal separation)
- Change in number of dependents (birth, death, adoption, ceases to satisfy eligibility requirements, child support order)
- Change in employment status
- Loss of certain other health coverage
- Medicare or Medicaid entitlement
- Significant cost or other coverage changes
- Family Medical Leave Act (FMLA) leave of absence, reduction of hours
- Exchange/Marketplace enrollment

Important! Please note that there are several conditions and/or limitations that apply to the events listed above. Please contact Human Resources if you have any questions or believe that you may qualify for an election change.

WELCOME TO YOUR BENEFITS

During the annual open enrollment period, you may make changes to your benefit plan elections and/or the family members you cover. Changes can only be made *outside of the annual enrollment period* if you experience a qualified family status change that permits changes in your plan election. So now is the time to carefully review your plan options. On the next page is an overview of the offerings for the 2023 plan year. Elections you make during open enrollment will become effective January 1, 2023.

WHAT'S OFFERED FOR 2023

At Cascade Christian Schools, we offer you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. You may choose to opt out if you have other coverage which you would like to keep.

Plans	Carriers
Medical / RX	Premera Blue Cross
Health Savings Account (HSA)	HealthEquity
Dental	Premera Blue Cross
Vision	Ameritas – VSP & EyeMed
Flexible Spending Accounts	HealthEquity
Employee Assistance Program (EAP)	Premera Blue Cross / Guidance Resources
Employee Assistance Program (EAP)	Principal / Magellan Healthcare
Life/AD&D	Principal
Voluntary Life/AD&D	Principal
Voluntary Long Term Disability	Principal
403b Retirement Savings Plan	Barron Financial Services

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare Part D Notice section of this Guide for more details.

QUESTIONS?

Because the world of healthcare and insurance can be confusing and hard to navigate, we are pleased to introduce your team at Brown & Brown Insurance who will be able to assist you with all things related to your benefits. Brown & Brown will be working in conjunction with the Human Resources Department so that benefit needs are addressed in a timely fashion.

Brown & Brown

Leslie Jesiel, Account Manager
253.396.5504
ljesiel@bbrown.com

CASCADE CHRISTIAN SCHOOLS

Tiffany Wakefield
Director of Human Resources
253.841.1776
tiffany@cascadechristian.org

Additionally, the carriers below may be able to assist.

Plan	Carrier	Phone	Website
Medical	Premera Blue Cross	Peak Care Customer Service: 855.250.7325 PPO Customer Service: 800.722.1471	www.premera.com
Health Savings Account	HealthEquity	866.348.5800	www.healthequity.com
Dental	Premera Blue Cross	800.722.1471	www.premera.com
Vision	Ameritas	800.659.2223	www.vsp.com www.eyemed.com
Flexible Spending Account	HealthEquity	877.924.3967	www.healthequity.com
EAP	Guidance Resources	844.862.0898	www.guidanceresources.com
EAP	Magellan Healthcare	800.450.1327	www.magellanascend.com
Life/AD&D	Principal	800.986.3343	www.principal.com
Voluntary Life/AD&D			
Voluntary Long Term Disability			

EMPLOYEE PAYROLL DEDUCTIONS

Cascade Christian's Benefits Plan is designed under "Section 125" of the IRS Code. This allows you to take advantage of federal and state laws by purchasing some of your benefits with pre-tax dollars. Under Section 125, any required contributions for medical, dental and vision will be made with pre-tax dollars. **You may only change your pre-tax benefit elections once per year, during open enrollment, unless you experience a qualified "change in status."**

Premera Peak Care 1500			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 433.94	$ 433.94	**$ -**
Employee & Spouse	$ 877.56	$ 433.94	**$ 443.62**
Employee and Child(ren)	$ 818.97	$ 433.94	**$ 385.03**
Employee and Family	$ 1,153.20	$ 433.94	**$ 719.26**

Premera Heritage Plus 3000			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 459.45	$ 433.94	**$ 25.51**
Employee & Spouse	$ 929.16	$ 433.94	**$ 495.22**
Employee and Child(ren)	$ 867.13	$ 433.94	**$ 433.19**
Employee and Family	$ 1,221.01	$ 433.94	**$ 787.07**

Premera Heritage Plus 2000			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 499.49	$ 433.94	**$ 65.55**
Employee & Spouse	$ 1,010.14	$ 433.94	**$ 576.20**
Employee and Child(ren)	$ 942.71	$ 433.94	**$ 508.77**
Employee and Family	$ 1,327.42	$ 433.94	**$ 893.48**

Voluntary Delta Dental PPO Base			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 36.45	$ -	**$ 36.45**
Employee & Spouse	$ 78.37	$ -	**$ 78.37**
Employee and Child(ren)	$ 80.20	$ -	**$ 80.20**
Employee and Family	$ 120.29	$ -	**$ 120.29**

Voluntary Delta Dental PPO Buy Up			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 44.67	$ -	**$ 44.67**
Employee & Spouse	$ 96.04	$ -	**$ 96.04**
Employee and Child(ren)	$ 98.27	$ -	**$ 98.27**
Employee and Family	$ 147.41	$ -	**$ 147.41**

Voluntary Ameritas VSP Choice & Eye Med			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 5.76	$ -	**$ 5.76**
Employee & Spouse	$ 11.52	$ -	**$ 11.52**
Employee and Child(ren)	$ 12.36	$ -	**$ 12.36**
Employee and Family	$ 19.76	$ -	**$ 19.76**

MEDICAL PLAN

PREMERA BLUE CROSS – MEDICAL PLAN COMPARISON

Exclusive Provider Organization (EPO) Plans cover services performed solely by in-network providers. Tends to be a lower cost system but is more restrictive than a PPO plan.

