

# ***East Valley School District No. 361***

## ***Certificated & Classified Employees***

### **GUIDE TO BASIC AND FRINGE BENEFITS**

### **WITH A SUMMARY OF HEALTH & WELFARE BENEFIT PLANS FOR THE 2009 – 2010 SCHOOL YEAR**

#### **Open Enrollment**

September 1, 2009  
through  
October 10, 2009

Enrollment forms are to be turned in to the Payroll office. To be effective by October 1<sup>st</sup>, your enrollment form must be received in the Payroll office no later than September 15<sup>th</sup>. If you turn in your enrollment form after October 5<sup>th</sup>, your effective date will be November 1<sup>st</sup>.

The information herein is not a contract. It is a summary of the benefits available to eligible employees and their dependents. Each plan described herein excludes certain conditions and types of treatment from coverage or payment. Be sure to consult your plan booklet, which is available in the Payroll office and/or the insurance company representative before making your selection. This summary was printed on August 18, 2009. Any information, revision by bargaining units or by providers after that date could change or modify the information contained herein.

*If you have a specific question or want to further discuss your health and welfare benefits, contact Ray Stookey, Manager of Human Resources, at 241-5053 or [stookeyr@evsd.org](mailto:stookeyr@evsd.org) or Terry Massender, Payroll Officer, at 241-5030 or [massendert@evsd.org](mailto:massendert@evsd.org).*

## DISTRICT INSURANCE COMMITTEE

Ray Stookey, Committee Chair & Manager of Human Resources-[stookeyr@evsd.org](mailto:stookeyr@evsd.org) or 241-5053  
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Stevie Skidmore, PSE Grievance Officer – [skidmores@evsd.org](mailto:skidmores@evsd.org) or 927-3200  
Terry Massender, Central Office Staff representative – [massendert@evsd.org](mailto:massendert@evsd.org) or 241-5030

## DISTRICT INSURANCE BROKERS

Mercer H&B	1-509-358-3900	Jeff Paxton, broker
Group Health	1-509-926-5432	Ed Mikesell, broker

## INSURANCE CUSTOMER SERVICE NUMBERS

Premera Blue Cross(Select plans)	1-800-932-9221	Teresa Sevigney, agent 509-252-7033
Premera MSC (Heritage plans)	1-800-722-1471	Robert Johnston, agent 509-467-5957
Group Health Cooperative	1-800-901-4636	Jackie McFarlin, agent 509-241-7123
NBN Vision	1-800-732-1123	Jeff Paxton, broker 509-358-3900
Washington Dental	1-800-554-1907	Megan McKinlay, agent 509-535-1080
Willamette Dental	1-800-360-1909 option 8	Robin Roberts, agent 1-800-360-1909 X 5222
VEBA	1-800-VEBA101(832-2101)	Jeff Gilson, rep. 509-534-0600

## INSURANCE WEBSITES

Premera Blue Cross	<a href="http://www.premera.com/wea">www.premera.com/wea</a>
Premera MSC	<a href="http://www.premera.com">www.premera.com</a>
Group Health Cooperative	<a href="http://www.ghc.org">www.ghc.org</a>
Washington Dental	<a href="http://www.ddpwa.com">www.ddpwa.com</a>
Willamette Dental	<a href="http://www.denkor.com">www.denkor.com</a>
NBN Vision	<a href="http://www.nwadmin.com">www.nwadmin.com</a>
VEBA	<a href="http://www.veba.org">www.veba.org</a>

***If you are experiencing any difficulty with your plan providers described in this guide, please let Ray Stookey or Terry Massender know. It is the goal of the District to ensure that you, as an employee of East Valley School District, receive the highest level of service available.***

## 2009-10 Basic Benefits

The following information is to help each employee to understand the Basic Benefits for the 2009-10 school year and the mandated pooling process.

### FUNDING

#### **State Funding**

The State allocation for employee benefits per full-time FTE in 2008-09 is \$745.00 per month. The Central Office Support Staff has bargained an additional \$19.26 bringing the allocation for COS Staff to \$764.26 per month. If you are working less than full-time, the calculated apportionment of the district monthly contribution is based on the employee contract/work period. Per legislative mandate, each school district is required to remit \$59.59 per full-time employee to the Health Care Authority, to be used to establish a retired school employee subsidy fund for health benefits. The EVEA has bargained to have the District pay this amount. The PSE has bargained to have the District pay the first \$25.00 and the member pay the difference or \$34.59 for a 1.0 FTE, \$19.69 for a .75 FTE and, \$4.80 for .5 FTE.

### POOLING

The employee-benefit allocation will be utilized to purchase medical, dental, vision, group disability(LTD), group term life insurance and the contribution to the retired school employee subsidy fund for each employee group and/or bargaining unit. It cannot be applied to elective or voluntary insurance programs such as supplemental term life, Accidental Death & Dismemberment (AD&D) or short-term disability (STD) insurance. In all groups, the first dollars are applied to negotiated benefits such as life, dental, vision and LTD, and the balance is available for medical. Any remaining dollars from an individual are then 'pooled', and divided among those employees with payroll deductions to increase their allocation for Basic Benefits. New benefit pooling rates are recalculated each year, in October, just prior to the completion of payroll. There is no guarantee that your employee group will have any available 'pooled dollars' to reduce out-of-pocket deductions for Basic Benefits.

