Riverview School District #407

Employee Benefit Guide

2016-2017 School Year

Important Open Enrollment Information

Open Enrollment Period: August 22nd to September 30th, 2016

- **If you are satisfied with the plans you are currently enrolled in, no action is required at this time.**
- November 1st is the effective date for all lines of coverage
- WEA Select Plans can be previewed beginning August 18th at http://resources.hewitt.com/wea.
- If you are currently enrolled in any WEA Select Plan and do not wish to make any changes, you will automatically stay in your current plan.
- If you are a new hire or wish to make changes, you will need to enroll using the online system or by calling the WEA Select Benefits Center at 1-855-668-5039.
- **You need to insure that all eligible dependents are listed as covered on your Delta Dental of Washington plan no later than September 30th! Mid year additions of dependents (unless eligibility is due to a Qualified Status change) will not be accepted.** This can be done by calling the WEA Select Benefits Center at 1-855-668-5039 or online at http://resources.hewitt.com/wea.

Benefits Fair

Please plan on attending this one time event as this will be your only chance to meet with our insurance representatives to answer your questions or to get further information and details.

Date: Wednesday, August 31st

Time: 10:30 am - 1:00 pm

Location: Educational Service Center

15510 1st Ave NE

Duvall, WA 98019

The information herein is not a contract. It is a brief 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, 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. Please direct any questions to **Cindy Sage (425) 844-4513** or **The Partners Group at (877) 455-5640.** This summary was printed on August 18, 2016 . Any further information, revision by bargaining units or by insurers after this date could change or modify the information contained herein.

Welcome to Your Benefits!

The District is proud to offer a comprehensive benefits package to its valued employees and their eligible family members. This package is designed to provide you with choice, flexibility and value.

This Benefits Guide will help you learn more about your benefits, review highlights of the available plans and make selections that best fit your lifestyle and budgetary needs. This information is also available on your District's website. In addition, you can contact the Payroll and Benefits Department or our Insurance Broker, The Partners Group for help in understanding your benefits. After enrollment, you will have access to insurance plan booklets that provide more detailed information on each of the programs you have selected.

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Enrolling or Making Changes to your Benefits

You may make changes to your benefit choices once a year during the open enrollment period. Outside of this period, you can add or drop dependents if there has been a qualifying event. Coverage will be effective for newborns on their actual date of birth. If you have been recently married, coverage becomes effective the 1st of the month after date of marriage.

You have the following time periods to enroll:

- 60 days from birth/adoption to add a child
- 30 days from date of marriage to add a spouse and stepchildren
- 30 days to add a spouse or children if there has been a loss of other group coverage
- 30 days to enroll dependents for voluntary benefits

Many of your benefits are on a pre-tax basis so the IRS requires you to have a qualified change in status in order to make changes to your benefits.

Types of Qualifying Events

- You get married or divorced
- You enter into a domestic partnership
- You have a child or adopt one
- An enrolled family member dies
- You (or your spouse) go on a leave of absence
- You waived coverage for yourself or your family member because of other coverage and that coverage is lost for qualified reasons

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may be able to enroll yourself or your dependents in our plans provided that you request enrollment within 30-60 days (depending on carrier) after your other coverage ends.

Unless one of the above Qualifying Events apply, you may not be able to obtain coverage under our insurance plans until the next open enrollment period.

New employees are eligible for group mandatory and voluntary benefits beginning the 1st of the month following the new employee's first paycheck. Please contact Cindy Sage in Payroll to find out the minimum number of hours you must work to become eligible for benefits. The required hours depend upon your specific bargaining unit.

Dependents

Your legal spouse or domestic partner is eligible for coverage as well as any of your children (biological or step) up to age 26. Coverage is also available beyond age 26 for incapacitated children. Please see Payroll and Benefits for more information if you have questions on dependent eligibility.

Benefit Changes for the 2016-2017 School Year

Washington State Allocation

- State allocation for employee benefits will remain at $780.00. The Retiree Medical Carve out amount will decrease from $65.25 to $64.39.

WEA - Premera Blue Cross (Plan 2, Plan 3, EasyChoice, Plan 5, Basic and QHDHP)

All Plans – Medical Management Programs

- Outpatient Rehabilitation: Prior Authorization will be required for physical therapy, occupational therapy and massage therapy. Enrollees can self-refer or be referred by a physician for physical or occupational therapy for the first visit. However, enrollees will need to be diagnosed and referred to a massage therapist by a health care provider.
- Infusion Therapy: Prior Authorization is required for the site/setting where the infusion therapy services will be provided (took effect 7/1/2016).
- Chronic Pain Management Program available to enrollees (took effect 4/1/2016).

All Plans – Benefit changes

- Community Health Benefit: enrollees can be reimbursed up to $250 per calendar year for this benefit, subject to plan deductibles and coinsurance.
- Hair Prosthesis Benefit: a full cranial wig will be covered, up to $500 every 2 calendar years, for enrollees with total permanent hair loss due to a covered medical condition.

Heritage Prime Network Changes (EasyChoice B, Basic)

- Effective January 1, 2017, Providence/Swedish and Franciscan Health Systems, including their clinics and ancillary services, will be removed from the Heritage Prime network. (This only affects the Heritage Prime network for EasyChoice B and Basic).

Plan 2

- The in-network medical deductible has increased from $200 to $300 for an individual and from $600 to $900 for a family
- The in-network individual medical out-of-pocket maximum has increased from $1,700 to $2,000 and from $5,100 to $6,000 for a family.
- A specialty provider office visit copay of $35 has been added.
- Prescription Mail Order copays have increased from $15/$30/$45 to $20/$40/$65 (generic/preferred/non-preferred)
- 8.9% rate increase.

Plan 3

- The in-network medical deductible has increased from $300 to $500 for an individual and from $900 to $1,500 for a family
- The in-network individual medical out-of-pocket maximum has increased from $2,950 to $3,000 and from $8,850 to $9,000 for a family.
- A specialty provider office visit copay of $40 has been added.
- Prescription Mail Order copays have increased from $20/$35/$50 to $30/$50/$70 (generic/preferred/non-preferred).
- 12.8% rate increase.

EasyChoice A

- The in-network medical deductible has increased from $1,000 to $1,250 for an individual and from $3,000 to $3,750 for a family
- The primary care office visit copay has increased from $15 to $25.
- A specialty provider office visit copay of $35 has been added.
- The Outpatient diagnostic lab benefit has been decreased from 100% for the first $1,000 to 80% (deductible waived) for the first $250.
- Generic Prescription copay has increased from $5 to $10.
- Prescription Mail order copay for generics has increased from $10 to $20.
- 13.7% rate increase.

EasyChoice B

- The network is being changed from the Heritage One network to the Heritage Prime network.
- A specialty provider office visit copay of $40 has been added.
- 13.7% rate increase.

Benefit Changes for the 2016-2017 School Year continued

Plan 5

- The in-network individual medical out-of-pocket maximum has increased from $700 to $1,000 and from $2,100 to $3,000 for a family.
- The primary care office visit copay has increased from $15 to $20.
- A specialty provider office visit copay of $30 has been added.
- Prescription Mail Order copays for generics has increased from $15 to $20.
- 7.7% rate increase.