Qualified High Deductible Health Plan (QHDHP) with Health Savings Account (HSA) Plans have a high calendar year deductible that must be met before medical and prescription drug benefits begin and allows you to set aside money in an HSA to pay for qualified medical, dental and vision expenses.

Preferred Provider Organization (PPO) Plans have a network of providers, but also allows for the use of providers outside the plan's network. It is more flexible than an HMO but is usually more expensive.

In Network Benefits	Plan 1 Peak Care 1500 EPO Network	Plan 2 Heritage Plus HSA 3000 PPO Network	Plan 3 Heritage Plus 2000 PPO Network
	*Denotes deductible apples	*Denotes deductible apples	*Denotes deductible apples
Annual Deductible	$1,500 Individual $3,000 Family[1]	$3,000 Individual $6,000 Family[2]	$2,000 Individual $4,000 Family[1]
Coinsurance	You pay 20%	You pay 10%	You pay 20%
Annual Out of Pocket Maximum (Includes deductible & copays)	$5,000 Individual $10,000 Family[4]	$5,000 Individual $10,000 Family[3]	$7,350 Individual $14,700 Family[1]
Preventive Care	Covered in full	Covered in full	Covered in full
Office Visit – Primary **Office Visit – Specialist** **Office Visit – Virtual Care**	$30 copay $30 copay $10 copay	You pay 10%*	$30 copay $30 copay $10 copay
Outpatient Diagnostic X-Ray & Lab	You pay 20%*	You pay 10%*	You pay 20%*
Major Lab – MRI, CAT, PET Scan	You pay 20%*	You pay 10%*	You pay 20%*
Emergency Room (copay waived if admitted)	$250 copay then you pay 20%*	You pay 10%*	$250 Copay, then 20%*
Hospital Services – In-Patient	You pay 20%*	You pay 10%*	You pay 20%*
Prescription Drugs (30-day supply) Preferred Generic Preferred Brand Non-Preferred	$15 Copay $50 Copay $80 Copay	You pay 10%* *(Deductible applies)*	$15 Copay $50 Copay $80 Copay
Out of Network Benefits	**EPO Network**	**PPO Network**	**PPO Network**
Annual Deductible	Emergency Services Only. No Out of Network Benefits.	$6,000 Individual $12,000 Family[2]	$4,000 Individual $8,000 Family[1]
Coinsurance		You pay 50%	You pay 50%
Annual Out of Pocket Maximum (Includes deductible & copays)		Unlimited	Unlimited

[1] Family embedded – members must only satisfy the individual deductible before coinsurance benefits apply.
[2] Family aggregate deductible – the entire family deductible must be met before coinsurance benefits apply to any individual within the family.
[3] Family aggregate out of pocket maximum – the entire family out of pocket maximum (OOPM) must be met before benefits are paid at 100%.
[4] Family embedded out of pocket maximum – the out of pocket max (OOPM) for any one member cannot be more than the individual OOPM.

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summary, Summary of Benefits and Coverage (SBC) and Booklet.

PRESENTED BY: CASCADE CHRISTIAN SCHOOLS Brown & Brown

HEALTH SAVINGS ACCOUNT (HSA)

HEALTHEQUITY

HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs).

HSA ADVANTAGES	
Save Money	HDHPs have lower monthly premiums, meaning you pay less out of your paycheck.
Portable	Money in your HSA is carried over year to year and remains yours, even if you leave the company.
Triple Tax Advantages	HSA contributions are tax-free. Interest earnings on HSA contributions accumulate tax-free. Amounts distributed for qualified expenses are tax-free as well.

Maximum Contributions: 2023 tax year

- **Individual Coverage:** $3,850
- **Family Coverage:** $7,750
- **Individuals age 55+:** additional $1,000 catch up contribution per year

HSA things you need to know:

Annual limits apply to HSA contributions:

- The amount is federally mandated and different for individual and family HDHP coverage.
- Contributions exceeding the maximum limits become taxable as income.
- Withdrawals used for non-qualified expenses are taxable as income and subject to 20% penalty.
- Changes to contributions can be made at any time throughout the year, contact HR/Payroll for guidelines.

Who is eligible to open and fund an HSA? Anyone who is:

- Covered by a qualified HDHP;
- Not covered under another medical plan that is not a qualified HDHP - including Medicare, Medicaid, TriCare, VA and/or a Health Care Flexible Spending Account (FSA); and

VALUE ADDED RESOURCES

Premera Mobile App

You can use Premera's mobile app to help you:

- Find Care: Search for a doctor, specialist, urgent care or hospital close by.
- Access your ID cards: Keep a version of your ID card handy. You can show it, fax it or email it right from your mobile device.
- Check claims: View detailed claims information anytime
- Track your spending: Know exactly how close you are to meeting your deductible and out-of-pocket maximum

Download the Mobile App: Just search for Premera. Can't get the app? You can use many of the same features on Premera's mobile web browser at www.Premera.com.

98point6

Care from anywhere, without ever leaving home. 98point6 is on-demand, text based primary care from the convenience of an app. Doctors are available 24/7 to deliver diagnosis and treatments without setting foot in a doctor's office, avoiding unnecessary exposure. The board-certified physicians can:

- Diagnose and treat
- Order prescriptions and labs as necessary
- Provider answers and peace of mind

Download the 98point6 app today to get started. Available on the App Store and Google Play.