#### **Step One - Basic Benefits**

Each employee group/bargaining unit chooses which Basic Benefits to offer their employees/members. The choices are:

Group Life	(100% Participation Required by law)
Dental (WDS or Willamette)	(100% Participation Required by law)
Vision	(100% Participation Required by Bargaining Unit)
Group LTD	(100% Participation Required by Bargaining Unit)
Medical	( <u>Optional</u> to employee election)
Health Care Authority	(As stated above per bargaining unit)
VEBA	(All bargaining units)

## **Step Two - Enrollment**

After the group has selected its Basic Benefits, employees may decide whether they want optional medical for themselves and/or their dependents and then enroll in their chosen medical plan based on their needs. Employees may also elect no medical coverage.

## **Step Three - Pooling**

All Employees' leftover benefit dollars go into a pool. This pool is then allocated equally, within an employee group and/or bargaining unit. These 'pooled dollars' will help reduce the employee's final out-of-pocket payroll deduction for medical benefits only. For example; if the pooled dollars equals \$3,000.00 and 200 employees in the employee group need dollars to reduce their out-of-pocket medical premium, each employee would receive \$15.00.

*If your hours are increased during the school year, your benefit dollar will be adjusted to reflect your increased hours. If your hours increase, your benefit dollar increases and your out-of-pocket medical insurance premium decreases.*

## **BASIC BENEFITS**

### **Group Term Life Insurance with AD&D**

The District provides \$50,000 group term life insurance for employees working half-time or more. For employees age 70 or older, the benefit is \$25,000.

Please refer to your *Certificate of Insurance* for complete information regarding benefits and eligibility requirements.

The Prudential Insurance Company of America is the District's provider.

### **Dental Insurances**

The District provides two dental plans, one an incentive plan (WDS) and the other a managed care plan (Willamette).

The WEA Select Dental Plan (Washington Dental) is an incentive plan. The plan covers eligible employees and dependents and pays for preventive, routine and major treatment. The payment level for covered and allowable dental benefits for Class I is 70-100%, Class II 70-100%, and Class III 50% which is subject to limitation and exclusions contained in the WEA Select Plan I (certificated) and Plan IV (classified) booklet. An incentive of 10% will be added each year the dental plan is used, starting at 70% and ending at 100%. If the plan is not used in a benefit year, the incentive will be dropped to 10% and the process will start over. The maximum amount payable by WDS for all covered dental benefits per eligible person is \$1,750 each benefit year (September 1 - August 31). Plan 1 covers orthodontia for dependents (not adults) with a lifetime maximum of \$1,250. Plan IV covers orthodontia for the subscriber and dependents including adults with a lifetime maximum of \$1,500.

It is recommended that you request pre-authorization by the dental plan for extensive treatment (including crowns, oral surgery, periodontics and prosthodontics). This will allow you to know in advance exactly which procedures are covered, the amount WDS will pay toward the treatment, and your financial responsibility. The pre-authorization forms are in the payroll office.

Please refer to your plan booklet (Plan I - certificated and Plan IV- classified) for complete information regarding benefits and eligibility requirements.

The Willamette Dental Plan is a managed care plan. The plan covers eligible employees and dependents and pays for preventive, routine and major treatment. All services are covered 100% after a \$15 office visit copay and a \$50 copay for crowns, dentures, onlays, bridges and partials. There are two clinics in the Spokane area to receive service. Plan 1 (certificated) covers orthodontia 100% for dependents after the first \$1,500 out-of-pocket is paid. Plan 5 (classified) covers orthodontia 100% for the subscriber, dependents and spouse after the first \$1,650 out-of-pocket is paid.

### **Vision Insurance**

The District provides a plan covering eligible employees and their dependents to assist with payment of eye care expenses when prescribed by an ophthalmologist or optometrist. The EVEA and PSE bargaining units have bargained this benefit for their members. Vision coverage provides for an eye exam per calendar year by a preferred provider. The calendar year starts in January. The plan also covers a selection of frames to \$250 every two calendar years, or contacts to \$250 every calendar year. The contact lens benefit is in lieu of all other benefits.

There are a number of other limitations. Please refer to the NBN Vision plan booklet.

### **Group Long-term Disability**

The District maintains a plan covering eligible employees with income protection if you become disabled by a covered sickness, accidental bodily injury or pregnancy. The EVEA and PSE bargaining units have bargained this benefit for their members. If a covered employee becomes disabled, the long-term disability (LTD) insurance will provide you with a monthly benefit equal to 60% of your basic monthly earnings. The plan pays in coordination with other benefits, such as social security, sick leave and or vacation leave. There is a maximum monthly benefit of \$5,000 and a minimum monthly benefit of \$100.

There is an elimination or waiting period before benefits become payable. This elimination period is ninety (90) calendar days of each continuous period of disability. It is the employee's responsibility to apply for benefits.

The Prudential Insurance Company of America is the District's long-term disability provider.

Please refer to your *Certificate of Insurance* for complete information regarding benefits and eligibility requirements.

