Seattle Public Schools
Employee Benefits Guidebook
For Newly Eligible Employees

For the Benefits Plan Year of
October 1, 2013 to October 31, 2014
Updated as of August 14, 2013

This benefits guidebook was created by Sprague Israel Giles, Inc. as a service to Seattle Public Schools. While the intention is to be as accurate as possible, if there is a discrepancy with any part of one of the contracts of the benefits program, the actual contract will always prevail. If you have questions about the content of this document, please contact Sprague Israel Giles at (206) 957-7066.

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Summary of Benefits and Coverage (SBC) Notice

Complying with the Affordable Care Act of 2009

IMPORTANT NOTICE REGARDING YOUR COVERAGE

The Patient Protection and Affordable Care Act of 2009 requires all group health insurance plans (such as those offered by Seattle Public Schools) to provide a Summary of Benefits and Coverage (SBC) for each of the health plans offered to eligible employees.

This statement is your notice, as a benefits-eligible employee, that all available SBCs can be found posted in electronic format at the Employee Benefits Website listed below. You may also request an SBC be sent directly to you by calling the Benefits Helpline at (206) 957-7066 or

How to access the SPS Employee Benefits Website:

1. Using the SPS intranet, find Employee Benefits and select the "Benefits Website" link, **or**
2. Using any browser to access the internet, go directly to OurPasswordPage.com and use the password "sps" to enter.

Questions about the SBCs?

Call the Benefits Helpline

(206) 957-7066 or (800) 946-7066

We're open Monday through Friday from 8am - 5pm

We are pleased to be able to provide you with this service.
For questions or comments you may also email us at questions@SIGinsures.com.

Benefits Contact List

For the Plan Year October 1, 2013 to October 31, 2014

Category	Contact	Phone	Fax	Email	Hours	Website
Benefits Helpline	**Sprague Israel Giles, Inc** 1501 Fourth Avenue, #730 Seattle, WA 98101-1637	(206) 957-7066 (800) 946-7066	(206) 682-4993	benefits @siginsures.com	M - F 8 to 5 PST	OurPasswordPage.com Password is "sps"
SPS Human Resources	**Human Resources Dept.** JSCEE Mail Stop 33-157 PO Box 34165 Seattle, WA 98124-1165	(206) 252-0377	(206) 252-0375	hrservicecenter @seattleschools.org	M - F 8 to 5 PST	seattleschools.org/area/hr
Medical Plans	**Group Health Cooperative** 320 Westlake Avenue N, Suite 100 Seattle, WA 98109	(206) 901-4636 (888) 901-4636	-	info@ghc.org	M - F 8 to 6 PST	ghc.org
Medical Plans	**Group Health Options** 320 Westlake Avenue N, Suite 100 Seattle, WA 98109	(206) 901-4636 (888) 901-4636	-	info@ghc.org	M - F 8 to 6 PST	ghc.org
Medical Plans	**KPS Health Plans** PO Box 34803 Seattle, WA 98124	(360) 478-6796 (800) 552-7114	-	customerservice@ kpshealthplans.com	M - F 8 to 5 PST	kpshealthplans.com
Medical Plans	**Premera Blue Cross** PO Box 327 Seattle, WA 98111	(800) 722-1471	-	via website	M - F 8 to 5 PST	premera.com/wea
Dental Plan	**Washington Dental Service** PO Box 75688 NG Station Seattle, WA 98175	(206) 522-2300 (800) 554-1907	-	cservice @deltadentalwa.com	M - F 8 to 5 PST	deltadentalwa.com
Vision Plan	**Northwest Administrators** NBN Vision Care Plan 2323 Eastlake Ave. E Seattle, WA 98102	(206) 329-4900 (800) 732-1123	(206) 528-2326	via website	M - F 8 to 5 PST	nwadmin.com
All Life and Disability Plans	**Standard Insurance** PO Box 2800 Portland, OR 97208-2800	(800) 368-1135	(503) 321-8400	via website	M - F 6 to 6 PST	standard.com
Flexible Spending Account (FSA)	**Flex-Plan Services** PO Box 53250 Bellevue, WA 98015-3250	(425) 452-3500 (800) 669-3539	(425) 451-7002	flexplan @flex-plan.com	M - F 7 to 5 PST	flex-plan.com
Employee Assistance Program (EAP)	**Employee Assistance Program**	(206) 252-4800	-	eap @seattleschools.org	M - F 8 to 5 PST	-
Washington State Pension Plans	**Department of Retirement Systems (DRS)** PO Box 48380 Olympia, WA 98504-8380	(360) 664-7000 (800) 547-6657	-	recep@drs.wa.gov	M - F 8 to 5 PST	drs.wa.gov
403(b) Tax Sheltered Annuity Plan	**Carruth Compliance Consulting, Inc** 11515 SW Durham Rd. STE E-10 Tigard, OR 97224-3476	(503) 968-8961 (877) 222-3090	(503) 968-7802	cccinfo @ncompliance.com	M - F 8 to 5 PST	ncompliance.com Click "Employee Entrance" Click "Seattle Public Schools - WA"
Workers Compensation	**CorVel Corporation** PO Box 230608 Portland, OR 98281	(800) 275-4463 Nurse Hotline: (877) 764-3574	(866) 734-3599	-	M - F 9 to 5 PST	-

Seattle Public Schools
Employee Benefits Website and Helpline

THE BENEFITS WEBSITE IS CUSTOM DESIGNED TO FIT YOUR BENEFITS PACKAGE.