Boulder Care

Boulder Care offers telehealth addiction treatment grounded in kindness, respect, and unconditional support. With a program designed by addiction medicine specialists and people with lived experience of recovery, Boulder Care's mission is to improve the lives of people with substance use disorders. Patients can connect with their providers from anywhere through secure video and messaging on the Boulder App.

Visit www.boulder.care/getstarted to learn more. You can also access Boulder Care on the Premera mobile app.

24/7 NurseLine

Call the 24/7 NurseLine phone number on the back of your ID Card any time to talk to a registered nurse who asks you the right questions and helps you decide what to do and where to go if your doctor isn't available. Going to the right place can save you time and money. And you can access better care, too.

VALUE ADDED RESOURCES

Workit Health

Workit Health is proud to partner with Premera to provide evidence-based, online treatment to help you quit alcohol, drugs, smoking, or other addictions. Use the Workit Health app to connect with licensed clinicians and counselors dedicated to helping you meet your recovery goals. The program is adaptable to all stages of substance use and recovery. Use this platform to:

- Join online recovery groups
- Work through a therapeutic curriculum to help you learn coping skills

Go to www.workithealth.com/Premera to get started. You can also access Workit Health on the Premera mobile app.

Designated Centers of Excellence

This program is an enhanced benefit for total joint replacement (knee and hip) when you use any of the 7 Premera designated centers of excellence. With this program you get:

- Innovative bundled pricing (a predictable packaged cost) for pre-surgical appointments, hospitalization, surgeries and post-surgery checkups
- Lower out-of-pocket costs
- Travel benefits, such as air travel, ground transportation, lodging for you and a companion when you live more than 50 miles away from a center of excellence (up to IRS limits)

Pregnancy Management with BestBeginnings

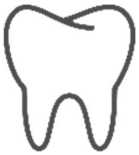
Premera offers a pregnancy management benefit that is designed to help support you on an adventure of a lifetime, that can also come with some uncertainty. Visit www.blue.premera.com/bestbeginnings to learn more about the services offered and how they can help you. BestBeginnings also offers a personal mobile app you can use to:

- Track your medical milestones
- Invite friends and family to follow your pregnancy
- Prep questions for your doctor visits
- Find out about important symptoms and issues during pregnancy

Download the Mobile App: Just search for BestBeginnings by Premera

DENTAL PLAN

PREMERA BLUE CROSS – DENTAL BASE PLAN



Preferred Provider Organization (PPO) Plans allow you the freedom to use the dentist of your choice or access the PPO network of dentists. There are reduced fees for services based on negotiated rates.

Out of network benefits are available

- **You will pay the difference in cost between a non-network provider's charges and the allowed amount.**

In Network Benefits	Premera Blue Cross **Dental PPO** – Base Plan
Annual Deductible	$50 Individual $150 Family Deductible is waived for Preventive Services
Annual Benefit Maximum	$1,000
Orthodontia Benefit	Not Covered
TMJ Services	Not Covered
Class I Preventive & Diagnostic Services	
Routine Exam Cleanings Fluoride X-Rays Sealants	Plan pays 100%
Class II Basic Services	
Fillings Endodontics (Root Canal) Periodontics Oral Surgery	Plan pays 80%
Class III Major Services	
Dentures/Partial Dentures Bridges Crowns Implants	Plan pays 50%
Out of Network Benefits	
Annual Deductible	Shared with In Network
Annual Benefit Maximum	Shared with In Network
Preventive / Basic / Major Services	100% / 80% / 50%
Usual Customary Reimbursement (UCR)	90th Percentile UCR

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summary and Booklet.

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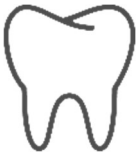
DENTAL PLAN

PREMERA BLUE CROSS – DENTAL BUY UP PLAN



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Out of network benefits are available

- **You will pay the difference in cost between a non-network provider's charges and the allowed amount.**

In Network Benefits	Premera Blue Cross Dental PPO
Annual Deductible	$50 Individual $150 Family Deductible is waived for Preventive Services
Annual Benefit Maximum	$2,000
Orthodontia Benefit	Not Covered
TMJ Services	Not Covered
Class I Preventive & Diagnostic Services	
Routine Exam Cleanings Fluoride X-Rays Sealants	Plan pays 100%
Class II Basic Services	
Fillings Endodontics (Root Canal) Periodontics Oral Surgery	Plan pays 90%
Class III Major Services	
Dentures/Partial Dentures Bridges Crowns Implants	Plan pays 60%
Out of Network Benefits	
Annual Deductible	Shared with In Network
Annual Benefit Maximum	Shared with In Network
Preventive / Basic / Major Services	100% / 90% / 60%
Usual Customary Reimbursement (UCR)	90th Percentile UCR

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summary and Booklet.

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VISION PLANS

AMERITAS – FOCUS AND VIEWPOINTE COMPARISON

The vision plan provides you with the freedom to use an eye doctor of your choice or access the **VSP Choice or EyeMed Insight Network** vision network of providers, depending upon your plan election. If you use a provider participating in the network, your out of pocket expenses will be reduced.

Extra Savings: In addition to the coverage below, the plan provides savings on additional pairs of glasses and sunglasses, retinal screening, and laser vision correction.