### **VEBA Plan( HRA for public employees of Washington)**

The VEBA plan is a tax-free health reimbursement arrangement (HRA) that enables your employer to make tax-free contributions into a special trust account on your behalf. These tax-free funds can then be used to pay or reimburse eligible out-of-pocket healthcare costs and premiums for yourself, your spouse and your qualified IRS dependents. Your VEBA account can be passed on to your beneficiaries in the event of your death.

VEBA contributions can be changed with a vote by the bargaining unit.

The district is contributing \$25 a month for the EVEA. The \$25 is prorated according to a teacher's FTE.

The district is contributing \$35 a month for the PSE. The \$35 is prorated according to a member's FTE.

The district is contributing \$50 a month for the Central Office Support Staff. The \$50 is prorated according to their FTE.

The district is contributing \$41.67 a month for the EVAA.

The Central Office Administrators contribute \$55 a month of their own.

### OPTIONAL MEDICAL HEALTH CARE PLANS

Deciding which medical/health care plan to join should be done carefully. It represents one of the biggest 'fringe benefits' of your employment, and you will not be able to change plans until the next annual open enrollment period unless an IRS 'qualifying event' occurs. The following is a summary of benefits for each medical plan offered by the District. Detailed benefits are provided in the plan booklet along with a list of providers in the area. These booklets are available in the Human Resources Office.

The East Valley School District offers the following ten medical plans.

Premera/MSC Comprehensive School Pool offers a choice of healthcare plans with a comprehensive network. This means that you can choose a benefit package that is good for you, your family, and your budget, and adjust yearly as life changes take place. Under any **Your Choice** plans, members have the largest network of contracted physicians and providers.

#### **PREMERA MSC Heritage Plus 1 plan1 \$15 Plan (available only to Central Office Support Staff)**

This plan features a \$15 copay for spinal manipulation, acupuncture, and naturopathic services. Covered in full benefits include immunizations, outpatient diagnostic imaging, lab services, x-rays, and outpatient mammography. The plan also offers an Rx drug card system, with a cost share of \$10 for generic and \$30 for brand names. A mail order system is also available. Other services are subject to a calendar year deductible of \$100, and are covered at 80% subject to a maximum out-of-pocket (stop loss) of \$1,000 in any calendar year.

#### **PREMERA MSC Heritage Plus 1 plan 2 \$20 Plan (available only to Central Office Support Staff)**

This plan features a \$20 copay for spinal manipulation, acupuncture, and naturopathic services. Covered in full benefits include immunizations, outpatient diagnostic imaging, lab services, x-rays, and outpatient mammography. The plan also offers an Rx drug card system, with a cost share of \$10 for generic and \$30 for brand names. A mail order system is also available. Other services are subject to a calendar year deductible of \$300, and are covered at 80% subject to a maximum out-of-pocket (stop loss) of \$1,100 in any calendar year.

#### **PREMERA MSC Heritage Plus 1 plan 3 \$30 Plan (available only to Central Office Support Staff)**

This plan features a \$30 copay for spinal manipulation, acupuncture, and naturopathic services. Covered in full benefits include immunizations, outpatient diagnostic imaging, lab services, x-rays, and outpatient mammography. The plan also offers an Rx drug card system, with a cost share of \$15 for generic and \$30 for brand names. A mail order system is also available. Other services are subject to a calendar year deductible of \$500, and are covered at 80% subject to a maximum out-of-pocket (stop loss) of \$2,300 in any calendar year.

**The Heritage Plus 1 plans 1, 2 and 3 can be further enhanced in combination with the debit card system of the Section 125 cafeteria plan (paperless claims). Out-of-pocket costs, such as copays, can be paid for at the time of services, with the debit card.**

### **GROUP HEALTH COOPERATIVE – Plan 1**

GROUP HEALTH COOPERATIVE is a consumer governed, not for profit healthcare system that coordinates care and coverage. The program offered East Valley School District includes participation in a school pool of K-12 public school districts throughout Eastern and Central Washington. The pool has 49 member school districts with 9,500 members. The components of Group Health's quality program include: evidence-based medicine, population-based medicine, patient safety, priority areas, clinical information systems, case management, and consumer involvement.

Plan #1 has no annual deductibles, no claim forms, worldwide emergency coverage, low co-pays for office visits and pharmacy, and outstanding coverage for hospitalization, lab, outpatient, and emergency room services.

Member's care is coordinated by a primary care physician using differing delivery methods such as on staff physicians in Group Health healthcare centers, community physician partners, or affiliated group practices [such as Rockwood Clinics of Spokane].

Group Health continues to be patient governed as the 11-member Board of Trustees is elected by consumers all while being accredited by the National Committee for Quality Assurance with an "Excellent" rating through 2007, and the JD Powers Award for Customer Service in 2008.

Further information such as: A Group Health Overview, Financial Information, Quality and Patient Safety, Leadership, Community Involvement, Annual Meetings, Member Governance, and Volunteer Opportunities may be obtained at the Group Health Cooperative website, for visitors - [www.ghc.org](http://www.ghc.org).