Basic Plan

- The in-network medical deductible has increased from $1,250 to $2,100 for an individual and from $2,500 to $4,200 for a family.
- The in-network individual medical out-of-pocket maximum has increased from $4,500 (plus $2,000 for Rx) to $6,600 (including Rx).
- The primary care office visit copay has increased from $30 to $35.
- A specialty provider office visit copay of $50 has been added.
- The prescription deductible has increased from $500 to $750 for an individual and from $1,000 to $1,500 for a family.
- Non-preferred prescription copay has increased from $45 to $50.
- Prescription Mail Order copays have increased from $15/$60/$90 to $30/$60/$100 (generic/preferred/non-preferred).
- 0.7% rate increase.

QHDHP

- The in-network medical deductible has increased from $1,500 to $1,750 for individual coverage and from $3,000 to $3,500 for family coverage.
- The in-network individual medical out-of-pocket maximum has increased from $4,000 to $5,000 for an individual and from $8,000 to $10,000 for a family. No one individual will be required to meet more than the individual out of pocket limit.
- If you are enrolling yourself with dependents, each enrolled person is only subject to the individual out of pocket maximum of $5,000. The family maximum still applies.
- 13.4% rate increase.

Group Health

- The in-network medical deductible has been increased from $200 to $350 for an individual and from $600 to $1,050 for a family.
- 1.6% rate increase.

WEA – Delta Dental of Washington

- Composite fillings will be covered on any tooth.
- 1.5% rate decrease.

NBN Vision Plan

- The contact lens exams is covered in full and will no longer offset the contact lens allowance.
- No rate change.

CIGNA- Long Term Disability

- No benefit changes.
- 5% rate increase.

CIGNA Group Term Life

- No benefit changes.
- No rate changes.

CIGNA- Voluntary Life Insurance

- No benefit changes.
- No rate changes.

WEA-Select Voluntary Short and Long Term Disability Plans - American Fidelity Assurance Company (AFA)

- The Voluntary Short Term Disability plans will no longer have two separate employee classifications. The Non-Clerical Classified plan will be eliminated and replaced with the Certificated, Administrative and Clerical Employees plan, which has comparable benefits and lower rates. The new plan will be labeled “All Employees”.
- The Waiver of Premium benefit on the Short Term Disability will decrease from a 90 day wait to a 30 day wait.
- Short Term Disability Only -No rate increase. Non-Clerical Classified participants will have a lower rate.

Medical Insurance

Comprehensive and preventive health care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. The District offers you a choice of a variety of plans and plan styles. All plans cover most of the same benefits but your out-of-pocket costs and network physicians vary. Please review the types of plans available, listed below, then review the highlights of what each plan covers on the following pages.

Preferred Provider Organization (PPO)

These type of 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 higher percentage of the charges. If you choose to receive your care through a non-preferred provider, then the insurance company will pay a lower percentage of the charges.

Your PPO plan options are available through Premera.

Qualified High Deductible Health Plan (QHDHP)

These type of plans operate almost like the PPO plans. If you choose to receive care through a preferred provider, the insurance company will pay a higher percentage of the charges than if you receive care from a non-preferred provider. ***Unlike a PPO plan, the deductible must be satisfied before the QHDHP plan will pay for any care (except preventive care), including prescriptions. Also, unlike a PPO plan, if there is more than one person enrolled on your plan, the family deductible must be satisfied before the plan will pay benefits (except for preventive care) for any enrolled member.***

If you choose to elect the QHDHP, you may be eligible for a Health Savings Account (HSA). An HSA is a bank account that allows you to deposit funds, on a pre-tax basis, that can be used to pay for qualified medical expenses. If you choose the QHDHP, you may be eligible for an HSA however if you do not choose the QHDHP, you are not eligible to participate in an HSA. Further information on QHDHP's and HSA's are located further in this guide.

Your QHDHP plan option is available through Premera.

To find a preferred provider through Premera, visit www.premera.com/wea.

Health Maintenance Organization (HMO)

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

Your HMO plan option is available through Group Health.

Special Note about Hospitals and Emergency Rooms

E.R. physicians and the hospitals they practice in are not always participating with the same insurance companies. The physicians and hospitals are *usually* under separate contracts.

To receive the highest benefits your insurance provides it is a good idea to check your nearest ER and physician participation prior to needing these services. You may do this by calling your insurance company or checking their website.

Medical Plan Options

Plan (Network)	Premera Blue Cross PPO 2 (Heritage)		Premera Blue Cross PPO 3 (Heritage)		Premera Blue Cross PPO 5 (Foundation)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$300 person / $900 family		$500 person / $1,500 family		$200 person/ $600 family	$350 per person
Rx Deductible	None		None		None	
4th Qtr. Carry Over	Nov & Dec Only		Nov & Dec Only		Nov & Dec Only	
Carrier Coinsurance	80%	60%	80%	60%	90%	70%
Medical Out of Pocket Max	$2,000 person / $6,000 family	$3,400 person / $10,200 family	$3,000 person / $9,000 family	$5,900 person / $17,700 family	$1,000 person/ $3,000 family	Unlimited
Rx Out of Pocket Max	$2,000 person/$4,000 family		$2,000 person/$4,000 family		$2,000 person/$4,000 family	
Office Visit *Primary/Specialist*	$25/$35 copay (dw)	$30/$40 copay (dw)	$30/$40 copay (dw)	$40/$50 copay (dw)	$20/$30 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Coinsurance only	Covered in full	Coinsurance only	Covered in full	Not covered
Diagnostic Lab & X-Ray	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance	
Advanced Diagnostic Imaging	Deductible & Coinsurance		Deductible & Coinsurance		Deductible & Coinsurance	
Emergency Care**	$75 copay + ded & coin		$100 copay + ded & coins		$50 copay + ded & coin	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance		$50 copay + deductible	
Hospital (Inpatient)	$150 copay per day / $450 max PCY then ded & coin		$300 copay per day / $900 max PCY then ded & coin		$150 copay per day / $450 max PCY then ded & coin	
Hospital (Outpatient)	Surgery- $100 copay then ded & coin All other services- Ded & coin		Surgery- $150 copay then ded & coin All other services- Ded & coin		Deductible & Coinsurance	
Spinal Manipulations	$25 copay (dw)	$30 copay (dw)	$30 copay (dw)	$40 copay (dw)	$20 copay (dw)	Ded &coin
	Unlimited Manipulations		Unlimited Manipulations		Unlimited Manipulations	
Vision Care	Not Covered		Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	45 visits Unlimited visits for PT		45 visits Unlimited visits for PT		45 visits	
	$35 copay (dw) PT: ded & coin	$40 copay (dw) PT: ded & coin	$40 copay (dw) PT: ded & coin	$50 copay (dw) PT: ded & coin	$30 copay (dw)	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	120 days PCY		30 days PCY		30 days PCY	
	See Hospital Inpatient		See Hospital Inpatient		See Hospital Inpatient	
Prescriptions	**Generic / Preferred / Non - Preferred - At Participating Pharmacies**					
Retail Cost Share	$10 / $20 / $35 (34 day supply)		$15 / $25 / $40 (34 day supply)		$10 / $15 / $30 (30 day supply)	
Mail Order Cost Share	$20 / $40 / $65 (100 day supply)		$30 / $50 / $70 (100 day supply)		$20 / $30 / $60 (90 day supply)	
Specialty Cost Share	$50 copay through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)		$60 copay through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)		$50 copay through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)	
Life/AD&D Insurance	$12,500 Term Life and AD&D for Employee Only					