In Network Benefits	Plan 1 Focus VSP Choice Network	Plan 2 ViewPoint Eyemed Insight Network
Eye Exam	$10 copay	$10 copay
Prescription Lenses & Frames		
Single Vision **Lined Bifocal** **Lined Trifocal** **Frames** **Frames Allowance**	$25 copay $25 copay $25 copay $130 max allowance, $70 Costco/Walmart allowance	$25 copay $25 copay $25 copay $130 max allowance
Lens Enhancements		
Progressive Lenes & Other Enhancements	Available at a discounted rate	Available at a discounted rate
Contact Lenses		
Lens Exam (fitting & evaluation) **Contacts** (instead of glasses)	Up to $60 $130 allowance	Up to $40 $130 allowance
Medically Necessary Lenses	Paid in full	Paid in full
Frequency		
Eye Exam **Lenses – Eyeglass or Contacts** **Frames**	Every 12 months Every 12 months Every 24 months	Every 12 months Every 12 months Every 24 months
Out of Network Benefits	**See Benefit Summary**	**See Benefit Summary**

USING YOUR BENEFITS IS EASY

There's no ID card necessary (but you can print a Member Vision Card if you'd like from www.ameritas.com)

- Just tell your provider you have Ameritas coverage along with your selected network
- Give the provider the primary member's name
    - It will be helpful to have the primary member's Date of Birth and Social Security Number handy, in case the provider asks for additional information to look up the coverage

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summary and Booklet.

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FLEXIBLE SPENDING ACCOUNT (FSA)

HEALTHEQUITY

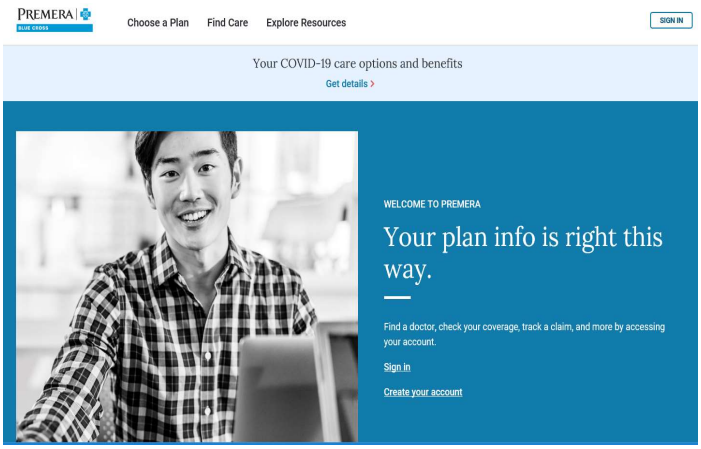
You have the opportunity to pay for out of pocket Medical, Dental, Vision, and/or Dependent Care expenses with pre-tax dollars through payroll deduction. This means that you don't pay federal income or FICA taxes on the portion of your paycheck you contribute to your FSA.
Important Note: If you will be funding an HSA, you cannot participate in the Health Care FSA or be covered by your spouse's FSA unless it is a Limited-Purpose FSA. Cascade Christian Schools does not offer a Limited Purpose FSA.

Plan Year: January 1, 2023 to December 31, 2023

Health Care Contribution Limit: $2000
Dependent Care Contribution Limit: $5,000

Health Care FSA	Set aside pre-tax dollars to pay for out-of-pocket health care expenses (medical, dental and vision) incurred by you, your spouse and/or your dependent children; whether you insure them or not.
Rollover/Carryover	If you still have money in the account at the end of the Plan Year (December 31, 2023), up to $610 of your unused balance will carry over into the new FSA plan year.
Dependent Care FSA	Used to reimburse childcare expenses; while you or your spouse work, look for work or attend school full-time or are physically unable to care for your dependent. Eligible children are under age 13, or a dependent who is physically or mentally not able to care for themself. Eligible dependent care expenses include:
	• Nanny • Nursery school • Before and after school care • Day Camp • Daycare
Plan Year:	January 1, 2023 through December 31, 2023

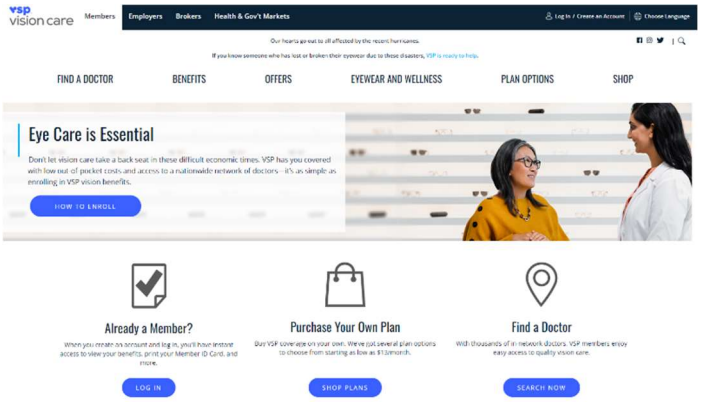
HOW TO LOCATE A PROVIDERS



Premera Medical and Dental

www.Premera.com

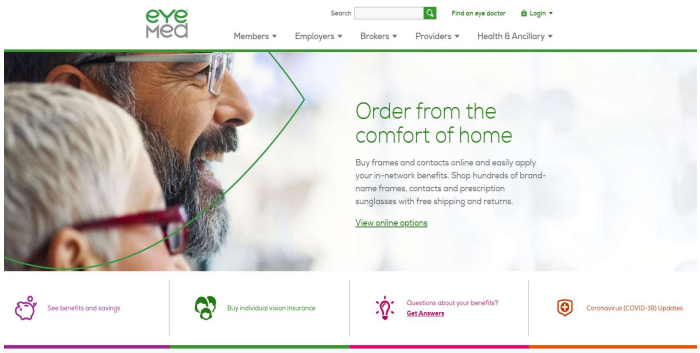
- Click on Find Care
- Click on Find a Doctor
- Select your network OR browse by category such as hospitals, dental care or walk In clinic's
- Enter your search criteria



