



Bellingham Public Schools

...where *every* student learns

A SUMMARY OF HEALTH AND WELFARE BENEFIT PLANS

Benefits Fair

Monday, August 31
2:00-6:00 pm
Kulshan Middle School

Open Enrollment

August 15
through noon
September 4, 2009

Applications are to be turned in to the **Human Resources Office**. To be effective for October 1, your application must be received by the Human Resources Office no later than noon on Friday, September 4, 2009.

The information herein is not a contract. It is a summary of the benefits available. It is not intended to be an all-inclusive description of Plan benefits, limitations or exclusions, and should not be used in lieu of a Plan book. Be sure to consult your Plan booklet available in the Human Resources Office, or consult with the insurance company representative before making your selection. If there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets prevail. For questions regarding plan features or options, please contact Emily Austin at Baldwin Resource Group (877-455-5640 ext. 311). For questions regarding current coverage, please contact your current carrier's representative listed on page 16 of this brochure. This summary was printed on August 11, 2009. Any information not provided by that time or revisions by bargaining units or by insurers after this date could change or modify the information contained herein.

Bellingham School District benefit information can also be found on the District Website @ www.bham.wednet.edu Select Staff, Employee Information, 2009-2010 Health Benefit Options.

For your convenience, an open enrollment benefits information table will be set up on the main floor lobby of the Roeder Administration Building.

For other benefit questions or enrollment forms, e-mail www.kkullas@bham.wednet.edu or leave a message at 676-6503.

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HOW TO SELECT A MEDICAL PLAN

You have a choice of eight different medical plans which offer a variety of plan designs. Be sure to compare the total cost when deciding on a plan, i.e., cost of premiums, deductibles, co-pays, etc. An explanation of each plan design and the plan names follow:

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

HMO Choices:

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

PREFERRED PROVIDER ORGANIZATION type plans contract with a large number of providers. If you choose to receive your care through a preferred provider, the insurance company will pay a very high percentage of the charges. If you choose to go to a non-preferred provider, then the insurance company will pay a lower percentage of the charges.

Preferred Provider Plan Choices:

- Regence Blue Shield Whatcom Educational Insurance Consortium Modified Copay Plan
- Regence Blue Shield Whatcom Educational Insurance Consortium Engage 80 Plan
- Regence Blue Shield Whatcom Educational Insurance Consortium High Option Plan
- Regence Blue Shield Whatcom Educational Insurance Consortium Innova 500 Plan
- WEA Premera Blue Cross Select PPO 1
- WEA Premera Blue Cross Select PPO 2

THE STATE OF WASHINGTON offers subsidized medical insurance for children in qualifying families. See page 12 of this booklet for more information.

**All enrollment forms must be received by the Human Resources Office
by noon on September 4, 2009 to be effective for October 1, 2009.**

SPECIAL ENROLLMENT RIGHTS DESCRIPTION

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

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

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

OPTION I

GROUP HEALTH COOPERATIVE TRADITIONAL PLAN

(Classified Group #0505300, Certificated Group #1236800)

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

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

OPTION II

GROUP HEALTH COOPERATIVE DEDUCTIBLE WELCOME PLAN

(Classified Group #1147200, Certificated Group #1236900)

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

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

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

OPTION III

REGENCE BLUE SHIELD WEIC MODIFIED COPAY PLAN (*Group # tbd*)

Category 1 – Preferred Providers

Category 2 – Participating Providers

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

OPTION IV

REGENCE BLUE SHIELD WEIC ENGAGE 80 PLAN (Group # tbd)

Category 1 – Preferred Providers

Category 2 – Participating Providers

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

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

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

MEDICAL COVERAGE

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

\$200/Individual, \$600/Family

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

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

Hospital Inpatient Deductible, then 80%.

Deductible, then **80%**.

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

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

Surgery Deductible, then 80%.

Deductible, then **80%**.

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

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

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

Deductible, then **80%**. Deductible is waived for a preventive mammogram and pap smear.

