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CASCADE CHRISTIAN SCHOOLS

EMPLOYEE BENEFIT GUIDE

January 1, 2024 through December 31, 2024

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, State Registered 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 2024 plan year. Elections you make during open enrollment will become effective January 1, 2024.

WHAT'S OFFERED FOR 2024

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)	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		CASCADE CHRISTIAN SCHOOLS
Denise Cooksey Sr. Account Manager 253.396.5582 denise.cookseyl@bbrown.com	Leslie Jesiel Account Manager 253.396.5504 leslie.jesiel@bbrown.com	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	Core HMO Customer Service: 844.722.4661 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	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

Below are the monthly plan costs.

Premera HMO Core 1500			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 485.77	$ 455.77	$ 30.00
Employee & Spouse	$ 981.76	$ 455.77	$ 525.99
Employee and Child(ren)	$ 916.78	$ 455.77	$ 461.01
Employee and Family	$ 1,290.91	$ 455.77	$ 835.14

Premera Heritage Plus HSA 3000			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 550.86	$ 455.77	$ 95.09
Employee & Spouse	$ 1,114.01	$ 455.77	$ 658.24
Employee and Child(ren)	$ 1,039.64	$ 455.77	$ 583.87
Employee and Family	$ 1,463.92	$ 455.77	$ 1,008.15

Premera Heritage Plus 2000			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 598.91	$ 455.77	$ 143.14
Employee & Spouse	$ 1,211.20	$ 455.77	$ 755.43
Employee and Child(ren)	$ 1,202.56	$ 455.77	$ 746.79
Employee and Family	$ 1,519.91	$ 455.77	$ 1,064.14

Voluntary Delta Dental PPO Base			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 38.05	$ -	$ 38.05
Employee & Spouse	$ 81.81	$ -	$ 81.81
Employee and Child(ren)	$ 83.72	$ -	$ 83.72
Employee and Family	$ 125.57	$ -	$ 125.57

Voluntary Delta Dental PPO Buy Up			
	Total Cost	Employer Cost	Your Monthly Cost
Employee Only	$ 46.64	$ -	$ 46.64
Employee & Spouse	$ 100.28	$ -	$ 100.28
Employee and Child(ren)	$ 102.60	$ -	$ 102.60
Employee and Family	$ 153.91	$ -	$ 153.91

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

Health Maintenance Organization (HMO) 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 HMO Core Plus 1500 HMO 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[3]	$5,000 Individual $10,000 Family[3]	$7,350 Individual $14,700 Family[3]
Preventive Care	Covered in full	Covered in full	Covered in full
Office Visit – Primary **Office Visit – Specialist** **Office Visit – Virtual Care**	$0 copay $50 copay $0 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)	$300 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 Specialty	$15 Copay $50 Copay $80 Copay 50%	You pay 10%* *(Deductible applies)*	$15 Copay $50 Copay $80 Copay 50%
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[1]	$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 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.

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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: 2024 tax year

- **Individual Coverage:** $4,150
- **Family Coverage:** $8,300
- **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)

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.

DispatchHealth

Access urgent and acute care from the comfort of your own home with DispatchHealth – a contracted provider with Premera. DispatchHealth sends a care team to a member's home to provide treatment for common injuries or health conditions that often send members to urgent care or the emergency room. With DispatchHealth, members receive high-quality care from a dedicated care team. Say goodbye to lengthy wait times in urgent care and emergency room facilities.

DispatchHealth has 44 service areas across the continental US. Members can initiate a visit by calling 855.354.8961.

VALUE ADDED RESOURCES CONTINUED

Rx Savings Solutions

A free-to-you benefit that helps you and others on your health plan easily find the lowest-price options for prescription drugs. This service is securely linked to your health plan, so everything is personalized for your medications. All you need to di is activate your account.

1. Check out what lower-cost prescriptions may be available under your health plan and compare prices at different pharmacies.
2. Rx Savings Solutions will handle everything with your doctor and pharmacy to switch your prescription to a lower-cost pharmacy.
3. You'll receive an email (or test message if you opt in to receive texts) any time you can spend less, taking the burden off you to find the lowest price on your medications.