Ameritas Vision - VSP

www.vsp.com

- Click on Find a Doctor
- Then search by location, office or doctor



Ameritas Vision - EyeMed

www.eyemed.com/en-us

- Click on Find an eye doctor
- Choose your network
- Then search by location or doctor

LIFESTYLE GUIDANCE RESOURCES (EAP)

PREMERA BLUE CROSS EAP

The EAP provides a positive, confidential tool to help resolve personal or family problems. You and your dependents can use EAP services to get support for and work towards solutions to solve a wide range of issues and concerns.

Services include support for:

- Anxiety and Depression
- Couples/Relationship/Parenting
- Crisis Support
- Alcohol/Drug Problems
- Grief and Loss
- Work Conflict
- Compulsive Behaviors
- Domestic Violence
- Legal and Financial
- Childcare and Eldercare
- Home Ownership
- ID Theft
- Healthy Living Tips

Your company's complimentary EAP program is available 24/7 and covers not only you, but spouses, domestic partners and children up to age 26. The EAP is here to help when you're facing issues that interfere with your health, well-being, and productivity at home or at work.

The EAP offers up to 3 **sessions face-to-face or telehealth** (no copay, deductible or premium) with a qualified clinical expert who can assess your concerns and develop a plan of action. If you need legal* or financial consultation, or ID theft resolution, you can speak with an expert for up to 30 minutes at no charge. EAP consultants can also provide you with childcare and eldercare information and resources for anywhere in the country. Additionally, the Home Ownership program is a valuable tool to gain a competitive edge as a buyer and can save you thousands when buying or selling a home.

Simply call us at 844.862.0898 or visit our website to request an appointment.

*Workplace issues are excluded.

Here's how to get started

Give us a call as 844.862.0898 and we will connect you with the right resource or professional.

Visit our website to learn more about all the services available at www.guidanceresources.com.

App: GuidanceResources Now

Web ID: premerawellness

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EMPLOYEE ASSISTANCE PLAN (EAP)

PRINCIPAL EAP

The EAP provides a positive, confidential tool to help resolve personal or family problems. You and your dependents can use EAP services to get support for and work towards solutions to solve a wide range of issues and concerns.

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- Healthy Living Tips

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The EAP offers up to 3 **sessions face-to-face or telehealth** (no copay, deductible or premium) with a qualified clinical expert who can assess your concerns and develop a plan of action. If you need legal* or financial consultation, or ID theft resolution, you can speak with an expert for up to 30 minutes at no charge. EAP consultants can also provide you with childcare and eldercare information and resources for anywhere in the country. Additionally, the Home Ownership program is a valuable tool to gain a competitive edge as a buyer and can save you thousands when buying or selling a home.

Simply call us at 800.450.1327 or visit our website to request an appointment.

*Workplace issues are excluded.

Here's how to get started

Give us a call as 800.450.1327 and we will connect you with the right resource or professional.

Visit our website to learn more about all the services available at www.MagellanAscend.com.

Enter **Principal Core** for the company name

PRESENTED BY: CASCADE CHRISTIAN SCHOOLS Brown & Brown

GROUP LIFE & AD&D INSURANCE

PRINCIPAL– 1X ANNUAL EARNINGS

Group Life and AD&D Insurance is arranged through **Principal**. All benefit eligible employees receive life and accidental death & dismemberment (AD&D) insurance.

This benefit is provided at no cost to you.

Benefits

Basic Life Coverage Amount

Your Basic Life coverage amount is 1 times your annual earnings to a maximum of $100,000.

Basic AD&D Coverage Amount

Your Basic AD&D coverage amount is equal to your Basic Term life coverage amount.

For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable, please refer to the contract for details.

Age Reductions

The amount of insurance reduces by 35 percent at the age of 65, to 50 percent at the age of 70, adjusted at policy renewal following the change in age.

Other Basic Life Features and Services

- Accelerated Death Benefit
- Waiver of Premium
- Right to Convert Provision
- Grief Counseling
- Will Preparation
- Beneficiary Assistance

Other Basic AD&D Features and Services

- Air Bag Benefit
- Seat Belt Benefit

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summary and Certificate.

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VOLUNTARY LIFE/AD&D INSURANCE

Voluntary Life and AD&D Insurance is arranged through **Principal**. This insurance can help your family meet daily expenses, maintain their standard of living, pay off debt, secure your children's education, and more in the event of your passing.

Coverage Information

Within the coverage amount guidelines shown below, you select the amount of Voluntary Life and Dependent Life insurance for which you are interested in applying. Additional AD&D insurance is included for Employees and Spouses only.

	Minimum	Incremental Unit	Guarantee Issue Amount	Maximum
Employee	$10,000	$10,000	$100,000 Age 70+ $10,000	5x annual earnings up to $500,000
Spouse	$5,000	$5,000	$25,000 Age 70+ $10,000	$100,000, not to exceed 100% of employee's benefit
Child	Options: $2,500, $5,000 or $10,000*. All amounts guaranteed. *Children under 14 days old limited to $1,000 benefit.			