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

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

Ambulance Deductible, then 80%.

Deductible, then 80%.

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

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

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

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

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

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

Preventive Care 80%. Deductible is waived.

80%. Deductible is waived.

Vision Care Not covered.

Not covered.

Maximum Lifetime Benefit \$2,000,000.

\$2,000,000.

Life Insurance Not applicable.

Not applicable.

OPTION V

REGENCE BLUE SHIELD WEIC HIGH OPTION PLAN (*Group # tbd*)

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

OPTION VI
REGENCE BLUE SHIELD WEIC INNOVA 500 PLAN (Group # tbd)

Category 1 – Preferred Providers

Category 2 – Participating Providers

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

OPTION VII

WEA PREMIERA BLUE CROSS SELECT PLAN PPO 1 (Group #8370200)

Eligible Health Care Providers	Any licensed provider worldwide (except as stated). Only In-Network Providers agree not to bill for amounts over the allowable charges. Enrollees receive greater benefits using Heritage Network Providers.	
Definition of a Dependent Child	Unmarried child(ren) from birth to their 25 th birthday	Unmarried child(ren) from birth to their 25 th birthday.
Annual Deductible	\$50 (Individual) / \$150 (Family) – Combined In & Out of Network	\$50 (Individual) / \$150 (Family) – Combined In & Out of Network
IN-NETWORK BENEFITS		
Coinsurance (Benefit) Level	90%	
Out of Pocket Maximum	Once Premiera has paid \$4,000 in plan payments (In & Out-of-Network combined), benefits will be covered at 100% of allowable charges for the remainder of the calendar year.	
Physician Office Calls	\$20 Co-pay then covered at 100% of allowable charges; Deductible waived.	\$25 Co-pay then covered at 100% of allowable charges; Deductible waived.
Preventive Care Services (PCY = Per Calendar Year)	Covered at 100% of allowable charges up to a maximum of \$300 per person ages 4 and older PCY. Well baby exams have a maximum of \$600 per person PCY from birth through age 3; Maximum includes related lab/x-ray/diagnostic tests. Deductible waived.	Covered at a 80% of allowable charges up to a maximum of \$300 per person ages 4 and older PCY. Well baby exams have a maximum of \$600 per person PCY from birth through age 3; Maximum includes related lab/x-ray/diagnostic tests. Deductible waived.
Chiropractic Services	<u>Unlimited Visits</u> \$20 Co-pay then covered at 100% of allowable charges; Deductible waived.	<u>Unlimited Visits</u> \$25 Co-pay then covered at 100% of allowable charges; Deductible waived.
Prescription Drug Co-payment	<u>At Participating Retail Pharmacies:</u> Deductible waived	<u>At Non-Participating Retail Pharmacies:</u> <u>Deductible waived</u> Paid at 60% of allowable charges <u>AFTER</u>
Retail (34 day supply)	\$10 – generic \$15 – preferred brand \$30 – non-preferred brand	\$10 – generic \$15 – preferred brand \$30 – non-preferred brand
Mail Order (100 day supply)	Same copay as Retail.	Same copay as Retail.
Ambulance Services	Subject to deductible, then covered at 90% of allowable charges.	Subject to deductible, then covered at 70% of allowable charges.
Emergency Room Co-payment	\$75 co-payment per ER visit; Co-pay waived if admitted.	\$75 co-payment per ER visit; Co-pay waived if admitted.
Hospital Inpatient Services (PCY = Per Calendar Year)	Subject to deductible & \$100 co-pay per day to a maximum of \$300 per person PCY; Covered at 90% of allowable charges thereafter.	Subject to deductible & \$100 co-pay per day to a maximum of \$300 per person PCY; Covered at 70% of allowable charges thereafter.
Inpatient Surgery	See <i>Hospital Inpatient Services</i> above.	See <i>Hospital Inpatient Services</i> above.
Outpatient Surgery	Subject to deductible & \$50 co-pay; Covered at 90% of allowable charges thereafter.	Subject to deductible & \$50 co-pay; Covered at 70% of allowable charges thereafter.
Lab & X-Ray Services	Subject to deductible, then covered at 90% of allowable charges thereafter.	Subject to deductible, then covered at 70% of allowable charges thereafter.
Mental Health Inpatient Services	Subject to inpatient co-pay & deductible, then covered at 90% of allowable charges thereafter.	Subject to inpatient co-pay & deductible, then covered at 70% of allowable charges thereafter.
Mental Health Outpatient Services (PCY = Per Calendar Year)	Limited to 50 one-hour visits PCY. \$20 Co-pay then covered at 100% of allowable charges; Deductible waived.	Limited to 50 one-hour visits PCY. \$25 Co-pay then covered at 100% of allowable charges; Deductible waived.
Routine Vision Care	Not Covered.	
Maximum Lifetime Benefit	\$5,000,000 revolving each 5 years.	
Life / AD&D Insurance	\$20,000 decreasing term Life & Accidental Death & Dismemberment for employee only.	