### **WEA PREMIERA Blue Cross Select Plan 1 – Available to all eligible employees**

The WEA Premiera Select Plan 1 is underwritten by Premiera Blue Cross. The plan is designed specifically for Washington school employees and uses the Heritage provider network throughout the state. The WEA plans also provide access to in-network providers nationwide through the Blue Card program. When using a Heritage provider, services that fall under the General Benefits Reimbursement Formula (GBRF) are subject to a \$50 per person/\$150 per family calendar year deductible and then paid at 90% of the allowable charge. Hospitalization is covered under the GBRF after a \$100 copay per day to a maximum of \$300 in hospital copays per person per calendar year. Office visits are not subject to the calendar year deductible and are covered in full after a \$20 office visit copay. Preventive care is not subject to the calendar year deductible and is covered in full when using a network provider up to a maximum calendar year benefit of \$300 per adult and \$600 per child through the age of 3. Prescription drugs are not subject to the calendar year deductible and covered in full after a \$10 copay for generic drugs, \$15 copay for preferred brand name drugs and a \$30 copay for non-preferred brand name drugs. Members are eligible for up to a 34 day supply at the retail pharmacy or a 100 day supply through the mail order program.

\$20,000 decreasing term life/AD&D is provided at no additional cost in all the WEA medical plans.

### **WEA PREMIERA Blue Cross Select Plan 2– Available to all eligible employees**

The WEA Premiera Select Plan 2 is underwritten by Premiera Blue Cross. The plan is designed specifically for Washington school employees and uses the Heritage provider network throughout the state. The WEA plans also provide access to in-network providers nationwide through the Blue Card program. When using a Heritage provider, services that fall under the General Benefits Reimbursement Formula (GBRF) are subject to a \$100 per person/\$300 per family calendar year deductible and then paid

at 80% of the allowable charge. Hospitalization is covered under the GBRF after a \$150 copay per day to a maximum of \$450 in hospital copays per person per calendar year. Office visits are not subject to the calendar year deductible and are covered after a \$25 office visit copay. Preventive care is not subject to the calendar year deductible and is covered in full when using a network provider up to a maximum calendar year benefit of \$300 per adult and \$600 per child through the age of 3. Prescription drugs are not subject to the calendar year deductible and paid in full after a \$10 copay for generic drugs, \$20 copay for preferred brand name drugs and a \$35 copay for non-preferred brand name drugs. Members are eligible for up to a 34 day supply at the retail pharmacy or a 100 day supply through the mail order program.

\$20,000 decreasing term life/AD&D is provided at no additional cost in all the WEA medical plans.

### **WEA PREMIERA Blue Cross Select Plan 3 – Available to all eligible employees**

The WEA Premiera Select Plan 3 is underwritten by Premiera Blue Cross. The plan is designed specifically for Washington school employees and uses the Heritage provider network throughout the state. The WEA plans also provide access to in-network providers nationwide through the Blue Card program. When using a Heritage provider, services that fall under the General Benefits Reimbursement Formula (GBRF) are subject to a \$200 per person/\$600 per family calendar year deductible and then paid at 80% of the allowable charge. Hospitalization is covered under the GBRF after a \$300 copay per day to a maximum of \$900 in hospital copays per person per calendar year. Office visits are not subject to the calendar year deductible and are covered after a \$30 office visit copay. Preventive care is not subject to the calendar year deductible and is covered in full when using a network provider up to a maximum calendar year benefit of \$300 per adult and \$600 per child through the age of 3. Prescription drugs are not subject to the calendar year deductible and paid in full after a \$15 copay for generic drugs, \$25 copay for preferred brand name drugs and a \$40 copay for non-preferred brand name drugs. Members are eligible for up to a 34 day supply at the retail pharmacy or a 100 day supply through the mail order program.

\$20,000 decreasing term life/AD&D is provided at no additional cost in all the WEA medical plans.

### **-- New Plan Effective October 1, 2009 --**

### **WEA PREMIERA Blue Cross Select EasyChoice Health Plan – Available to all eligible employees**

The WEA Premiera Select EasyChoice Health Plan is underwritten by Premiera Blue Cross. The plan is designed specifically for Washington school employees. EasyChoice is a lower cost option that will replace WEA Select Plan's 4-500 and 4-750 effective October 1, 2009. This new plan offers a choice of three options all at the same monthly subscription rate. Each option offers various levels copays, deductibles and coinsurance to meet different needs.

Key features for EasyChoice in-network services include:

- No deductible for office visits, preventive care and generic drugs
- Unlimited preventive care and immunizations – Paid in full
- Generic drugs are covered in full – No cost shares

EasyChoice A and B use the Heritage provider network throughout the state. EasyChoice C uses the statewide Foundation provider network. EasyChoice plan also provides access to in-network providers nationwide through the Blue Card program.

EasyChoice A has a \$1000 per person/\$3000 per family calendar year deductible and then pays 80% of the allowable charge. Hospitalization is subject to deductible and coinsurance (80% payment level) and not subject to an additional hospital copay. Office visits are not subject to the calendar year deductible and are covered in full after a \$15 office visit copay. Preventive care exams are not subject to the calendar year deductible and are covered in full when using a network provider including preventive screenings and mammograms. Prescription drugs are subject to a separate \$500 calendar year

deductible per person (waived for generics) and paid in full for generic drugs, 30% coinsurance for preferred brand name and non-preferred brand name drugs for a 30 day supply at the retail pharmacy. A 90 day supply is available through the mail for a \$0 copay for generic drugs, 25% coinsurance for preferred brand name and non-preferred brand name drugs.