What is Guarantee Issue?

This is the maximum amount of coverage you can elect during your initial enrollment as a new hire or during a carrier approved open enrollment opportunity without answering health questions. Otherwise, all elections require the completion of a health statement and are subject to underwriting approval.

Age Reductions

The amount of insurance reduces by 35 percent at the age of 70, with an additional 20% reduction at age 75, adjusted at policy renewal following the change in age.

Additional Features

- Accelerated Death Benefit
- Portability of Insurance Provision
- Waiver of Premium
- Right to Convert Provision

Rates and Calculation

Employee & Spouse Rates* per $1,000 of coverage	
Age	**Rate****
Under 25	$0.061
25-29	$0.061
30-34	$0.080
35-39	$0.111
40-44	$0.146
45-49	$0.211
50-54	$0.315
55-59	$0.495
60-64	$0.639
65-69	$1.027
70+	$1.640
Child Rate	
$.500 per $2,500 of benefit regardless of the number of children in the family	

Here's how to calculate your monthly premium:

Step 1
Select your volume (amout of coverage) = $ _____

Step 2
Multiply your volume by your Age Rate = $ _____

Step 3
Divide the amount in Step 2 by $1,000 = $ _____
Monthly Premium

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DISABILITY INSURANCE

Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness. If you become disabled from an injury or sickness, disability income benefits will provide a partial replacement of lost income. Cascade Christian Schools provides full time employees the option to purchase long term disability on a voluntary basis, through payroll deduction.

PRINCIPAL

	Voluntary Long Term Disability
Benefits Begin	91st day
Percentage of Pre-Disability Income Replaced	60%
Duration of Benefits Payable	Until age 65 or Social Security Normal Retirement Age
Maximum Benefit	Up to $5,000 monthly
Monthly Rates – Your age as of January 1st	**Long Term Disability Per $100 Monthly**
Under 35	$0.160
35-39	$0.340
40-44	$0.470
45-49	$0.640
50-54	$0.850
55-59	$0.970
60-64	$0.760
65+	$0.280

How to Calculate Your Monthly Premiums

How to Calculate Your Monthly Premium Costs

Long-term Disability	_____	÷ 100 X	_____	= _____
	Monthly Earnings*		Your Age Rate	Monthly Premium

*Please note: If your monthly salary exceeds the benefit maximum stated above, use that amount in replace of your salary.

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summary and Certificate.

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SHORT TERM DISABILITY & WASHINGTON PAID FAMILY AND MEDICAL LEAVE COORDINATION

FOR EMPLOYEES: What you need to know

If you are unable to work due to an illness or injury and want to file a disability claim with your insurance, there are some important things to keep in mind.

Don't' forget to file for Washington Paid Family & Medical Leave

In general, insurance carriers will assume that you are taking WPFML concurrently with any disability and will automatically reduce your benefit by the anticipated WPFML you would receive.

If you do not qualify for WPFML, the insurance carrier will reinstate your full benefit upon receipt of documentation that you are not eligible or that WPFML benefits have been denied.

How long will benefits last?

WPFML provides up to 12 weeks of medical leave benefits per year. Your disability plan may provide a similar number of weeks; however, you should contact the carrier's customer service or review your plan booklet to confirm the number of short term disability weeks available.
Your particular situation will determine the actual number of weeks you are approved for, for both WPFML and your Short Term Disability.

What if I have Long Term Disability?

For most people, WPFML and LTD will never overlap. If your approved WPFML does overlap slightly with an LTD claim, benefits will continue to be reduced until your WFPML benefits have been exhausted. Once WPFML benefits are exhausted, your full disability benefit would be reinstated. It will not be necessary to provide additional documentation for the end of the WPFML because that will have been collected during the time you were on STD.

If you have Long Term Disability, without a Short Term Disability benefit, you will still report the WPFML benefit as income being received. You should indicate when the WPFML benefits are expected to end, and it would be beneficial to include a copy of your WPFML benefit letter to confirm the benefit expiration date.

Resources

- Please review **your specific disability plan booklet/contract** for specific details of coverage and coordination of benefits
- **Washington Paid Family Medical Leave**
  https://paidleave.wa.gov/individuals-and-families/

RETIREMENT SAVINGS PLAN – 403B

Barron Financial Services

Cascade Christian Schools - 403b Opportunities
YOUR FUTURE…is in YOUR Hands!

Julie M. Drennon, M.Ed, CRPC®, Barron Financial Services

Why Thinking about Goals for Your Future NOW is Important!
- *Social Security?*
- *Health Care Costs?*
- *Longer Life Spans?*

What is a 403b?
- *VOLUNTARY Tax Deferred Retirement Savings Plan*
- *Also known as TSA (Tax Sheltered Annuity)*
- *Time+Compound Interest = GROWTH*

What are Cascade Christian Schools' Plan Highlights?
- *ALL employees eligible to participate in 403b Plan*
- *A variety of investment products available through a menu of Approved Vendors including Great American, GWN Securities Managed Account Program, (American Funds, Vanguard, Blackrock, etc), VOYA, and Oppenheimer Funds*
- *A variety of investment vehicles in which to invest*
- *A choice to work with an Advisor that best works for you*

What are My Options?
- *Painless Payroll Deduction*
- *$50 - $1416 per month (can defer $24,000 per year and more with "catch ups")*
- *Flexible vendors and investment vehicles*

How do I Get Started?
- *Discuss your goals, timelines and risk tolerance with your Advisor*
- *Determine best investment vehicle for you*
- *Determine the $$ amount you can afford "live without" each month to determine deferred contribution*
- *Complete forms with advisor*
- *Consider getting a COMPLIMENTARY Goal Setting and Retirement Analysis*
- *Kick back and SAVE, SAVE, SAVE!*
- *Enjoy your "Golden Years"*

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"Planning for YOUR Future!"