*Preventive Services as defined by the Affordable Care Act
**Copay waived if admitted to hospital

(dw)= Deductible Waived
(PCY) = Per Calendar Year
Ded & coin = Deductible & Coinsurance Apply
OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

To locate a Premera provider, visit www.premera.com/wea

Medical Plan Options

Plan (Network)	Premera Blue Cross EasyChoice A (Heritage)		Premera Blue Cross EasyChoice B (Heritage Prime)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$1,250 person/ $3,750 family	$2,000 person/ $6,000 family	$750 person/ $2,250 family	$1,500 person/ $4,500 family
Rx Deductible	$500		$250	
4th Qtr. Carry Over	Nov & Dec Only		Nov & Dec Only	
Carrier Coinsurance	80%	50%	75%	50%
Medical Out of Pocket Max	$4,000 person/ $8,000 family	None	$3,500 person/ $7,000 family	None
Rx Out of Pocket Max	$2,500 person/$5,000 family		$2,500 person/$5,000 family	
Office Visit *Primary/Specialist*	$25/$35 copay (dw)	Ded & coin	$30/$40 copay (dw)	Ded & coin
Preventive Care*	Covered in full	Not covered except Screenings-ded & coin	Covered in full	Not covered except Screenings-ded & coin
Diagnostic Lab & X-Ray	First $250 subject to coinsurance then ded & coins		Deductible & Coinsurance	
Advanced Diagnostic Imaging			Deductible & Coinsurance	
Emergency Care**	$100 copay + ded & coin		$150 copay + ded & coin	
Ambulance	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Inpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Hospital (Outpatient)	Deductible & Coinsurance		Deductible & Coinsurance	
Spinal Manipulations	$25 copay (dw)	Ded & coin	$30 copay (dw)	Ded & coin
	12 manipulations PCY		12 manipulations PCY	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits		45 visits	
	$35 copay (dw)	Ded & coin	$40 copay (dw)	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY		45 days PCY	
	Ded & coin		Ded & coin	
Prescriptions	**Generic / Preferred / Non - Preferred - At Participating Pharmacies**			
Retail Cost Share	$10 (dw) / 30% / 30% (30 day supply)		$5 (dw) / $30 / $45 (30 day supply)	
Mail Order Cost Share	$20 (dw) / 30% / 30% (90 day supply)		$10 (dw) / $75 / $112 (90 day supply)	
Specialty Cost Share	30% through Accredo or Walgreens Specialty Pharmacy only (30 day supply)		30% through Accredo or Walgreens Specialty Pharmacy only (30 day supply)	
Life/AD&D Insurance	$12,500 Term Life and AD&D for Employee Only			

*Preventive Services as defined by the Affordable Care Act

**Copay waived if admitted to hospital

(dw)= Deductible Waived
(PCY) = Per Calendar Year
Ded & coin = Deductible & Coinsurance Apply
OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

To locate a Premera provider, visit www.premera.com/wea

Medical Plan Options

Plan (Network)	Premera Blue Cross Basic (Heritage Prime)		Premera Blue Cross QHDHP (Foundation)	
Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Medical Deductible	$2,100 person/ $4,200 family	$2,500 person/ $5,000 family	$1,750 person/ $3,500 family†	$3,000 person/ $6,000 family†
Rx Deductible	$750 person/ $1,500 family	Not covered	Subject to Medical Deductible	
4th Qtr. Carry Over	Nov & Dec Only		Does NOT Apply	
Carrier Coinsurance	70%	50%	80%	50%
Medical Out of Pocket Max	$6,600 person/ $13,200 family	Unlimited	$5,000 person/ $10,000 family	Unlimited
Rx Out of Pocket Max	Shared with Medical	Not covered	Shared with Medical	
Office Visit *Primary/Specialist*	$35/$50 copay (dw)	Ded & coin	Ded & coin	Ded & coin
Preventive Care*	Covered in full	Not covered except Screenings-ded & coin	Covered in full	Not covered except Screenings-ded & coin
Diagnostic Lab & X-Ray	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Advanced Diagnostic Imaging	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Emergency Care**	$200 copay + Ded & coin		Ded & coin	
Ambulance	Deductible & coinsurance		Ded & coin	
Hospital (Inpatient)	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Hospital (Outpatient)	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Spinal Manipulations	$35 copay (dw)	Ded & coin	Deductible & Coinsurance	
	12 manipulations PCY		12 manipulations PCY	
Vision Care	Not Covered		Not Covered	
Rehab - Outpatient (Speech, Massage, OT, PT)	30 visits		15 visits PCY	
	$50 copay (dw)	Ded & coin	Ded & coin	Ded & coin
Rehab - Inpatient (Speech, Massage, OT, PT)	30 days PCY		30 days PCY	
	Ded & coin	Ded & coin	Ded & coin	Ded & coin
Prescriptions	**Generic / Preferred / Non- Preferred - At Participating Pharmacies**			
Retail Cost Share	$15 / $30 / $50 (30 day supply)		Ded & coin (30 day supply)	
Mail Order Cost Share	$30 / $60 / $100 (90 day supply)		Ded & coin (90 day supply)	
Specialty Cost Share	30% through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)		20% through Accredo or Walgreens Specialty Pharmacy Only (30 day supply)	
Life/AD&D Insurance	$12,500 Term Life and AD&D for Employee Only			

*Preventive Services as defined by the Affordable Care Act
**Copay waived if admitted to hospital

†Premera QHDHP, the deductible must be satisfied before benefits are payable. If more than one person is enrolled, the family deductible must be satisfied before benefits are payable for ANY enrolled person.
To locate a Premera provider, visit www.premera.com/wea

(dw)= Deductible waived
PCY= Per Calendar Year
Ded & coin = Deductible & coinsurance apply
OT= Occupational Therapy
PT= Physical Therapy
Rx = Prescription Medication