EasyChoice B has a \$750 per person/\$2250 per family calendar year deductible and then pays 75% of the allowable charge. Hospitalization is subject to deductible and coinsurance (75% payment level) and not subject to an additional hospital copay. Office visits are not subject to the calendar year deductible and are covered in full after a \$30 office visit copay. Preventive care exams are not subject to the calendar year deductible and are covered in full when using a network provider including preventive screenings and mammograms. Prescription drugs are subject to a separate \$250 calendar year deductible per person (waived for generics) and paid in full for generic drugs, \$30 copay for preferred brand name and a \$45 copay for non-preferred brand name drugs for a 30 day supply at the retail pharmacy. A 90 day supply is available through the mail for a \$0 cost share for generic prescription drugs, \$75 copay for preferred brand name drugs and a \$112 copay for non-preferred brand name drugs.

EasyChoice C has a \$0 per person/\$0 per family calendar year deductible when using a Foundation provider and then pays 65% of the allowable charge. Hospitalization is subject to coinsurance (75% payment level) and not subject to an additional hospital copay. Office visits are not subject to the calendar year deductible and are covered in full after a \$35 office visit copay. Preventive care exams are not subject to the calendar year deductible and are covered in full when using a network provider including preventive screenings and mammograms. Prescription drugs are subject to a separate \$500 calendar year deductible per person (waived for generics) and paid in full for generic drugs, \$30 copay for preferred brand name and a \$45 copay for non-preferred brand name drugs for a 30 day supply at the retail pharmacy. A 90 day supply is available through the mail for a \$0 cost share for generic prescription drugs, \$75 copay for preferred brand name drugs and a \$112 copay for non-preferred brand name drugs.

\$20,000 decreasing term life/AD&D is provided at no additional cost in all the WEA medical plans.

#### **WEA PREMIERA Blue Cross Select Plan 5-Foundation Plan– Available to all eligible employees**

The WEA Premiera Select Plan 5 is underwritten by Premiera Blue Cross. The plan is designed specifically for Washington school employees and uses the Foundation provider network throughout the state. This plan also provides access to in-network providers nationwide through the Blue Card program. When using a Foundation provider, services that fall under the General Benefits Reimbursement Formula (GBRF) are subject to a \$100 per person/\$300 per family calendar year deductible and then are covered in full to the allowable charge. Hospitalization is covered under the GBRF after a \$200 copay per admission to a maximum of \$600 in hospital admission copays per person per calendar year, \$1,000 per family per calendar year. In-Network office visits are not subject to the calendar year deductible and are covered in full after a \$15 office visit copay. Preventive care exams are not subject to the calendar year deductible and are covered in full after a \$15 copay with no limit when using a network provider. Related preventive lab and x-ray are paid under the GBRF. Prescription drugs are not subject to the calendar year deductible and paid in full after a \$10 copay for generic drugs, \$15 copay for preferred brand name drugs and a \$30 copay for non-preferred brand name drugs for a 30 day supply at the retail pharmacy. A 90 day supply is available through the mail for a \$10 copay for generic, \$30 copay for preferred brand name and a \$60 copay for non-preferred brand name drugs.

\$20,000 decreasing term life/AD&D is provided at no additional cost in all the WEA medical plans.

## HELPFUL INFORMATION

### **Government-Sponsored Health Programs**

#### **Children's Health Coverage**

The State Children's Health Insurance Program (CHIP) is a federal/state program that covers children under age 19 in families whose income is too high for Medicaid and Basic Health, but below 250% of the federal income guidelines. The program is administered by the Department of Social and Health Services. For more information about CHIP, go to [www.cms.gov/schip\\_or\\_fortress.wa.gov/dshs/maa/CHIP/Index.html](http://www.cms.gov/schip_or_fortress.wa.gov/dshs/maa/CHIP/Index.html) or call 1-877-543-7669.

### **Healthy Options**

Healthy Options is a health care coverage program available to low-income Washington State residents. It is one of several medical and/or dental programs administered by the Department of Social and Health Services' Medical Assistance Administration (MAA). To find out if you or your family members qualify for Healthy Options or other MAA health programs, call your local Community Services Office (CSO). For information about your local CSO, visit <https://www2.wa.gov/dshs/onlinecso/findservice.asp> or look in the phone book in the State Government section under Social and Health Services.

### **Washington State Health Insurance Pool**

If you do not qualify for private health insurance, the Washington State Health Pool (WSHIP) is available. The WSHIP was created by the Washington State Legislature to provide coverage to Washington residents who are unable to obtain adequate health insurance coverage in the private market. The WSHIP offers several plan options with annual deductible amounts ranging from \$500 to \$1,500. Rates vary slightly by ZIP Codes and are higher for policies with lower annual deductibles. For information on WSHIP, go to [www.onlinehealthplan.com/oasys/wship](http://www.onlinehealthplan.com/oasys/wship) or call 1-800-877-5187.