You will find custom documents and useful resource tools.

In addition, benefits summaries and the full insurance contracts are available if you need to investigate details.

Here's What You'll Discover:

- Enrollment information
- Summaries of all our insurance plans
- Access to provider directories
- Complete contact lists
- Enrollment and change forms
- Life and disability information
- Links to state retirement websites
- Complete insurance booklets

How to get there:

- Go directly to
  www.ourpasswordpage.com

  or go to

- **The "inside" Seattle Schools site:**
  - ⇒ **go to the site index**
  - ⇒ **choose Employee Benefits**
  - ⇒ **click on the link provided**

For everyone the password is the same: "**sps**" in lower case letters.

Here's a great tip:

Drag the password page's address to your computer's desktop - at work *and* at home.

This way, 24/7 access to all your benefits information will be quick

Can't find what you're looking for?

Call the Benefits Helpline

206.957.7066 or 800.946.7066

We're open Monday through Friday

8am - 5pm.

We are pleased to be able to provide you with this great service.
For questions or comments on this website please email benefits@seattleschools.org.

New Hire Benefits Checklist

Forms Required to Sign Up for Benefits

Welcome to the Seattle Public Schools!

Please use this employee benefits checklist to help you complete the forms needed to enroll in SPS benefits. All forms must be returned to Human Resources, MS 33-157, within 30 days following your employment date.

Required Forms

☐ **Enrollment & Change Form for Medical, Dental, and Vision Plans**

Dental and Vision: The District's WDS dental and NBN vision plans provide "family coverage" which means that all family members are eligible for coverage along with you at no extra charge. You must complete the enrollment form and indicate every family member who is to be enrolled. The default dental plan is the WDS Incentive Plan.

Medical: You may choose one of the seven medical plan options. If you do not want the District's medical plan for either yourself or your family members, you must check the box in Section 3 where it says, "I Waive Coverage." Complete all sections that apply and be sure the form is signed and dated.

☐ **Group Life & Long Term Disability Insurance Enrollment and Beneficiary Form**

Complete the Standard Insurance Company enrollment and beneficiary form so that we have your beneficiary designation(s) on file. This form can be updated at any time.

☐ **Affidavit of Marriage or Domestic Partnership *(Required to enroll your spouse or partner)***

Complete this form if you plan to cover a spouse or domestic partner on any of your employee benefit plans. If you are enrolling a domestic partner who is also a tax dependent, please complete the *Certification of Tax Status for Domestic Partnership* on the back of the form so that you can pay your portion of your partner's premium with pre-tax dollars.

Forms for Optional Coverage (coverage you pay for entirely via payroll deduction)

☐ **Voluntary Short Term Disability**

This coverage is available to employees who do not have enough sick leave to maintain full pay through the 45-day waiting period before Long Term Disability benefits would begin. This plan is designed to help fill that potential income gap.

☐ **Voluntary Life Insurance**

This additional life insurance provides coverage beyond the District's basic Group Life Insurance. Coverage for your spouse/partner and children is also available.

☐ **Flexible Spending Accounts**

These tax-favored accounts allow you to obtain reimbursement for certain health care or dependent care services with pre-tax dollars. The tax savings equate to a great discount on your predictable out-of-pocket costs.

DEADLINE NOTE: If you begin work on or before the 15th of the month and your paperwork is received by Human Resources on or before the 20th day of that month, your coverage will begin on the first of the following month. However, if your work begins after the 15th of the month or your paperwork is received after the 20th day of the month, your coverage will begin on the first of the month following one full calendar month of employment.

Please make sure that you print legibly. Return all completed forms to Human Resources, MS 33-157.

All your forms must be submitted within 30 calendar days following your employment date.

****If you do not submit your enrollment forms by the deadline, you will not be allowed to enroll until the next Open Enrollment period unless you experience a Qualifying Event.****

General Eligibility and Enrollment Information

What Benefit Plans are Available?

Eligible employees at Seattle Public Schools ("SPS") have access to a wide selection of excellent employee benefits. Enrollment in some plans is mandatory, while enrollment in other plans is optional.