Medical Plan Options

Plan (Network)	Group Health
Network	**At a GHC Facility/Provider Only**
Medical Deductible	$350 person / $1,050 family
Rx Deductible	None
4th Qtr. Carry Over	Does NOT Apply
Coinsurance	90%
Medical Out of Pocket Max	$2,500 person / $7,500 family
Rx Out of Pocket Max	Included in Medical
Office Visit	$20 copay + ded & coins
Preventive Care*	100% (dw)
Diagnostic Lab & X-Ray	Deductible & Coinsurance
Advanced Diagnostic Procedures	Deductible & Coinsurance
Emergency Care**	$200 copay + ded & coins
Ambulance	80% (dw)
Inpatient	$200 copay per day (up to 3 days per admit) + ded & coins
Outpatient	$20 copay + ded & coins
Spinal Manipulations	10 visits PCY
Vision Care	One exam every 12 months
Rehab - Outpatient (Speech, Massage, OT, PT)	60 visits PCY
	$20 copay + ded & coins
Rehab - Inpatient (Speech, Massage, OT, PT)	60 days PCY
	$200 copay per day (up to 3 days per admit) + ded & coins
Prescriptions	**Generic / Formulary At GHC Pharmacies Only**
Retail Cost Share (30 Day Supply)	$10 / $20
Mail Order Cost Share (90 Day Supply)	$20 / $40
Specialty Cost Share (30 Day Supply)	Subject to applicable retail copay through GHC Specialty Medication Pharmacy Only
Life/AD&D Insurance	None

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OT = Occupational Therapy
PT = Physical Therapy
Rx = Prescription Medication

To locate a Group Health provider, visit www.ghc.org

High Deductible Health Plan and HSA Questions and Answers

How does the High Deductible Health Plan (HDHP) work?

- Unlike your other health plans that have co-pays for certain services that do not apply toward the deductible, on an HDHP, your deductible **must be met before** payments are provided for any services (except for Preventive Care) including prescriptions. If there is more than one person covered by your HDHP (spouse and/or child) the family deductible **must be met before** payments are provided for ANY person enrolled.

What is a Health Savings Account (HSA)?

- A Health Savings Account is a special bank account tied to your HDHP where you can put in money, on a pre-tax basis, to pay for "qualified medical expenses" such as prescriptions, services provided by your HDHP, dental plan and vision plan.

Who is eligible to participate in an HSA?

- Anyone covered by an HDHP, however, you or your enrolled spouse cannot be covered under another medical plan unless that plan is also an HDHP.
- If you are no longer covered by an HDHP, or you enroll in Medicare, you can no longer contribute funds to an HSA but you can use the remaining funds toward eligible expenses.
- You cannot participate in an HSA if you can be claimed as a dependent on another person's tax return.
- As this is a bank account, you must be eligible to open a bank account. This process may include a credit check.

Can I have an HSA and a Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA)?

- Any person covered by an HDHP **cannot** have an FSA or HRA **including VEBA** unless it is a **non-medical** FSA or HRA such as a daycare reimbursement FSA or a "limited purpose" non-medical FSA.
- If your spouse has an FSA that could cover your medical expenses, you **cannot** participate in an HSA.

How much can I contribute to my HSA?

- You (and/or your employer) can contribute up to the Federal Annual Limit. For 2016, including employer contributions, it is $3,350 (individual) or $6,750 (family). The limit for 2017 stays at $6,750 (family) and increases to $3,400 (individual).
- If you are over age 55, contributions may include an additional $1,000 per calendar year.
- Married couples with two separate HSAs are limited to a total of $6,750 between the two accounts if one has an HDHP with employee & dependents enrolled.
- Contributions to your HSA are deducted from your paycheck on a pre-tax basis and deposited by your employer.

How do I use my HSA?

- Most HSAs come with a debit card attached to the account. Use or provide this card at time of service/purchase to use the funds in your HSA.
- You may also provide receipts for eligible expenses to your HSA administrator for reimbursement if you do not use your HSA debit card.

Please note that the Riverview School District does not provide any contributions towards your Health Savings Account.

High Deductible Health Plan and HSA Questions and Answers continued

Important Things to Be Aware of About your HDHP and HSA

- The HSA is a bank account, in your name, that belongs to you. If you leave your employer, the account goes with you and you can continue to use it for qualified medical expenses. Any monthly banking fees for the HSA are your responsibility and will be deducted directly from your HSA.
- Over-the-Counter medications are not a qualified medical expense under an HSA.
- Any use of HSA funds for a non-qualified medical expense are subject to a 20% tax penalty and applicable income taxes. You should keep all your receipts for purchases made with your HSA in case you are audited by the IRS.
- You cannot use HSA funds for any item or service provided prior to your effective date on your HDHP. For example, if your HDHP was effective 11/1/2016 and your dentist performed a crown on 9/5/2016, you cannot use HSA funds on this service.
- Unlike an FSA, you can only use the funds that have already been deposited in your HSA. If you receive a bill for $400 for services but only have $200 in your HSA available, you can only use $200.
- You can use your HSA funds for qualified medical expenses for any tax dependent even if they are not covered by your HDHP. You cannot, however, use your HSA funds for qualified medical expenses for someone who is not a tax dependent (e.g. a child over the age of 26.)
- All deductibles on your HDHP reset January 1st of each calendar year. There is no carry forward of deductibles met in the prior year. If you enroll in an HDHP on November 1, your medical expenses will be subject to the entire annual deductible for the remainder of the calendar year and will reset on January 1.

This is just a brief overview of HSAs and HDHPs and is not inclusive of all tax laws. More information can be found at www.treasury.gov , and on IRS Publication 969 and 502 or by consulting your tax professional.

Saving Money on Your Medical Costs

Health care costs can be expensive. You can help keep your costs down for yourself and for everyone enrolled under our plans by making wise choices.

Use The Emergency Room for Emergencies Only

If you have a life threatening emergency, contact 911 or go to an emergency room but if your condition is not life threatening or a medical emergency, use an urgent care facility or see your doctor. Urgent Care facilities are significantly cheaper than emergency rooms and generally only require a small co-pay for their use.

Select Generic Prescription Drugs When Available

If a generic drug is available and will work for you, select the generic. Generic drugs are considerably less expensive for you and our insurance plan. Some plans, like the Premera EasyChoice plans, include a separate deductible for prescriptions that is waived if you select generic drugs.

Choose to Receive Care from a Preferred (In-Network) Provider on Your PPO Plan.

To make sure you are receiving the maximum coverage possible, ask if the physician or the medical facility whose services you want to use is in your plan's "preferred provider" network. Always be sure to ask, if you are being referred for any services, that you are being referred to a preferred provider. While your hospital or physician may be a preferred provider, the lab they use or refer you to for tests may not be and you will be responsible for a greater percentage of the charges as a result.

Participate in the Flexible Spending Account

Our Flexible Spending Account (FSA), described under the Voluntary Benefits section of this guide, allows you to pay many of your out-of-pocket expenses such as deductibles, co-pays, co-insurance, non-covered health care costs and dependent care with before-tax dollars. The FSA allows you to spread these costs over the year as just a portion of your annual election is deducted from each paycheck.

Mandatory Dental Benefits

Dental is a mandatory benefit that comes out of your state allocation. **All employees working a minimum of .396 FTE are eligible.**

Under the Delta Dental of Washington Incentive Plan, you may receive care from any dentist. However, if you receive care from a preferred provider dentist, your out-of-pocket expenses will be lower and your maximum plan year benefit will be higher.

To find a Delta Dental of WA provider go to www.deltadentalwa.com/wea.