### **Community Clinics**

There are many community clinics throughout the state that receive state funding to help provide medical and/or dental care to people who do not have health insurance coverage. **Although the clinics provide health care services, they do not provide health insurance coverage.** You can find a list of community clinics in your county online at [www.chs.hca.gov](http://www.chs.hca.gov).

## **ELECTIVE OR VOLUNTARY INSURANCE PLANS (self-pay)**

The following is a summary of elective or voluntary plans offered by the District. Since these are plans that are not included in the Basic Benefits they are considered 'fringe benefits' and are paid in whole by the employee.

### **Prudentail Insurance Additional Life and AD&D Insurance**

You may elect to purchase additional term life insurance in \$10,000 increments up to \$500,000 or 5 X your annual salary. The rate is based on your age. That rate is multiplied by each \$10,000 worth of insurance you purchase. For example;

You are 30 years old, your rate is \$.75 per ten thousand and you want \$100,000 of life insurance. Your monthly rate would be \$7.50 (\$.75 X 10 = \$7.50). Your spouse may purchase 50% of your coverage amount starting at \$5,000 to \$100,000.

You may purchase \$1,000, \$2,000, \$3,000, \$5,000 or \$10,000 for your minor children from \$.44 - \$4.35 a month, regardless of how many children you cover.

The **open enrollment** period is during the first 30 days of employment. After the first 30 days of employment, you must complete a Health Statement and be accepted by Prudential before you can purchase additional life and AD&D insurance. Each September you may purchase an additional \$10,000 up to the guarantee issue of \$100,000 or 5 X your annual salary, whichever is less. After you reach your guarantee issue, you must provide a Health Statement and be accepted by Prudential to increase your coverage.

### **American Fidelity Insurance Company (STD)**

The WEA Select short-term disability (STD) insurance is administered by American Fidelity Insurance Company. The insurance coverage pays accident and sickness benefits to you during the qualifying or elimination period of your long-term disability coverage. This STD is **only** available to employees who already have long-term disability insurance.

Benefits are paid for each new period of disability based on the option selected, provided the monthly benefit of the class selected does not exceed 66 2/3% of your regular basic salary. (Annual salary divided by twelve). Disability benefits are paid on the first day of a **covered** accident or the fourth day of a **covered** sickness and continue while you are totally disabled, but not to exceed ninety (90) days for any one continuous period of disability.

### **Accident Only Insurance**

Do you need accident protection? On average, 1 out of every 13 Americans suffered a disabling injury in 2004 (National Safety Council, Injury Facts, 2005-2006 Edition).

### **Cancer Insurance**

American Fidelity has a Cancer policy available with optional Riders that can be purchased or paid for with pre-tax dollars. The ICU Rider benefits reduce by half at age 70.

## MISCELLANEOUS PLANS (self-pay)

**AFLAC** Supplemental Insurances – short-term disability, accident expense, cancer protector, hospital intensive care, sickness indemnity

## OPTIONAL CAFETERIA FLEXIBLE BENEFIT PLANS (Under IRC Section 125)

### **AMERICAN FIDELITY**

The Section 125 Cafeteria Flex Plan makes it possible for you to take home more pay and to reduce your taxes while allowing you to pay for medical expenses, dependent care and out-of-pocket insurance premiums with tax free dollars. The Flex Plans allow you to avoid social security and federal income tax on one or more of the following benefits:

**PLAN YEAR: November 1 – October 31**

### **Health Insurance Premium Plan**

This plan allows you to use tax-free dollars to pay for your out-of-pocket medical insurance premium. The District sets you up on the Plan automatically, if your out-of-pocket premium is more than \$10.

### **Medical Reimbursement Plan**

You can set aside up to \$3,600 per year to be reimbursed for out-of-pocket medical expenses incurred by you and your dependents. Qualified expenses include medical, dental, vision, and other expenses that have not been paid fully by insurance. These expenses are described in IRC Section 213. (You can request an IRS publication or consult your tax advisor for further information on qualified expenses.)

### **Dependent Care Assistance Plan**

You can set aside up to \$5,000 per year to pay for work-related dependent care costs for a child under age 13, or a disabled parent, spouse, or child of any age. Expenses can include babysitting, and other types of day care.

**REMEMBER:** *The money set aside in any of these plans must be used for reimbursement by January 15th, (two and half months after the end of the plan year). All money left in the Plan after January 15th, will not be reimbursable. It is very important that your yearly calculation not be more than your estimated reimbursable expenses.*

If currently enrolled in the Flex Plan for last year, you must still submit a new enrollment form to participate in the new plan year. Annual enrollment forms are distributed under a separate memorandum to all participating employees for each specific plan and must be returned by the stated deadline.

## OTHER DISTRICT PROGRAMS

### **Employee Assistance Program**

The APS Healthcare is a confidential counseling service providing three sessions per school year to the East Valley School District employees and eligible family members. This service is a benefit provided by the District at absolutely no cost to the employee or the dependent using the service. Problems do not have to be major to seek help from a qualified EAP counselor. Some common issues addressed are: marital and family problems, individual issues, grief, stress, depression, anxiety, effective communication, time management and drug and alcohol abuse. To schedule an appointment, simply call 800-999-1077. If there is an emergency call the 24-Hour Crisis line at 800-833-3031.