Call 800.268.4476 (TTY: 800.877.8973) or email support@rxsavingssolutions.com for more information.

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

Premera MyCare App

Virtual care from your couch 24/7 with in-network, board-certified doctors, therapists, other specialists. Prescriptions can be sent to your pharmacy. MyCare is the Mobile App (android and iOS) and the related data services that enable members to find and get care.

- Get immediate in-app care
- Engage with providers
- Answers to care questions
- Weigh care options
- Select care path

Kinwell Primary Care Clinics

As a Premera member, you and your family have access to Kinwell Clinics, which are delivering a new standard for primary care in Washington.

The Kinwell clinic experience includes same and next-day appointments, high quality, accessible and patient-centered health care for the whole family, integrated preventive services and behavioral health care, virtual or in-person appointments with a provider of choice, easy online scheduling and in-clinic lab tests.

Clinics available in Federal Way, Redmond, Bellingham, Ballard, Westlake, Olympia, Mill Creek, Poulsbo, Denny Way, Lynnwood, Renton, Spokane, Spokane Valley, Yakima, Wenatchee, and Pasco.

Schedule a virtual or in-person appointment today at kinwellhealth.com.

VALUE ADDED RESOURCES CONTINUED

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

VIRTUAL BEHAVIORAL HEALTH THERAPY

With Talkspace through Premera Blue Cross

One in five Americans struggle with some form of mental illness. And yet, 60% of those folks don't seek help. Premera is committed to making it easy for people who need help to find the help that works for them. With Talkspace, you can easily connect to therapists and psychiatrists by video and text for about the same cost as an in-person visit. Regardless of the time of day or where you're at, with Talkspace, you can reach your dedicated therapist.

In a crisis, call or text 24/7:
National Suicide Prevention Lifeline: 800.273.TALK (8255)
En Espanol: 888-628-9454
Deaf & Hard of Hearing: 800.799.4889
Crisis Text Line: Text HOME to 741741

To get started, sign up for Talkspace at talkspace.com/premera, get matched with the best therapist for you and start messaging your therapist right away.

MATCHMAKER FOR BEHAVIORAL HEALTH

One in three adults report experiencing symptoms of depression or anxiety right now. Change, uncertainty, and new ways of going about our daily lives can take a toll, and yet finding a mental health provider who is accepting new patients can be hard.

Matchmaker for Behavioral Health will connect you to a care provider based on your health plan, needs and preferences. Any information you share is confidential. This service is available to all members on your Premera health plan at no out of pocket cost.

Call customer service at the number on the back of your ID card to request help finding a provider.

When you're ready, visit the resource center at premera.com/visitor/care-essentials/mental-health to find additional information on your benefits, finding care, and more.

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

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
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 PLAN

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** 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, 2024 to December 31, 2024

Health Care Contribution Limit: $3,200
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, 2024), up to $640 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, 2024 through December 31, 2024

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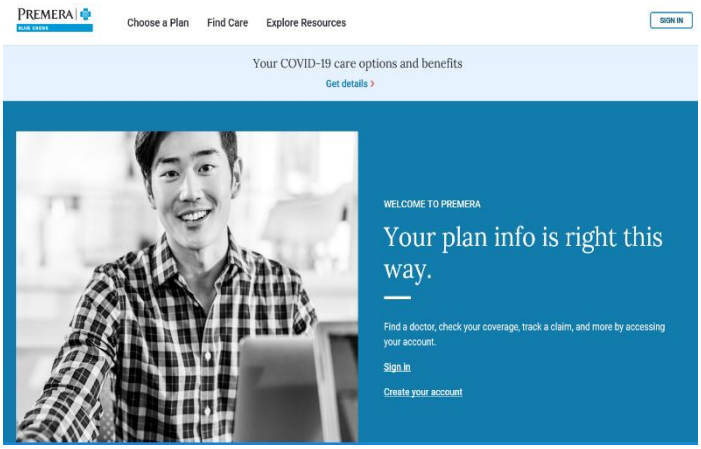
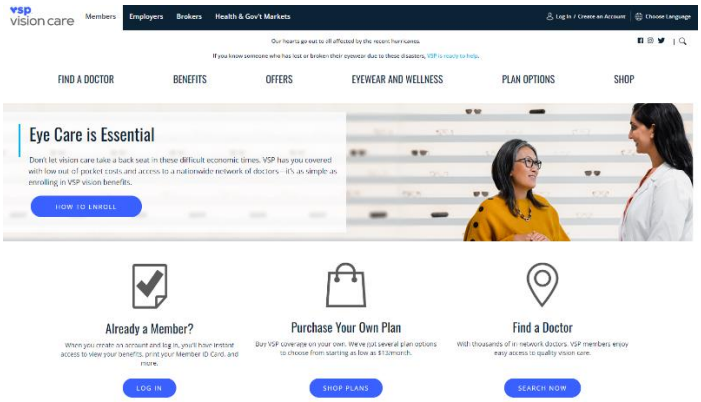
HOW TO LOCATE A PROVIDER