Delta Dental Incentive Plan A (Group #186)	
Plan Year Maximum (Nov 1 - Oct 31)	$1,750 per person (Non-PPO providers) $2,000 per person (PPO providers)
Preventive Services (Exams, X-Rays, Cleanings, Fluoride, Sealants)	70% - 100% Incentive
Restorative Services (Fillings, Oral Surgery, Endo, Perio)	70% - 100% Incentive
Onlays, Crowns	70% - 100% Incentive
Major (Dentures, Bridges, Partials & Implants)	50%
Temporomandibular Joint Disorder	50% up to $1,000 Annual Maximum $5,000 Lifetime Maximum

During your 1st benefit year on this plan, 70% of covered benefits are paid. This advances by 10% annually (on November 1) **providing you use the program at least once each benefit year** to a maximum of 100%. Failure to use the program once each benefit year causes your benefit level to drop by 10% but never lower than 70%. Each eligible employee creates their own percentage level. Percentage levels do not affect the 50% level on allowable prosthetics (dentures and bridges) and orthodontics.

Orthodontia Benefits	For Children Only
Admin., Certificated, Non-Rep Employees (Ortho Plan C)	50% to $500 - Lifetime Max Benefit
Classified Employees (Ortho Plan B)	50% to $1,000 - Lifetime Max Benefit

Mandatory Vision Benefits

The District provides its eligible employees working a minimum of **.396 FTE (3 hours per day)** vision care coverage through Northwest Benefit Network (NBN). This plan allows you to use any licensed provider. However, if you use an NBN panel provider, your benefits are greater, your out of pocket costs are less and payment is made directly to the provider. Please refer to the table below to find out how often you are eligible for services and what benefits are provided.

This plan covers you and your entire family (spouse, domestic partner and children up to age 26).

	Frequency	Panel Provider
Copayments		$10.00
Exams	Once each 365 days	Paid in full*
Lenses (pair)	Once each 365 days	Paid in full*
Frames	Once each 730 days	Paid in full**
Contacts -subnormal (in lieu of all other services, requires approval from NBN Claims)	Once each 365 days	Paid in full*
Contacts - elective (in lieu of all other hardware services)	Once each 365 days	$175.00 allowance towards the cost of a fitting fee and lenses at an NBN provider

PLEASE NOTE: Your benefits are tracked from service date to service date; there is no "grace period."

*When services are provided by a Northwest Benefit Network Provider.
**Paid in full means the cost of basic lenses are covered in full when service is provided by a panel provider.
***Paid in full means for the cost of frames covered by your Plan when provided by a panel provider. Your panel provider will inform you of which frames are covered and which frames will require out-of-pocket costs for you.

Obtaining services from a Panel Provider:

1. Log on to www.nwadmin.com or NWA's mobile app and use the NBN Vision Provider Locator feature to find an NBN eye care professional. It's also a good idea to verify your eligibility status online prior to receiving services.

2. Present your NBN Vision ID card when you arrive for your appointment. Failure to tell your NBN eye care professional that you have NBN Vision eye care coverage could result in significant out of pocket expenses. Need additional ID cards? You can print extras online at www.nwadmin.com.

3. Complete any paperwork your eye care provider may require.

4. After your services are complete, pay your NBN Vision provider any co-payments (if your plan requires them) and/or charges for any uncovered items you elected to receive. NBN will pay the panel provider directly for professional services and eyewear covered under your NBN Vision Plan.

Obtaining reimbursement for services at a Non-Panel Provider:

If you decide to use the services of a vision care provider not in the NBN network, simply pay for your vision services and/or materials and send the itemized bill to NBN with a completed NBN Vision claim form. Claim forms are available online at www.nwadmin.com. You will be reimbursed according to the out-of-network schedule of benefits (see your plan booklet for details). Payment for your claim will typically be made within 10 – 14 business days from receipt of your claim.

If you obtain services or eyewear before you are eligible, you will be responsible for all charges incurred. If a non-covered lens extra or a frame that exceeds the plan allowance is ordered, you are responsible for the additional costs including any fees. All claims must be submitted within 365 days from the date of service to be considered for payment. There will be additional patient responsibility if a premium version of a covered item is ordered as the plan only covers standard styles of lens extras.

This is a summary only of the benefits of the plan. Actual benefits are based upon the plan agreement which may contain plan details not specified in this plan summary.

Register at www.nwadmin.com to review your past claims history, eligibility status, plan documents, print a claim form and more.

Mandatory Vision Benefits continued

Lens Extras

The following lens extras are covered by your NBN Vision Plan when a network provider is used:

Generic Flat Top Multi Focal	Blended	Progressive**
Oversize blanks	Prism Segs	Slab Off
Laminated	Double Segs	Pink 1 & 2 Tints
Sun Tints	Glass Photo Chromatic Lite Shades	Glass Photo Chromatic Dark Shades
Other Tints	Anti-Reflective Multi Layer	Color Coat
Scratch Coat	Anti-Reflective + Scratch Coat**	

The following lens extras are available but the costs for these are the responsibility of the patient:

Plastic Photo Chromatic**	Edge Coat	Special Lens Edge Treatments

Hi-Index** (extra thin, light weight lenses) are covered by your NBN Vision plan only when necessary under the terms of the plan.

**If covered, plan pays for standard or basic styles. Patient pays the difference in cost of “premium” progressives, “premium” photochromatic, “premium” anti-reflective + scratch coat and “premium” hi-lens extras.

Mandatory Long Term Disability Insurance

All Administrators, Certificated and Classified exempt employees working a minimum of **.5 FTE** will be covered by our District’s Long Term Disability Policy provided by Cigna. This plan provides financial assistance if you are not able to return to work due to a qualified disabling condition. Plan benefits are below.

Benefits begin paying at:	After the 90th day of disability
Benefit Amount	60% of your gross monthly income up to $6,000/month
Minimum Benefit Amount	10% of your maximum benefit or $100, whichever is greater.
Benefits stop paying at:	Your Social Security Normal Retirement Age (if disabled before age 65) If disabled after age 65, benefits end based on age when disabled. See plan documents for schedule.
Restrictions	Mental/Nervous related disability are covered only for 24 months

There are other benefits and restrictions on these benefits. Please review the Plan Summary for details.

Mandatory Life/AD&D Insurance

All Administrators, Certificated and Classified exempt employees will be covered by our District’s Life/AD&D Insurance Policy provided by Cigna. Plan benefits are below.

Benefit Amount:	Age 64 and under: $25,000. Benefit reduced to 65% @ age 65 and reduced again @ age 70 to 50%
Life Insurance Benefits	Living Benefit, Waiver of Premium due to total disability prior to age 65. Policy is portable and convertible.
AD&D Benefits	Seat belts, exposure and disappearance, education, speech and hearing, paralysis and felonious assault.

Please review the Plan Summary for further details.

Employee Assistance Program

Covered employee groups are: Administrators, Certificated and Classified Exempt.

CIGNA's Life Assistance[SM] Program helps all covered members and their immediate family members (living in their household) to better balance their work and personal lives with access to online tools, in-person behavioral health assistance and live telephonic counseling - 24 hours a day, seven days a week.