### **Tax Sheltered Annuities (TSA)**

The District maintains a list of suppliers who provide tax sheltered annuities for employees interested in future retirement planning. Please contact the Payroll Office for more information and assistance in setting up a TSA.

### **Deferred Compensation Program (DCP)**

The Deferred Compensation Program (DCP) helps you save for retirement on a pre-tax basis. DCP is a part of the Washington State Retirement System and has the same investment choices, plus a few more.

You may defer as little as \$30 a month or as much as \$1,250 a month. Please contact the HR or Payroll office for more information and forms for opening your own DCP account.

## HOW TO ENROLL

As a new or continuing employee of the East Valley School District, the beginning of the school year is a time to either sign up for benefits or to review current benefits in effect. Benefit decisions during the annual open enrollment period impact you and your dependents the entire plan year. Therefore, informed decisions become vital.

After making your benefits selections, please review your payroll warrant for correct premium deductions. Should the benefit deduction information appear incorrect, please contact the Payroll Office at 241-5030 immediately.

## INITIAL ENROLLMENT

As a new eligible employee you must enroll yourself and your eligible dependents in the basic and fringe benefit programs within **30 calendar days of the date you qualified for employee benefits**.

Coverage will begin for yourself and your dependents effective the first day of the month you were hired if you were hired the 1<sup>st</sup> day of the month or the first day of the next month if you were hired after the 1<sup>st</sup>.

Enrollment/application forms may be obtained at the Benefits Orientation in September or in the Payroll Office any time during the year. If you fail to enroll during this period, you and your eligible dependents may not enroll until the next annual open enrollment period or unless an IRS qualifying event occurs.

## OPEN ENROLLMENT

As a continuing employee you have the opportunity to access insurance plans open for enrollment annually during the open enrollment period - September 1- October 1. During 'open enrollment' you may add, delete, or change insurance coverage for the plan year. If you choose to make no changes, your present coverage will remain the same with only a premium increase during the plan year. This premium change would reflect on your monthly pay warrant.

### **Changing Your Plans**

You must complete a new enrollment/application form in order to **change from one plan to another**. For example, if you desire to change from the WEA Select Medical 5 plan to the WEA Select Medical 2 plan you must fill out a new Premera medical insurance enrollment form indicating the new plan. The completed form must be submitted to the Human Resources office by September 15<sup>th</sup> for October 1<sup>st</sup> coverage.

Should you wish to **change carriers** (companies), you must fill out the new company's medical insurance enrollment/application form and submit the completed form to the Human Resources office.

Also, if you wish to **cancel** voluntary coverage, you must submit a request in writing indicating the change to the payroll office by September 15<sup>th</sup> for October 1<sup>st</sup> cancellation.

**REMEMBER:** PLEASE COMPLETE THE ENROLLMENT/APPLICATION FORMS CAREFULLY. When enrolling in a medical plan, list only the dependents that you wish covered. The dental and vision are composite rate group plans, therefore, list all eligible dependents for coverage. Make sure to **sign** all enrollment/application forms. The payroll office will fill in the group numbers, so don't worry about them.

All enrollment/application forms are due in the Human Resources Office, between **September 15<sup>th</sup> and October 5<sup>th</sup>**.

## IDENTIFICATION CARDS

After you enroll, you'll receive an identification card from your medical plan. The vision and dental plans **do not** issue identification cards. If you have questions about your identification cards, contact your plan directly. Please allow about one month from enrollment date to receive your identification card. You may use your enrollment/application form if you need services before you receive your ID card.

## UPDATED PLAN BOOKLETS

Certificate of Insurance and/or plan description booklets provided by the carriers describing the plan coverage will be in the Human Resources Office in October. Please call to request one and it will be sent out through the inter-school mail. All plan description booklets are online.

## ***Changing Your Benefit Choices***

Each year the District holds an open annual enrollment period September 1 to October 1st. At this time you may choose to continue your benefits with the provider as they were the previous year, or you may choose to change to better fit your personal needs.

If you need to change your benefits elections outside of the annual open enrollment period, **you may only do so if you meet one of the IRS 'qualifying events' listed below**. To make the change, you will need to complete new enrollment/application forms in the Human Resources office and attach all pertinent documentation. The completed forms must be in the office by the 15th to be included in that month's payroll processing.

## ***Qualifying Events***

A change in family or employment status may include the following events:

- \* Marriage, divorce, or legal separation of the employee
- \* The death of the employee's spouse or dependent
- \* The birth or adoption of a child of the employee (change may be made within 60 days of the change in status in these circumstances)
- \* Medical child support orders
- \* Legal guardianship/nonparental custody
- \* The termination or the commencement of employee of the employee's spouse

\* The employee or spouse changing between part-time and full-time employment status or significant increase/decrease in hours. Increase/decrease must be equivalent to a minimum of twenty percent (20%) change in employer's contribution toward insurance.