Premera Medical and Dental

www.Premera.com

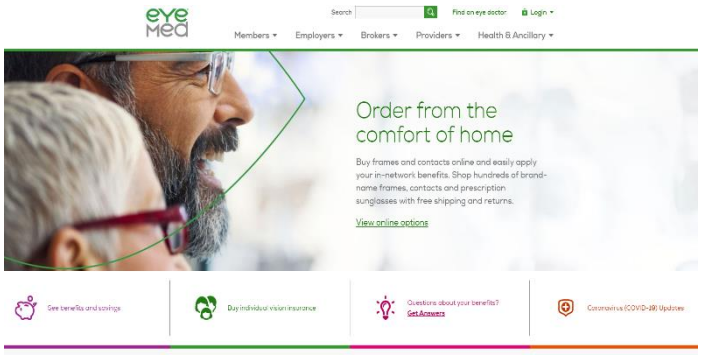
- Click on Find Care
- Click on Find a Doctor
- Select your network OR browse by category such as hospitals, dental care or walk In clinic's
- Enter your search criteria



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

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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.

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
- 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 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

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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

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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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.

PRESENTED BY: CASCADE CHRISTIAN SCHOOLS & Brown & Brown

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 disability weeks available.
Your particular situation will determine the actual number of weeks you are approved for, for both WPFML and your 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/

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!"

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
  - Premera Heritage Plus 2000 Summary of Benefits & Coverage
  - Premera Heritage Plus HSA 3000 Summary of Benefits & Coverage
  - Premera Core HMO Plus 1500 Summary of Benefits & Coverage

- A uniform glossary of terms commonly used in health insurance coverage such as “deductible” and “copayment”

2024 SBCs are not yet available. For those who would like to review a more detailed benefit summary, Plan Highlight Summaries have been attached in lieu of SBCs. An updated guide will be provided once the SBCs become available.

PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

Cascade Christian Schools

Group Number: 4018665

Effective Date: 01/01/2024

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**MEDICAL $2,000-$4,000 20%/50% $7,350-NA $30**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$2,000	$4,000
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$7,350	Unlimited
Office Visit Cost Share	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Kinwell Connect Cost Share Waiver (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Covered in Full
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Covered in Full
Health Education (HE) (Unlimited)	Covered in Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$10 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$10 Copay, applies to the $7,350 Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered

MEDICAL PLAN	MEDICAL $2,000-$4,000 20%/50% $7,350-NA $30	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam	Covered in Full	Covered as any other service
FACILITY CARE OPTIONS		
Inpatient Facility	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max
Inpatient Professional Services	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	MEDICAL $2,000-$4,000 20%/50% $7,350-NA $30	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$2,000 Deductible, 0% Coinsurance, applies to $7,350 Out of Pocket Maximum	$2,000 Deductible, 0% Coinsurance, applies to $7,350 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$250 Copay then $2,000 Deductible and 20% Coinsurance; all cost shares apply to the $7,350 Out of Pocket Maximum	$250 Copay then $2,000 Deductible and 20% Coinsurance; all cost shares apply to the $7,350 Out of Pocket Maximum
Emergency Room Physician	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum
Urgent Care Center	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and other) (12 visits PCY)	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max
Chemical Dependency Outpatient Professional Care (Unlimited)	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max
Mental Health Outpatient Professional Care (Unlimited)	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max	$500 Copay per Admit, then Deductible/Coinsurance, applies to the OOP Max
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$30 Copay, applies to the $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	MEDICAL $2,000-$4,000 20%/50% $7,350-NA $30	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
OTHER SERVICES		
Allergy/Therapeutic Injections	Covered in Full	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$2,000 Deductible, then 20% Coinsurance, applies to $7,350 Out of Pocket Maximum	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 every 36 months)	$30 Copay	$4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hearing Hardware (WA Mandate $3,000 per ear with hearing loss every 36 months)	Covered in Full	Covered in Full
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Health Care Coverage

Cascade Christian Schools
Group Number: 4018665

Effective Date: 01/01/2024

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**MEDICAL $3,000-$6,000 10%/50% $5,000-NA**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$3,000/$6,000	$6,000/$12,000
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$5,000 PCY	Unlimited
Office Visit Cost Share	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Kinwell Connect Cost Share Waiver (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Covered in Full
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Covered in Full
Health Education (HE) (Unlimited)	Covered in Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	Not Covered

MEDICAL PLAN	MEDICAL $3,000-$6,000 10%/50% $5,000-NA	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	Covered as any other service
FACILITY CARE OPTIONS		
Inpatient Facility	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		

MEDICAL PLAN	MEDICAL $3,000-$6,000 10%/50% $5,000-NA	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$3,000/$6,000 Deductible, 0% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$3,000/$6,000 Deductible, 0% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum
Emergency Room Physician	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum
Urgent Care Center	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	MEDICAL $3,000-$6,000 10%/50% $5,000-NA	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Manipulations (Spinal and other) (12 visits PCY)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PHARMACY		
Drug List	Open A1 No Tiers	Open A1 No Tiers
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	MEDICAL $3,000-$6,000 10%/50% $5,000-NA	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Medical Supplies, Equipment, Prosthetics (Unlimited)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 every 36 months)	$3,000/$6,000 Deductible, then 10% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	$6,000/$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hearing Hardware (WA Mandate $3,000 per ear with hearing loss every 36 months)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $5,000 PCY Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

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Highlights of your Health Care Coverage

Cascade Christian Schools
Group Number: 4018665

Effective Date: 01/01/2024

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	**RX $15/$50/$80/50% MAIL 2X**
PRESCRIPTION DRUGS	
Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	$15/$50/$80/50%
Mail Cost Shares	$30/$100/$160/50%
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

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Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	$15/$50/$80/50%
Mail Cost Shares	$30/$100/$160/50%
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

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Highlights of your Dental Coverage

Cascade Christian Schools

Group Number: 4018665

Effective Date: 01/01/2024

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	DENTAL $50-$150 0%-20%-50% $1000 MAX	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$50	Shared with In Network
Family Deductible	$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Annual Maximum	$1,000 PCY	Shared with In Network
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (Unlimited)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 19)	Covered in Full	Covered in Full
Sealants (Under age 19 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 19)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%

Highlights of your Dental Coverage

Cascade Christian Schools

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DENTAL PLAN	**DENTAL $50-$150 0%-20%-50% $1000 MAX**	
	IN-NETWORK	**OUT-OF-NETWORK**
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Occlusal (Night) Guard (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%

Annual deductible waived for Diagnostic/Preventive services

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Highlights of your Dental Coverage

Cascade Christian Schools

Group Number: 4018665

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DENTAL PLAN	DENTAL $50-$150 0%-10%-40% $2000 MAX	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$50	Shared with In Network
Family Deductible	$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 10%	Deductible, then 10%
Major Cost Share	Deductible, then 40%	Deductible, then 40%
Dental Annual Maximum	$2000 PCY	Shared with In Network
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (Unlimited)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 19)	Covered in Full	Covered in Full
Sealants (Under age 19 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 19)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 10%	Deductible, then 10%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 40%	Deductible, then 40%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 10%	Deductible, then 10%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 10%	Deductible, then 10%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 10%	Deductible, then 10%