This program focuses on providing consultation, information, success planning and referral to resources for a variety of concerns including:

Adoption (includes online resources)	**Parental Care**	**Summer Care**
Pet Care (includes online resources)	**Parenting**	**Legal Services**
Child Care (includes online resources)	**Special Needs**	**Financial Information**
Senior Care (includes online resources)	**Education** (includes online resources)	

Research and up to 3 qualified referrals within 12 business hours (6 for emergencies)

This program's unique advantages include:

- **Proactive Outreach** – Important outreach features promote usage of Cigna's Life Assistance[SM] program when you need it most. Outreach includes reminders throughout the length of the issue.
- **Emphasis on Personal Interaction** – Cigna's Life Assistance[SM] offers 24 hour live, telephone access to Cigna's licensed behavioral clinicians and up to three, free face to face behavioral counseling sessions with independent specialists when needed.
- **Extensive Network of Behavioral Health Resources** – Cigna Behavioral Health's network of more than 54,000 contracted licensed behavioral health clinicians provide prompt, local access to support.
- **Comprehensive Life Event Services** – Your EAP program offers information and referrals on a wide variety of topics such as finding qualified child care, summer care, senior care facilities, research and information on education programs, adoption, and financial information plus a 30-minute free legal consultation for most legal issues.
- **Unique Health Rewards® Program** – Cigna's Life Assistance[SM] includes Healthy Rewards®, which offers discounts (up to 60%) on a range of health and wellness related services and products including discounts on Jenny Craig, smoking cessation programs, chiropractic care, fitness club memberships, hearing and vision care, massage therapy, acupuncture, pharmacy, vitamins and more.
- **Assessment and Counseling** – Up to three (3) in-person counseling sessions for you and your family members for assessment, problem solving and referral to resources.

To access online resources visit: www.cignabehavioral.com/cgi

To contact a Cigna licensed behavioral clinician call 1-800-538-3543

Voluntary Benefits

The District offers a variety of voluntary benefits to eligible employees on the following pages. *Please be aware that these benefits cannot be paid for from monies from your state allocation*.

Voluntary Short Term Disability/Salary Insurance (All Benefit Eligible Employees)

Our district offers its eligible employees Short Term Disability/Salary insurance through American Fidelity. This policy is designed to provide you with a cash benefit in the event you suffer a qualified short term disability. This plan includes offsets that will subtract any other sources of income, such as Social Security. This plan will not offset income received from sick pay for the first 30 days. Injury or sickness arising out of or in the course of any occupation for wage or profit for which you are entitled to. Worker's Compensation will not be covered under the benefits listed below.

AmFi Brochure #	SB-30485
Benefit Amount	Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month
Waiting Period	0 days for injury / 7 days for sickness (benefits begin on 8th day for sickness)
Benefit Period	90 days

Voluntary Long Term Disability/Salary Insurance (All Benefit Eligible Employees)

Our district offers its eligible employees Long Term Disability/Salary insurance through American Fidelity. Similar to the short term disability policy, the long term disability policy provides you with a cash benefit in the event you suffer a qualified disability. This plan will not offset income received from sick pay for the first 60 days. Injury or sickness arising out of or in the course of any occupation for wage or profit for which you are entitled to Worker's Compensation will not be covered under the benefits listed below. These plans also have limitations and exclusions. Consult the appropriate American Fidelity brochure for details.

Eligible Class	**All Benefit Eligible Employees**
AmFi Brochure #	SB-30486
Benefit Amount	Up to 66 2/3rd% of your monthly income to a maximum of $7,500 per month
Waiting Period	Several Benefit options are available
Benefit Period	To your normal Social Security Retirement Age

The above information does not constitute a contract. It only highlights some general information. These products contain limitations, exclusions, and waiting periods. Please be sure to consult the appropriate WEA Select American Short-Term brochure for a summary of the plan's rates, specific benefits, limitations, exclusions, and elimination period information before making your selection. The brochure is available in the human resource department and/or through an American Fidelity Assurance Company representative at 1-866-576-0201 between 8:00 AM and 5:00 PM or via the Internet at www.americanfidelity.com.

Voluntary Long Term Disability (Administration, Certificated and Classified Exempt Employees)

Voluntary Long Term Disability insurance is available to you through Massachusetts Mutual Insurance Company. If you enroll during your first open enrollment period following your start date, you are guaranteed certain issue amounts. These amounts depend on your job classification and income. The benefit amount, waiting periods, benefit period and costs all vary based on factors such as your age, income and the coverage you selected. See Human Resources for details on this coverage.

Voluntary Life/AD&D Insurance (Classified Employees)

This coverage is provided by Cigna to benefit eligible Classified employees.

Benefit Amount:	Age 64 and under: $25,000. Benefit reduced to 65% @ age 65 and reduced again @ age 70 to 50%
Life Insurance Benefits	Living Benefit, Waiver of Premium due to total disability prior to age 65. Policy is portable and convertible.
AD&D Benefits	Seat belts, exposure and disappearance, education, speech and hearing, paralysis and felonious assault.

Please review the Plan Summary for further details.

Voluntary Life/AD&D Insurance (Administrators, Certificated, Classified Exempt & Classified Employees)

This coverage is provided by Unum to eligible Administrators, Certificated, Classified Exempt and Classified Employees.

Benefit Amount:	**Employee:** Life/AD&D insurance up to $150,000 (in $10,000 increments) **Spouse: Life coverage only.** Up to 50% of the employee elected amount subject to a short Health Evidence form. **Dependent Children: Life coverage only.** Under age 26: Up to $2,000 ($1,000 benefit up to age 6 months.)
Life Insurance Benefits	Living Benefit, Waiver of Premium due to total disability prior to age 65. Policy is portable and convertible.
AD&D Benefits **(available to the employee only)**	Seat belts, airbag, exposure and disappearance, repatriation, education, speech and hearing, paralysis and felonious assault.

See the WEA Select Voluntary Term Life brochure for a summary of the AD&D benefit information as well as the subsidy for this plan.

The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage, please refer to your plan certificate available from your plan administrator.

Section 125 Plan / Flexible Spending Account

Section 125 Plan enables participating employees to reduce their income tax liability by setting aside pre-tax dollars from their earning to pay for out-of-pocket premiums, health care, and dependent care costs.

American Fidelity Assurance Company:

There are three ways to save by participating in the Section 125 Plan – by pre-taxing eligible insurance premiums, by participating in the Dependent Day Care Flexible Spending Account (Dependent Day Care FSA), and by participating in the Health Flexible Spending Account (Health FSA). Consider the following reasons to participate:

- Tax Advantages – Participating in the Section 125 plan helps you lower the amount you pay in taxes and thereby, increase your take-home pay.
- Control – You decide how much to put into the Flexible Spending Accounts.
- Out-of-Pocket Medical / Dental Expenses –You can pre-tax eligible medical and dental expenses, such as orthodontia, copayments, and deductibles. You must have a medical practitioner's prescription on file in order to be reimbursed for over-the-counter drugs and medicines. .
- Dependent Care Expenses – The Dependent Day Care FSA reimburses for certain eligible dependent care costs (e.g., day care) with pre-tax dollars and thus reduces your taxable income.