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SUMMARY OF BENEFITS AND COVERAGE & UNIFORM GLOSSARY

The next pages contain the following mandatory compliance information:

- An easy-to-understand summary of benefits and coverage for the medical plan(s) offered by your employer
- A uniform glossary of terms commonly used in health insurance coverage such as “deductible” and “copayment”

Premera Blue Cross : Peak Care

Coverage for: Individual or Family | **Plan Type:** EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-722-1471 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-722-1471 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,500 Individual / $3,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care, copayments, and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,000 Individual / $10,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-722-1471 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	Not covered	None
	Specialist visit	$30 copay/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Prior authorization required for some outpatient imaging tests. Penalty: 50% of allowable charge to $1,500 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.premera.com/documents/052147_2023.pdf	Generic drugs	$15 copay/prescription (retail), $30 copay/prescription (mail)	$15 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
	Preferred brand drugs	$50 copay/prescription (retail), $100 copay/prescription (mail)	$50 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Non-preferred brand drugs	$80 copay/prescription (retail), $160 copay/prescription (mail)	$80 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Specialty drugs	50% coinsurance	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior authorization required for some services. Penalty: 50% of allowable charge to $1,500 per occurrence.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay/visit + 20% coinsurance	$250 copay/visit + 20% coinsurance	Emergency room copay waived if admitted to hospital.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	Hospital-based: $250 copay/visit + 20% coinsurance Freestanding center: $30 copay/visit0% coinsurance	Hospital-based: $250 copay/visit + 20% coinsurance Freestanding center: Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Prior authorization required for all planned inpatient stays. Penalty: 50% of allowable charge to $1,500 per stay.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 copay/visit Facility: 20% coinsurance	Not covered	None
	Inpatient services	20% coinsurance	Not covered	Prior authorization required for all planned inpatient stays. Penalty: 50% of allowable charge to $1,500 per stay.
If you are pregnant	Office visits	20% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery facility services	20% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $30 copay/visit Inpatient: 20% coinsurance	Not covered	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty: 50% of allowable charge to $1,500 per stay.
	Habilitation services	Outpatient: $30 copay/visit Inpatient: 20% coinsurance	Not covered	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty: 50% of allowable charge to $1,500 per stay.
	Skilled nursing care	20% coinsurance	Not covered	Limited to 60 days per calendar year. Prior authorization required for all planned inpatient stays. Penalty: 50% of allowable charge to $1,500 per stay.
	Durable medical equipment	20% coinsurance	Not covered	Prior authorization required to buy some medical equipment. Penalty: 50% of allowable charge to $1,500 per occurrence.
	Hospice services	20% coinsurance	Not covered	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Hearing aids	• Private-duty nursing
• Cosmetic surgery	• Infertility treatment	• Routine eye care (Adult)
• Dental care (Adult)	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 1-800-842-5357. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-722-1471 or TTY 1-800-842-5357, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-722-1471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-722-1471.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,500**
Specialist copay	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,770**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist copay	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist copay	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,010**

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Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

Premera Blue Cross : Your Future HSA Agg NGF

Coverage for: Individual or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-722-1471 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-722-1471 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Calendar year aggregate deductible. In-network: $3,000 Individual / $6,000 Family. Out-of-network: $6,000 Individual / $12,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,000 Individual / $10,000 Family, Out-of-network: Not Applicable	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-722-1471 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	50% coinsurance	None
	Specialist visit	10% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	Prior authorization required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.premera.com/documents/052148_2023.pdf	Generic drugs	10% coinsurance	10% coinsurance (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
	Preferred brand drugs	10% coinsurance	10% coinsurance (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). Prior authorization required for some drugs.
	Non-preferred brand drugs	10% coinsurance	10% coinsurance (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). Prior authorization required for some drugs.
	Specialty drugs	10% coinsurance	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Prior authorization required for some services. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	Hospital-based: 10% coinsurance Freestanding center: 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	50% coinsurance	None
	Inpatient services	10% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
If you are pregnant	Office visits	10% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	10% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Habilitation services	10% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Durable medical equipment	10% coinsurance	50% coinsurance	Prior authorization required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Hospice services	10% coinsurance	50% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Hearing aids	• Private-duty nursing
• Cosmetic surgery	• Infertility treatment	• Routine eye care (Adult)
• Dental care (Adult)	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 1-800-842-5357. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-722-1471 or TTY 1-800-842-5357, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-722-1471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-722-1471.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$3,000**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,000**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,000**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