Highlights of your Dental Coverage

Cascade Christian Schools

Group Number: 4018665

Effective Date: 01/01/2024

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	DENTAL $50-$150 0%-10%-40% $2000 MAX	
	IN-NETWORK	OUT-OF-NETWORK
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 10%	Deductible, then 10%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 10%	Deductible, then 10%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 10%	Deductible, then 10%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 10%	Deductible, then 10%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 10%	Deductible, then 10%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 40%	Deductible, then 40%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 10%	Deductible, then 10%
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 40%	Deductible, then 40%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 10%	Deductible, then 10%
Surgical Extractions (Unlimited)	Deductible, then 10%	Deductible, then 10%
Oral Surgery (Unlimited)	Deductible, then 10%	Deductible, then 10%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 10%	Deductible, then 10%
Occlusal (Night) Guard (Once every 36 consecutive months)	Deductible, then 10%	Deductible, then 10%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 10%	Deductible, then 10%

Annual deductible waived for Diagnostic/Preventive services

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PREMERA HMO

Highlights of your Health Care Coverage

Cascade Christian Schools
Group Number: 4018665

Effective Date: 01/01/2024

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**HMO $1,500 20% $5,000 $0/$50**	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$1,500	Not Covered
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Not Covered
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$5,000	Not Covered
PCP Office Visit Cost Share	$0 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
Specialist Office Visit Cost Share	$50 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
Kinwell Connect Cost Share Waiver (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Health Education (HE) (Unlimited)	Covered in Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit	PCP: $0 Copay, applies to the $5,000 Out of Pocket Maximum; Specialist: $50 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - General Medical	$0 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered

MEDICAL PLAN	HMO $1,500 20% $5,000 $0/$50	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
Telemedicine with Traditional Providers - Specialist	$50 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$0 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Not Covered
Other Professional Diagnostic Imaging	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Professional Diagnostic Major Imaging	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Other Professional Diagnostic Laboratory/Pathology	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Diagnostic Mammography	Covered in Full	Not Covered
Supplemental Breast Exam	Covered in Full	Not Covered
FACILITY CARE OPTIONS		
Inpatient Facility	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Outpatient Surgery Facility	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered

MEDICAL PLAN	HMO $1,500 20% $5,000 $0/$50	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
Sterilization - Female (Unlimited)	Covered in Full	Not Covered
Sterilization - Male (Unlimited)	Covered in Full	Not Covered
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$1,500 Deductible, 0% Coinsurance, applies to $5,000 Out of Pocket Maximum	$1,500 Deductible, 0% Coinsurance, applies to $5,000 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$300 Copay then $1,500 Deductible and 20% Coinsurance; all cost shares apply to the $5,000 Out of Pocket Maximum	$300 Copay then $1,500 Deductible and 20% Coinsurance; all cost shares apply to the $5,000 Out of Pocket Maximum
Emergency Room Physician	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum
Urgent Care Center	$25 Copay, applies to the $5,000 Out of Pocket Maximum	$25 Copay, applies to the $5,000 Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$0 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
Manipulations (Spinal and other) (12 visits PCY)	$0 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Professional Care (Unlimited)	$0 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility Care (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Professional Care (Unlimited)	$0 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	$50 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$50 Copay, applies to the $5,000 Out of Pocket Maximum	Not Covered
OTHER SERVICES		

MEDICAL PLAN	HMO $1,500 20% $5,000 $0/$50	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
Allergy/Therapeutic Injections	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Medical Supplies, Equipment, Prosthetics (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	Not Covered
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 every 36 months)	$25 Copay	Not Covered
Hearing Hardware (WA Mandate $3,000 per ear with hearing loss every 36 months)	Covered in Full	Covered in Full
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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Cascade Christian Schools
Group Number: 4018665

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PRESCRIPTION DRUGS	
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	$0
Family Deductible PCY	No Family Deductible
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	$15/$60/$100/50%
Mail Cost Shares	$37.50/$150/$100/50%
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

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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. ໂທ 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.

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