OPTION VIII

WEA PREMIERA BLUE CROSS SELECT PLAN PPO 2 (Group #8370202)

Eligible Health Care Providers	Any licensed provider worldwide (except as stated). Only In-Network Providers agree not to bill for amounts over the allowable charges. Enrollees receive greater benefits using Heritage Network Providers.	
Definition of a Dependent Child	Unmarried child(ren) from birth to their 25 th birthday.	Unmarried child(ren) from birth to their 25 th birthday.
Annual Deductible	\$100 (Individual) / \$300 (Family) – Combined In & Out of Network	\$100 (Individual) / \$300 (Family) – Combined In & Out of Network
IN-NETWORK BENEFITS		
Coinsurance (Benefit) Level	80%	
Out of Pocket Maximum	Once Premera has paid \$5,500 in plan payments (In & Out-of-Network combined), benefits will be covered at 100% of allowable charges for the remainder of the calendar year.	Once Premera has paid \$5,500 in plan payments (In & Out-of-Network combined), benefits will be covered at 100% of allowable charges for the remainder of the calendar year.
Physician Office Calls	\$25 Co-pay then covered at 100% of allowable charges; Deductible waived.	\$30 Co-pay then covered at 100% of allowable charges; Deductible waived.
Preventive Care Services (PCY = Per Calendar Year)	Covered at 100% of allowable charges up to a maximum of \$300 per person ages 4 and older PCY. Well baby exams have a maximum of \$600 per person PCY from birth through age 3; Maximum includes related lab/x-ray/diagnostic tests. Deductible waived.	Covered at a 80% of allowable charges up to a maximum of \$300 per person ages 4 and older PCY. Well baby exams have a maximum of \$600 per person PCY from birth through age 3; Maximum includes related lab/x-ray/diagnostic tests. Deductible waived.
Chiropractic Services	<u>Unlimited Visits</u> \$25 Co-pay then covered at 100% of allowable charges; Deductible waived.	<u>Unlimited Visits</u> \$30 Co-pay then covered at 100% of allowable charges; Deductible waived.
Prescription Drug Co-payment	<u>At Participating Retail Pharmacies; Deductible waived.</u>	<u>At Non-Participating Retail Pharmacies; Deductible waived.</u>
Retail (34 day supply)	\$10 – generic \$20 – preferred brand \$35 – non-preferred brand	Paid at 60% of allowable charges <u>AFTER</u> \$10 – generic \$20 – preferred brand \$35 – non-preferred brand
Mail Order (100 day supply)	Same copay as Retail.	Same copay as Retail.
Ambulance Services	Subject to deductible, then covered at 80% of allowable charges.	Subject to deductible, then covered at 60% of allowable charges.
Emergency Room Co-payment	\$75 co-payment per ER visit; Co-pay waived if admitted.	\$75 co-payment per ER visit; Co-pay waived if admitted.
Hospital Inpatient Services (PCY = Per Calendar Year)	Subject to deductible & \$150 co-pay per day to a maximum of \$450 per person PCY; Covered at 80% of allowable charges thereafter.	Subject to deductible & \$150 co-pay per day to a maximum of \$450 per person PCY; Covered at 60% of allowable charges thereafter.
Inpatient Surgery	See <i>Hospital Inpatient Services</i> above.	
Outpatient Surgery	Subject to deductible & \$100 co-pay; Covered at 80% of allowable charges thereafter.	Subject to deductible & \$100 co-pay; Covered at 60% of allowable charges thereafter.
Lab & X-Ray Services	Subject to deductible, then covered at 80% of allowable charges thereafter.	Subject to deductible, then covered at 60% of allowable charges thereafter.
Mental Health Inpatient Services	Subject to inpatient co-pay & deductible, then covered at 80% of allowable charges thereafter.	Subject to inpatient co-pay & deductible, then covered at 60% of allowable charges thereafter.
Mental Health Outpatient Services (PCY = Per Calendar Year)	Limited to 50 one-hour visits PCY. \$25 Co-pay then covered at 100% of allowable charges; Deductible waived.	Limited to 50 one-hour visits PCY. \$30 Co-pay then covered at 100% of allowable charges; Deductible waived.
Routine Vision Care	Not Covered.	
Maximum Lifetime Benefit	\$5,000,000 revolving each 5 years.	\$5,000,000 revolving each 5 years.
Life / AD&D Insurance	\$20,000 decreasing term Life & Accidental Death & Dismemberment for employee only.	