\* The taking of Family Medical Leave by the employee or the employee's spouse

\* The taking of an unpaid leave of absence by the employee or the employee's spouse

\* A significant change in health coverage of the employee or the employee's spouse attributable to the spouse's employment

**Acceptance and approval of the changes made by an employee are subject to the terms and conditions of the official contract and plan description of the insurance carrier.**

*Note: As an eligible employee of East Valley School District, you have the option to drop your coverage or your dependents coverage at any time during the plan year.*

## ***Continuing Coverage Under COBRA***

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

A.W. Rehn Company administers the COBRA program for East Valley School District No. 361. If you qualify for COBRA, you will receive a letter from A.W. Rehn explaining how to continue your medical, dental and/or vision insurance.

You and/or your enrolled dependents may self-pay for continued coverage or extended coverage in the following circumstances:

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

To be eligible for COBRA continuation coverage, you or your family member must inform payroll within 60 days of the date of a legal separation, divorce, or child losing eligibility; or the date coverage is lost due to such an event (whichever is later). The District will notify you and/or your dependents in the other circumstances.

The events which allow you and/or family members to continue coverage, and the maximum coverage period applicable to each event are listed below:

Retirement	18 months for employee and/or family members
Disability	18 months for employee and/or family members
Any other reason (except gross misconduct)	18 months for employee and/or family members

Reduction of hours	18 months for employee and/or family members
Death	36 months for spouse and/or dependents
Separation or Divorce	36 months for spouse and/or family member
No longer Dependent Child	36 months for dependent child
Employee entitled to Medicare	36 months for spouse and/or dependent

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

1. the premium is not paid on time;
2. the District terminates all group health plans for all employees;
3. the person continuing coverage becomes entitled to Medicare;
4. the person continuing coverage is covered by another group health plan, unless the new plan has limitations on preexisting conditions; and/or
5. in the case of a disability extension, the disabled individual recovers.

## ***Conversion of Coverage***

East Valley School District sponsored health benefit plans offer a 'conversion options' (giving you the right to switch from group to individual insurance policy) when you are no longer able to continue the group plans. Conversion plans are almost always more expensive than the group plans or COBRA and provide fewer benefits, but you are not required to provide evidence of insurability in order to obtain the conversion coverage. To obtain detailed information on your conversion options under your current District-sponsored plan, please call your plan insurance provider customer service representative.

## ***Third Party Liability***

If you or your covered dependents become ill or injured as the result of an action by a third party, and you sue the third party, benefits paid for your treatment must be included in your lawsuit. While you receive treatment, covered expenses will be paid as outlined by your particular plan.

It is your responsibility to notify the Human Resources Office that you are bringing suit, and you must agree to protect the plan's right to act in your place (subrogation) in pursuing the claim against the third party.

If the third party is found liable and you receive payment for the treatment of the illness or injury, it is your **obligation** to reimburse the plan for the benefits that were paid for your care.

## ***FAMILY MEDICAL LEAVE ACT (FMLA)***

The Family and Medical Leave Act (FMLA) was signed into law in February 1993. The law took effect on August 5, 1993 and guarantees up to 12 weeks of unpaid leave to workers who need time off for birth or adoption of a child, to care for a spouse or immediate family member with a serious illness, or who are unable to work because of a serious health condition.

The FMLA is an employer law; it covers employers with 50 or more employees and affects many job-related rights of employees. Among other things, this law also affects the health benefit plans maintained by employers who are required to comply. Employers are required by FMLA to continue to provide group health benefits at the same level and under the same conditions as if the employee had continued to be actively at work. A person who fails to return from an FMLA leave may be entitled to continuation of coverage under COBRA.

If you qualify to use the Family and Medical Leave act, you will need to fill out paperwork in the Human Resource Office. You may choose to use all or part of your sick leave and annual leave or be on unpaid leave. If you do not return to work for 30 days after 12 weeks of FMLA, the district has the right to charge you for all the benefits that were paid in your behalf.

East Valley School District Board policy 5329P. View on East Valley website: [district info/board of directors/board policies/family leave](#)

## ***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 safeguard the privacy of individuals. You have probably received some information from your bank, credit card company and your doctors office outlining their privacy policy. This act is also applicable to insurance companies and school districts and how they conduct business with regards to applications, claims, customer service inquiries, employment verifications, etc.

This means that in order for the Payroll Officer or school district personnel to give out any information on your behalf, you must first sign an authorization to release the information. The authorization must be specific to a particular issue and must be submitted to the payroll office before the information is to be released. If you have questions or concerns, please contact the Payroll office at 241-5030.

## ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides protection for individuals and their families who have pre-existing conditions or might suffer discrimination in health coverage based on a factor that relates to a health issue. Although HIPAA allows for an exclusion period, the District's medical, dental and vision plans do **not** have a pre-existing exclusion periods. Upon separation from a District health plan, you will receive a Certificate of Creditable Coverage from the health plan to show your most recent period of continuous coverage.

On April 2003, the HIPAA Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) went into effect. The Privacy Rule provides privacy protection of personal medical information. The District will not disclose protected information without written consent from the employee. The District will not speak on behalf of the employee to a health plan without the employee's written permission. The employee is encouraged to call the health plan's customer service if there is a problem with a claim.

## EAST VALLEY SCHOOL DISTRICT NO. 361

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