The eligible insurance plans available under Section 125 include dental, health, and vision insurance. These benefits will automatically be pre-taxed under the plan. If an employee does not want to participate in this plan, they must sign and return a "Premium Payment Plan Refusal" form to Cindy Sage, Payroll by October 3, 2016. Elections made under the Section 125 plan must remain in place for the length of the plan year unless the employee experiences an allowable election change event mid-plan year (consult your employer for more details). An employee cannot change or revoke their Health FSA election during the contract year. Cancellation or changes for this account are allowed only during the next annual open enrollment period.

Employees wishing to participate in either or both Flexible Spending Plans should plan to meet with the plan representative during the month of December to activate or continue their enrollment for the coming calendar year. Any new employees wishing to start a plan immediately after the start of the school year should contact the Payroll and Benefits office for immediate enrollment. Representatives will be available in each building to meet with interested staff on an individual basis in December. Schedule to be posted on the district website in November.

IMPORTANT REMINDER: Employees currently participating in a Flexible Spending plan will need to submit a new election form each year!

Carryover: The Health FSA allows up to $500 of unused contributions to be carried over to the next plan year. This amount will be added to any contributions you elect for the next plan year. The plan allows for a 90 day runoff period after the end of the plan year during which the participant can submit eligible Health FSA or Dependent Day Care FSA claims incurred during the preceding plan year for reimbursement. Any amount over $500 remaining at the end of the runoff period will be forfeited.

To take advantage of the Flexible Spending Accounts, you must complete the appropriate election form with the American Fidelity Representative. All employees participating in the plan need to submit an application for 2016-2017. All employees will need to see the American Fidelity Representative as no manual forms will be accepted.

Credit Union Options

Mountain Crest Credit Union	Inspirus Credit Union (formerly School Employees Credit Union)
877-601-0000	888-628-4010
www.mountaincrestcu.com	www.inspiruscu.org

Active school employees, working in Washington State or retired school employees who live in Washington State, are eligible to become members of the above named Credit Unions. The advantages of joining a Credit Union include paying lower interest rates on loans, Classic Money Market Accounts, Savings Plans, Check Overdraft Protection along with specific accounts just for children. If you'd like more information please contact Cindy Sage in the Payroll Office or the Credit Unions above.

MetLife Auto & Home Insurance

Active and retired employees are eligible for special group rates and discounts on Auto, Home and other types of property and casualty insurance through MetLife. Visit www.metlife.com or contact them at 800-438-6388 for further details.

Tax Sheltered Annuities (TSA)

All employees of the District are eligible to elect to participate in the Tax Sheltered Annuity (TSA) program. TSAs are a unique retirement savings plan available to education employees of certain non profit organizations. For the 2015 calendar year, a participant may elect to contribute a maximum of $18,000 or more (in certain situations) to a Tax-Deferred account available under the plan. Such contribution reduces taxable income and any earnings in the plan are tax deferred. The district's statement of Universal Availability is posted on the district website or contact Cindy Sage, (425) 844-4513.

The District currently works with The Omni Group, a third party administrator of 403(b) plans, to ensure compliance with the IRS regulations governing the operation of 403(b) plans. OMNI is NOT an investment company or service provider. They do NOT offer and cannot recommend any specific investment vehicle. The OMNI Group does provider a user friendly website (www.omni403b.com) where employees can go to make 403(b) elections and changes, in addition to providing consumer education in the form of product neutral video presentation and other materials available on the website regarding financial literacy and retirement planning.

Please note: The Riverview School District does not represent, imply or recommend any specific tax deferred 'type' contracts or accounts. Information provided herein is of a general nature and selection and participation of a TSA program is the sole responsibility of the employee. Advice should be sought from your tax provider as well as any other investment professionals the employee chooses to contact.

Helpful Information

The information on the following pages is presented for your information. If you have any questions on this information, please contact Human Resources.

Family Medical Leave Act of 1993 (FMLA)

The Federal Family Medical Leave Act (FMLA) was signed into law in February 1993. The law guarantees up to 12 weeks of unpaid leave each year to workers who need time off for the 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. Employees are eligible if they worked for a covered employer for at least one year and for 1,250 hours over the previous 12 months.

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.

COBRA and Continuation of Coverage

If you or a qualifying family member have any questions about notices provided to you by your employer or questions about COBRA please contact:

Cindy Sage
Riverview School District
15510 1st Ave NE
Duvall, WA 98019
Mailing: PO BOX 519 Duvall, WA 98019
425-844-4513

School Employees Retirement Systems

If you have questions regarding your retirement information under PERS/SERS/TRS, please contact

Department of Retirement Systems

800-547-6657

www.drs.wa.gov

Healthy Kids Now through Apple Health

Infants through teenagers may be eligible to receive free or low cost health insurance in Washington State. Many families qualify and don't know it. These programs are flexible and cover kids in many types of households. This program covers a full range of services that all children need to stay healthy. For more information, please contact or visit:

Apple Health Hotline

1-877-KIDS-NOW

www.insurekidsnow.gov

Washington State Deferred Compensation Program (DCP)

The Deferred Compensation Program (DCP) helps you save for retirement on a pre-tax basis, offering the options you need to develop a personal investment strategy. With DCP, you authorize your employer to postpone or defer a part of your income, before taxes are calculated, and have that money invested in your DCP account. Both the income you save and the earnings on your investments grow tax-deferred to add to your future retirement and Social Security benefits.

With DCP, you decide how much money you want deducted from each paycheck. That can be as little as $360 per year or as much as the annual legal maximum of $18,000 if you are under age 50 and $24,000 if you are over age 50 for 2016.

How does Deferred Compensation Work?

With DCP, you may elect to defer a portion of your salary until retirement or separation from service. Automatic payroll deduction makes savings easy as the amount you choose to defer is taken from your gross income before taxes. For example, if you are in the 15% tax bracket, for every $100 you earn, you keep only $85 because $15 is withheld for federal income taxes. If you elect to defer $100 into a DCP, your take home pay is only reduced by $85 because the $100 is deferred before taxes are calculated. When deciding how much to save, consider adding that extra income to your deferral amount. It can have a significant impact at the time you retire.

Should you have any questions or would like more information on the Washington State Deferred Compensation Program, contact the DCP at:

Phone: 1-888-327-5596 (Mon-Fri 8:00-5:00pm)

Email: dcpinfo@drs.wa.gov

Mail: PO BOX 40931 Olympia, WA 98504-0931

Workers' Compensation, Occupational Safety & Accident Prevention Program

The Riverview School District is a self-insured district. All claims are handled by the Puget Sound Workers' Compensation Trust. DO NOT FILL OUT OR FILE AN L&I REPORT FROM THE STATE.

Worker's Compensation Claim Procedure

- Go to the district website (www.riverview.wednet.edu).
- On the website under Staff Resources / Employee Forms / Employee Accidents, clink on the link to Web Access Claim Form.
- Click on the Red Online Claim Form in the box in the upper right hand side of the page and follow the directions.