Help Getting Healthcare

- Know your insurance options
- Find a doctor
- Get the care you need

WAHA is a local non-profit organization that offers assistance in obtaining health insurance and access to healthcare services. We can help you with the application process for:

- Children's Medicaid coverage
- Children's Health Insurance Program (CHIP)
- Basic Health (commercial insurance with a sliding scale premium)
- Medicaid Premium Payment (DSHS pays a private insurance premium)
- Health Savings Accounts
- Coordinating coverage amongst several insurances

Family Size	Medicaid & Basic Health	CHIP
	Gross Monthly Income	
1	1804	2709
2	2428	3642
3	3050	4575
4	3674	5511
5	4298	6447
6	4920	7380
7	5544	8316
8	6168	9252
9	6790	10185

Health Access Services

WAHA's professional staff and trained volunteers offer free telephone consultation and one-on-one assistance to **help you understand insurance options for your family and establish a *medical home* for your children.**

- ✓ Go to www.WhatcomAlliance.org to find easy-to-understand and impartial health information.
- ✓ Make an appointment with a WAHA Access Coordinator at **(360) 715-6594** to get assistance completing insurance paperwork and connecting with other community programs, including speech services, pharmacy resources, and transportation assistance.
- ✓ Email the Access Coordinators with your questions or make an appointment at WAHA@hinet.org
- ✓ WAHA and Department of Social and Health Services will have representatives available at the benefits fair on August 31, 2009 to answer your questions, give out applications and information, and even set up appointments for one-on-one insurance counseling.

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

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

For some circumstances, in order for the school district or their agent, Baldwin Resource Group, to act on behalf of a Bellingham School District employee, a signed authorization is required. The authorization must be specific to the particular issue and must be submitted to the insurance company before the company can provide any school district personnel or Baldwin Resource Group with any information. This authorization has a 3-12 month limitation depending on the carrier. These procedures also comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

MANDATORY BENEFITS FOR ALL DISTRICT EMPLOYEES

WORKERS' COMPENSATION & OCCUPATIONAL SAFETY & ACCIDENT PREVENTION PROGRAM

The Bellingham School District has all workers' compensation claims handled by the State Department of Labor and Industries. Our occupational safety and accident prevention program applies to any work-related injury or illness. If you sustain a work-related injury, the steps below are to be followed:

- Immediately report any injury (treated or untreated) to your supervisor and complete the Employee Injury Report.
- When injury requires medical care, in addition to the above, and before seeing your doctor:
 - Obtain a Return to Work Release Form from the District Claims Manager or from your building secretary and have your doctor complete during your office visit.
 - Inform the doctor that we are state funded, not self-insured.
 - Fill out the Report of Accident form which your doctor will give you on your first visit. Boxes 29, 32 and 33 ask for company information. Our company name is Bellingham School District. Our phone number is (360) 676-6522 and our address is 1306 Dupont Street, Bellingham, WA 98225, Attention: Denise Suess.
- Immediately following your doctor's appointment, take the completed Return to Work Release Form to the District Claims Manager or to your supervisor. This is required before you can return to work.

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

In the event of a period of absence due to injury or occupational disease resulting from an employee's employment with the District, the employee has the right to elect to either use their available illness, injury, and emergency leave or take unpaid leave for the period of absence. If the employee chooses to use their available illness, injury, and emergency leave, the employee will keep any time loss payment(s) they receive. Since the employee cannot receive both the time loss payment(s) and injury leave for the same time period, the District will deduct the amount of the time loss payment(s) through payroll. The District will credit the employee's illness, injury, and emergency leave for the amount of leave the time loss payment equals based on the employee's hourly rate. If the employee chooses to use unpaid leave for the period of absence they will keep any time loss payment(s) they receive and no adjustments will be made to the employee's illness, injury and emergency leave.

An Occupational Safety and Accident Prevention notebook is available at each work site. Questions regarding any of the information outlined above, may be directed to the District Claims Manager at 676-6522.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

VOLUNTARY BENEFITS FOR ALL DISTRICT EMPLOYEES

VOLUNTARY CANCER, INTENSIVE CARE, AND ACCIDENT INSURANCE

The District offers cancer insurance through AFLAC. Premiums are paid through payroll deduction. The rates you pay for this benefit are considerably less than the rates you would pay for an identical individual plan that is not tied to the District. If you should leave the District, you can maintain your same plan at the same rate. All benefits received from this policy are paid to you in addition to your medical insurance benefits.

There are also Intensive Care and Accident Insurance policies offered through AFLAC.

TAX SHELTERED ANNUITIES

Tax Sheltered Annuities (TSAs) are available through the District. Contact the Payroll Office for more information.

SALARY INSURANCE

Plan brochures are available in the Human Resources Office. Salary insurance is available to assist in covering lost income in the event of a disability, sickness, or injury.

DEFERRED COMPENSATION

A Deferred Compensation program is available through the District. Please contact Deferred Compensation at 888-327-5596 for more information.

SECTION 125 PLANS

The District offers a Section 125 Plan that allows you to use before-tax dollars for amounts that will be deducted from your paycheck for your choice of three programs:

- * Dependent Care
- * Medical Spending Account
- * Out-Of-Pocket Medical Insurance Premiums (medical, dental, cancer, intensive care and accident)

Your taxable income would be reduced by the amount of these deductions, thereby lowering the monthly amount you pay in Federal Income Tax and Social Security Tax. Please be aware that participation in this plan may result in reduced Social Security benefits in the future. By reducing your taxable income for Social Security tax, you may receive less credit toward Social Security benefits. You are encouraged to consult your tax advisor/financial planner before making the decision. If you would like to participate in the dependent care or medical spending account please contact American Fidelity for more information about this plan at 866-576-0201.

Your current election for the Out-Of-Pocket plan will remain in effect for the new plan year. You will be given the option to change your election in September. If you have questions regarding the Out-Of-Pocket plan, please contact the Payroll Office.

U.S. SAVINGS BONDS

U.S. Savings Bonds can be purchased through payroll deduction. Prices start at \$50 for a \$100 bond and higher denominations are available. Bonds may be eligible for a special tax exclusion if used to pay the tuition fees of higher education. Call 800-US-BONDS for more information or visit online at www.savingsbonds.gov.