Premera Blue Cross : Your Choice NGF

Coverage for: Individual or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-722-1471 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-722-1471 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,000 Individual / $4,000 Family. Out-of-network: $4,000 Individual / $8,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care, copayments, prescription drugs and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $7,350 Individual / $14,700 Family, Out-of-network: Not Applicable	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-722-1471 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	50% coinsurance	None
	Specialist visit	$30 copay/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior authorization required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.premera.com/documents/052147_2023.pdf	Generic drugs	$15 copay/prescription (retail), $30 copay/prescription (mail)	$15 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
	Preferred brand drugs	$50 copay/prescription (retail), $100 copay/prescription (mail)	$50 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Non-preferred brand drugs	$80 copay/prescription (retail), $160 copay/prescription (mail)	$80 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Specialty drugs	50% coinsurance	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior authorization required for some services. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 copay/visit + 20% coinsurance	$250 copay/visit + 20% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	Hospital-based: $250 copay/visit + 20% coinsurance Freestanding center: $30 copay/visit0% coinsurance	Hospital-based: $250 copay/visit + 20% coinsurance Freestanding center: 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admit + 20% coinsurance	$500 copay per admit + 50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 copay/visit Facility: 20% coinsurance	50% coinsurance	None
	Inpatient services	$500 copay per admit + 20% coinsurance	$500 copay per admit + 50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery facility services	$500 copay per admit + 20% coinsurance	$500 copay per admit + 50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $30 copay per/visit Inpatient: $500 copay per admit + 20% coinsurance	Outpatient: 50% coinsurance Inpatient: $500 copay per admit + 50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay. Deductible applies.
	Habilitation services	Outpatient: $30 copay per/visit Inpatient: $500 copay per admit + 20% coinsurance	Outpatient: 50% coinsurance Inpatient: $500 copay per admit + 50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay. Deductible applies.
	Skilled nursing care	$500 copay per admit + 20% coinsurance	$500 copay per admit + 50% coinsurance	Limited to 60 days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Hospice services	Outpatient: 20% coinsurance Inpatient: $500 copay per admit + 20% coinsurance	Outpatient: 50% coinsurance Inpatient: $500 copay per admit + 50% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Hearing aids	• Private-duty nursing
• Cosmetic surgery	• Infertility treatment	• Routine eye care (Adult)
• Dental care (Adult)	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 1-800-842-5357. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-722-1471 or TTY 1-800-842-5357, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-722-1471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-722-1471.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist copay	**$30**
Hospital (facility) copay	**$500**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist copay	**$30**
Hospital (facility) copay	**$500**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist copay	**$30**
Hospital (facility) copay	**$500**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,420**

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Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

ANNUAL HEALTH PLAN COMPLIANCE NOTICES

PRESENTED BY: CASCADE CHRISTIAN SCHOOLS Brown & Brown

HEALTH PLAN COMPLIANCE NOTICES

Cascade Christian Schools

11/8/2022

Provided by: Brown & Brown

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage aren't required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

- You become divorced or legally separated from your spouse.

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;

Death of the employee;

- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days days after the qualifying event occurs. You must provide this notice to:

Tiffany Wakefield
815 21st St SE
Puyallup, Washington 98372

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

2023 Plan Year
Tiffany Wakefield
815 21st St SE
Puyallup, Washington 98372

General FMLA Notice

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

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

Tiffany Wakefield
815 21st St SE
Puyallup, Washington 98372

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Cascade Christian Schools	4. Employer Identification Number (EIN) 91-1572300	
5. Employer address 815 21st St SE	6. Employer phone number 253.841.1776	
7. City Puyallup	8. State Washington	9. ZIP code 98372
10. Who can we contact about employee health coverage at this job? Tiffany Wakefield		
11. Phone number 253.841.1776	12. Email address tiffany@cascadechristian.org	

Here is some basic information about health coverage offered by this employer:

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

  ☑ Some employees. Eligible employees are: Full Time Employees working a minimum of 30 hours per week

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: Lawful Spouse, State Registered Domestic Partner and Dependent Children up to age 26

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

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

Medicare Part D Creditable Coverage Notice

Important Notice from Cascade Christian Schools About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Cascade Christian Schools has determined that the prescription drug coverage offered by the 2023 Plan Year is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Cascade Christian Schools coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Cascade Christian Schools coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Cascade Christian Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information call Tiffany Wakefield at 253.841.1776. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Cascade Christian Schools changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	11/8/2022
Name of Entity/Sender:	Cascade Christian Schools
Contact--Position/Office:	Tiffany Wakefield, Human Resources
Address:	815 21st St SE Puyallup, Washington 98372
Phone Number:	253.841.1776

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the 2023 Plan Year with respect to mental health or substance use disorder benefits, please contact Premera Blue Customer Service.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

https://www.insurance.wa.gov/surprise-billing-and-balance-billing-protection-act

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

https://www.insurance.wa.gov/surprise-billing-and-balance-billing-protection-act

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit https://www.cms.gov/files/document/memo-no-surprises-act-phone-number-and-website-url-clean-508-mm2.pdf for more information about your rights under federal law.

Notice of Patient Protections

2023 Plan Year generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Tiffany Wakefield at 815 21st St SE, Puyallup, Washington 98372.

For children, you may designate a pediatrician as the primary care provider.

Notice of Privacy Practices

Cascade Christian Schools
815 21st St SE
Puyallup, Washington 98372

Privacy Official:
Tiffany Wakefield
815 21st St SE
Puyallup, Washington 98372

Effective Date: 11/08/2022

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Tiffany Wakefield
  815 21st St SE
  Puyallup, Washington 98372
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Information

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Tiffany Wakefield at 815 21st St SE, Puyallup, Washington 98372.

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
    - Initial employment;
    - Reemployment;
    - Retention in employment;
    - Promotion; or
    - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.* Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Premera BlueCross Customer Service.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? If you would like more information please call Premera BlueCross Customer Service.


Brown & Brown