- It is IMPORTANT to file all claims promptly - day of injury if possible.
- If you encounter any issues while filing, please contact Puget Sound Workers' Compensation Trust at 425-917-7667 or at 253-778-7667.
- If you do not have access to a computer, ask your supervisor of building/program secretary for assistance.

Insurance Committee

Your insurance committee is made up of elected representatives from our district. The Committee reviews all the plans available to us from our Insurance Broker and advises District leadership on the benefits offered to employees.

If you are interested in participating on this committee, please contact Human Resources.
Your committee members are:

Dr. Anthony Smith - Superintendent	Gus Kiss - The Partners Group
Bill Adamo - Dir. of Business & Operations	Kenny Strong - The Partners Group
Cindy Sage - Payroll & Benefits Coordinator	Jennifer Spencer - The Partners Group

***Please note that PSE & REA members have not yet been determined.**

Insurance Contact Information

Carrier Name	Coverage	Group/ Policy #	Phone Number	Website
Premera	Medical	8000199	800-932-9221	www.premera.com/wea
Group Health	Medical	0069300	888-901-4636	www.ghc.org
Delta Dental of WA	Dental	186	800-554-1907	www.deltadentalwa.com
Northwest Administrators	Vision	RV	800-732-1123	www.nwadmin.com
Unum/AON Consulting	WEA Voluntary Life/ Disability	W-138 Plan 11	206-467-4646	N/A
Cigna	Long Term Disability	LK-961161	800-362-4462	www.cigna.com
Cigna	Life/AD&D Insurance	FLK-963814 (Life) OK-965449 (AD&D)	800-362-44652	www.cigna.com
Cigna	Employee Assistance Program	N/A	800-538-3543	www.cignabehavioral.com
American Fidelity	WEA Short/Long Term Disability & Flexible Spending Account	N/A	866-576-0201	www.afadvantage.com
Massachusetts Mutual	Voluntary Long Term Disability	N/A	425-285-237	sheri@meachamfi.com
MetLife	Auto & Home Insurance	N/A	800-438-6338	www.metlife.com

Benefit Support Information

Payroll & Benefits	**Cindy Sage**	**425-844-4513 sagec@riverview.wednet.edu**

If you need assistance or have questions on any of your benefits, you can always contact Human Resources or our Insurance Broker.

The Partners Group
Phone: 1-877-455-5640
Kenny Strong or Jennifer Spencer
kstrong@tpgrp.com; jspencer@tpgrp.com

Glossary of Terms

Advanced Diagnostic Imaging – Diagnostic services such as CAT scans, MRIs, and PET scans.

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.

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.

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 the eligible charges and the enrollee will pay 20%.

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

Deductible – The amount of out-of-pocket expenses that must be paid for services by the covered person before the carrier will begin to pay benefits. Please note that your medical deductible is run on a calendar year basis.

Explanation of Benefits (EOB) – A description sent to you by your carrier that describes what benefits were paid for a particular claim.

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. Under a High Deductible Health plan, the full family deductible must be satisfied before benefits are payable under anyone enrolled if there is more than one person enrolled.

Maximum Benefit – The largest dollar amount or number of visits a plan will pay towards the cost of a specific benefit or overall care.

Open Enrollment – A period in which you have an opportunity to make changes in your benefit selections 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%.

Specialty Medication – Medications that treat serious health condition such as cancer and rheumatoid arthritis. They are complex and expensive, and may require intensive monitoring.

Estimating Your Benefit Allocation

This year the state will provide **$780.00** per full time employee to be used to pay for health benefits offered by the district. This rate is effective November 1, 2016. Benefits that must be purchased from those monies are dental, vision, long term disability (for Certificated, Administrative and Classified Exempt employees only.) The remaining funds after those benefits are purchased may be used to purchase medical insurance if you wish to purchase it.

- If you are less than a full time employee, your benefits allocation is pro-rated based on hours worked (see worksheet below to estimate your benefits allocation).

If you decide to change or drop your medical insurance from the previous year, you must contact Cindy Sage, Payroll & Benefits Coordinator and request the appropriate paperwork. Open enrollment periods are listed earlier in this guide.

To Estimate Your Benefit Allocation:

If you are a **CLASSIFIED** employee, begin by inserting the hours you work each day (average if different day to day) and follow the below calculations.

1. Hours worked per day	
2. Multiply by **190** (180 work days + 1 PSE day + 9 holidays)	
3. Divide the result by 1440	
4. Your Estimated Benefit Factor (result cannot be greater than 1.0)	

CLASSIFIED employees, enter your Estimated Benefit Factor (from above) or if you're a **CERTIFICATED** employee, enter in your FTE below.

1. Enter your Estimated Benefit Factor / FTE	
2. Multiply by $780.00 (State allocation for 1.0 FTE)	
3. **Your estimated amount of your benefit allocation**	

How much do I have to apply to medical insurance?

Certificated Employees	**Classified Employees**	
$	$	Estimated Benefit Allocation (from above)
-$109.60	-$113.60	Mandatory Dental Insurance
-$24.50	-$24.50	Mandatory Vision Insurance
-$11.26	N/A	Mandatory Long Term Disability*
$	$	**Estimated Amount Available for Medical Insurance**

*Mandatory for all Admin, Certificated and Classified Exempt employees.

Monthly Insurance Rates for 2016-2017

MEDICAL	Premera Plan 2	Premera Plan 3	Premera Plan 5	Premera EasyChoice A & B	Premera Basic Plan	Premera QHDHP
Employee Only	$979.90	$895.85	$1,133.45	$659.70	$532.55	$516.80
Employee & Spouse	$1,793.75	$1,640.10	$2,178.35	$1,198.70	$966.80	$938.05
Employee & Child(ren)	$1,308.40	$1,196.30	$1,546.60	$875.30	$706.25	$685.30
Family	$2,150.55	$1,966.50	$2,624.25	$1,436.35	$1,158.20	$1,108.40

MEDICAL	Group Health
Employee Only	$815.79
Employee & Spouse	$1,492.58
Employee & Child(ren)	$1,088.94
Family	$1,789.34

DENTAL	Delta Dental w/ Ortho Plan C (Certificated)	Delta Dental w/ Ortho Plan B (Classified)
Composite/Family Rate	$109.60	$113.60

VISION	NBN Vision
Composite/Family Rate	$24.50

The rates for these plans are composite rates. Your premium is the same regardless of the number of people enrolled.

LONG TERM DISABILITY	Cigna (Admin, Certificated, Classified Exempt)
Employee Only	$11.26

LIFE/AD&D	Cigna (Admin, Certificated, Classified Exempt)	Cigna (Classified)
Employee Only	$2.53	$4.31

2016-2017 State Allocation = **$780.00** for full time employees (varies depending on pooling outcome). From the above state allocation, Dental, Vision and Disability are deducted. The amount remaining, depending on pooling outcome, may be applied towards your medical premiums. Retiree medical (**$64.39**) is paid for by the District.

It is recommended that all employees read this page. Because of rate increases, you may now have payroll deduction costs or your current costs may increase with your present medical plan.

Please Note: For Exclusions, Limitations and Clarifications, see the individual plan booklets. This comparison is not a contract.