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

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

Blaine School District, Tuesday, September 1st, 7:00-8:30 a.m.
Blaine Middle School / High School Cafeteria
975 "H" St.
Blaine, WA 98230

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

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

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

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

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

PLEASE NOTE: A Premera Blue Cross representative will be attending the Bellingham, Ferndale and Mt. Baker benefits fair ONLY.

A Willamette Dental representative will be attending the Bellingham, Ferndale and Meridian benefits fairs ONLY.

BELLINGHAM SCHOOL DISTRICT

INSURANCE COMMITTEE MEMBERS

Rosa Hoagland, BEA	Allan Botts, SEIU	Ron Cowan, Asst. Supt., Bus. & Operations
Becky Walstad, BEA	Ken Strand, SEIU	Kris Hessen, Payroll Supervisor
Jane Tromburg, BAO	Maria Tyas, SEIU	Maris Holmgren, Personnel Specialist
Janice Burns, BASE	Kathy Kullas, Non-Rep.	Rachel Mc Kibbin, Union Rep., Teamsters
Terri Inge, BASE	Nora Klewiada, Exec. Dir., Human Resources	

INSURANCE COMMITTEE SUPPORT

Human Resources.....Kathy Kullas360-676-6503
Insurance Consultants.....Baldwin Resource Group.....877-455-5640

INSURANCE COMPANY REPRESENTATIVES

MEDICAL

Group Health Cooperative
Customer Service (www.ghc.org)
888-901-4636

Regence Blue Shield
Customer Service (www.wa.regence.com)
888-367-2112

WEA Premera Blue Cross
Washington Education Association (WEA)
Customer Service (www.premera.com/wea)
800-932-9221 (Premera)

DENTAL

Washington Dental Service
Washington Education Association
Customer Service (www.deltadentalwa.com)
800-554-1907

Willamette Dental
(www.willamettedental.com)
800-360-1909 x 8 Patient Relations
800-359-6019 Appointments

VISION

Northwest Benefit Network
Customer Service (www.nwadmin.com/members)
800-732-1123

OTHER

American Fidelity
Flexible Spending Account - Section 125
Salary Insurance
Washington Education Association
(www.afadvantage.com) 866-576-0201

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

Long Term Care
WEA Premera Blue Cross
Washington Education Association
Customer Service (www.premera.com/wea/ltc)
866-528-1734

*Should you have any questions, please contact any of the above insurance carriers or our agent,
Baldwin Resource Group at 877-455-5640 – Emily Austin at ext. 311.*

*Bellingham School District benefit information can also be found on the District Website @
www.bham.wednet.edu. Select Staff, Employee Information, 2009-2010 Health Benefit Options.*

*For your convenience, an open enrollment benefits information table will be set up on the main floor lobby of the Roeder
Administration Building.*

*For other benefit questions or enrollment forms, e-mail www.kkullas@bham.wednet.edu
or leave a message at 676-6503.*

***** *Glossary of Terms* *****

Agreement – A term often used to refer to a contract (with providers, subscribers or groups).

Allowed charges – Services rendered or supplies furnished by a health provider that qualify as covered expenses and for which insurance coverage will pay in whole or in part, subject to any deductible, coinsurance or table of allowances included within the plan design.

Alternative care – Generally refers to care that is not provided by a medical doctor or a provider affiliated with the traditional medical system. Examples of alternative care providers are chiropractors, naturopaths and acupuncturists.

Beneficiary – On life policies, this describes the individual eligible to receive the life benefit payout upon the enrollee's death.

Benefit period – The period designated for application of deductibles or specific types of benefits, after which, the deductible must be satisfied again before the benefits are again available. A typical benefit period is a calendar year.

Birthday rule – That process under "Coordination of Benefits" clauses in a contract that determines which parent's coverage pays first when a dependent child has health insurance coverage through both parents. This rule says that the parent whose birthday falls first during the calendar year is primary (his or her coverage pays first).

Calendar year deductible – The requirement that individuals satisfy a deductible amount each calendar year before benefits will be paid.

Case management – Term used to designate special handling of health care services and benefits, often outside the contract limits. Case management is most often used for catastrophic illnesses, although it can be used for chronic illnesses as well. The case manager nurse works with the patient and the provider to manage potentially high cost situations.

Coinsurance – A provision under which the enrollee and the carrier each share a percentage of the cost of a covered service. A typical coinsurance arrangement is 80% / 20%. This means the carrier will pay 80% of eligible charges and the enrollee will pay 20%.

Contribution – The portion of the premium that the employer pays (employer contribution), the employee pays for himself or herself (employee contribution) or for dependents (dependent contribution).

Coordination of benefits (COB) – Term used to describe the process by which benefits paid under multiple health coverages are coordinated to determine in what order benefits are paid and how much each carrier should pay.

Copayment – Generally used to refer to a fixed dollar amount the subscriber pays to the provider at the time of service.

Deductible – The amount of out-of-pocket expenses that must be paid for health services by the covered person before the carrier will begin to pay benefits.

Dependents – The term generally applies to the spouse and children of a covered individual.

Elimination period – Term used in disability insurance to refer to a waiting period. It is the period for which a person must be disabled before benefits begin.

Explanation of benefits (EOB) – A description, sent to patients by health insurance carriers, that describes what benefits were paid for a particular claim. Also called a “Claims Processing Report”.

Family deductible – A deductible that is satisfied by the combined expenses of all family members. For example, a program with a \$200 deductible may limit its application of the deductible to a maximum of three deductibles (\$600) for the family, regardless of the number of family members enrolled.

Formulary – A list of preferred medicines chosen by each medical insurance company.

Inpatient – A person who has been admitted to a hospital or other facility and requires an overnight stay.

Maximum allowable charges – The largest dollar amount to which an insurance carrier will apply plan benefits.

Maximum benefit – The largest dollar amount the plan will pay toward the cost of a specific benefit or for health care overall. The maximum benefit available under most traditional plans for instance is usually between \$1,000,000 and \$2,000,000 (lifetime per enrollee).

Open enrollment – A period during which subscribers in a health benefit program have an opportunity to make changes in their health coverage or a period when uninsured individuals can obtain coverage without presenting evidence of insurability (health statements).

Out-of-pocket expenses – Those health care expenses for which the enrollee is responsible. These include deductible, coinsurance, copayments and any costs above the amount the insurer considers usual and customary or reasonable (unless the provider has agreed not to charge the enrollee for those amounts).

Out-of-pocket maximum – The amount that the enrollee must pay for deductibles, coinsurance and copayments in a defined period (usually a calendar year) before the insurer covers all remaining eligible expenses at 100%.

Outpatient services – Services provided to an individual who has not been admitted to a hospital or other facility. These services may be provided in the outpatient department of a hospital, in a doctor’s office or in some other setting.

Pooling – The amount of money that remains from the state allocation dollars, after the mandatory insurance premiums and the medical premiums have been deducted.

Preauthorization – Often used interchangeably with precertification. Refers to certifying the medical necessity and level of care in advance. Preauthorization does not guarantee that contract benefits will be available.

Primary care physician (PCP) – The physician with overall responsibility for a patient’s care under a Health Maintenance Organization or Point of Service type plan. Primary care physicians are usually general practitioners, family practitioners, pediatricians or internists. Primary care physicians provide all routine medical care and arrange for referrals for specialty care.

Provider – One who provides health care services (examples: hospital, physician, physical therapist, home health agency) or supplies.

Referral – A formal process that authorizes a Health Maintenance Organization (HMO) or Point of Service (POS) member to receive care from a specialist or hospital. To assure coverage, an HMO or POS member must obtain a referral from his or her primary care physician (PCP) before seeing a specialist.

*****NOTES*****

Summary Prepared by Baldwin Resource Group, Inc.

*For the Bellingham School District
1306 Dupont St.
Bellingham, WA 98225*