Mandatory employee benefit plans include:

- Dental Insurance
- Vision Insurance
- Group Life Insurance
- Long Term Disability Insurance
- State Pension Plans (DRS)

Optional or voluntary plans include:

- Medical Insurance (plan of your choice)
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Voluntary Term Life Insurance
- Voluntary Short Term Disability Insurance
- 403(b) Tax-Sheltered Annuity (TSA)

Detailed descriptions of these plans can be found by visiting the SPS Employee Benefits Website, found at www.OurPasswordPage.com (password: 'sps'), or by calling the Benefits Helpline at (206) 957-7066.

Eligibility for Benefits

For represented employees, participation in the SPS group benefits program is based upon the eligibility criteria contained in the prevailing collective bargaining agreement. In the case of non-represented employees, participation is based upon the eligibility criteria contained in the Salary & Benefits Package for Non-Represented Employees as most recently approved by the Seattle Public Schools Board of Directors.

It is the employee's responsibility to submit application forms in a timely manner. All applications must be received by Human Resources within 30 calendar days of the initial employment or eligibility date. Employees who do not properly submit applications will be deemed to have waived coverage. (See also *When Coverage Begins*)

Generally, to be eligible for SPS benefit contributions you must be working in a regular, budgeted position of 0.5 FTE or greater and not be covered under another SPS benefits program through a union contract.

If you cease to become eligible for benefits, your coverage may usually be continued for a period of time on a self-pay basis. (See *Leaves of Absence and Benefits*)

Costs and SPS Contributions

Most employees who are eligible for benefits are also eligible to receive a monthly SPS contribution toward the cost of benefits. This contribution will pay all or part of the cost of the plans selected.

SPS contributions may be applied to:

- All mandatory benefits (i.e., vision, dental, group life and long term disability)
- The medical plan of your choice

Many employees have no payroll deductions because the plan elections of their choosing cost less than their SPS contribution. However, if the combined cost of your benefits is not fully covered by the SPS benefit contribution, the excess amount will be your responsibility and will be deducted from your pay warrant each month.

Employees whose total monthly cost exceeds their SPS contribution allowance will be automatically enrolled in the SPS premium conversion plan. This means that premiums will be withheld on a pre-tax basis, unless you are covering a domestic partner who is not your income tax dependent or if you request in writing to pay tax on these expenses. Contact the Benefits Helpline at (206) 957-7066 for more information.

SPS contributions may not be applied to:

- Flexible Spending Accounts
- Voluntary Life Insurance
- Voluntary Short Term Disability Insurance
- Voluntary 403(b) Retirement Plan
- State Pension Plans (DRS)

Some part-time employees receive a prorated or reduced benefit contribution, based on their part-time status. Specifically, prorated contributions apply to part-time Non-represented SPS staff, part-time Machinists and Warehouse Teamsters, and all part-time employees covered by Seattle Education Association bargaining agreements. Prorated contributions do not apply to those represented by Local 609.

If you hold a prorated part-time position, then the amount of SPS money available to you will be proportionate to your FTE status. For example, if you work half-time (0.50 FTE), then you will receive half of the full monthly SPS contribution.

Employees who receive a prorated contribution still have access to the same benefit plans - they just have less SPS money to cover the premiums.

Enrollment Procedures

All enrollment policies and procedures are handled through SPS Human Resources and the employee benefits administrators, Sprague Israel Giles, Inc. Plan elections and changes can only be made during one of three periods:

1. The employee's initial eligibility period (See *Eligibility for Benefits)*
2. The annual Open Enrollment period for that specific plan (See *Three Annual Open Enrollment Periods*)

3. Within 30 or 60 calendar days of a "Qualifying Event" (See *Changing Your Coverage*)

When Coverage Begins

For newly eligible employees: If your hire date is on or before the 15th of the month and your completed enrollment forms are received by Human Resources on or before the 20th day of that month, your coverage will begin on the first of the following month. However, if your hire date is after the 15th of the month or your paperwork is received after the 20th day of the month, your coverage will begin on the first of the month following one full calendar month of employment.

In all cases you must submit your enrollment forms within 30 days of your hire date in order to secure coverage. Employees who do not enroll during this 30-day period will be deemed to have waived coverage and will not be able to enroll until the next annual Open Enrollment period, unless a Qualifying Event occurs.

You may apply for **Voluntary Term Life Insurance** at any time. However, the only time in which employees can be guaranteed to be approved for this coverage is during the initial eligibility period, when first eligible for benefits. The guaranteed term life insurance amount is limited, however, and any amount beyond that would require medical underwriting.

If you apply for voluntary term life insurance after your initial eligibility period, no amount of coverage is guaranteed and the insurance company can deny coverage based on your answers to required health questions. This plan is not eligible for SPS contributions.

Three Annual Open Enrollment Periods

Each year there are three Open Enrollment periods when all eligible employees may change plan enrollment and elections.

- **Medical, Dental, and Vision Plans:** Open Enrollment is generally held mid- August through mid-September for an effective date of October 1. This is the only time for most employees to change medical plans, or add or drop dependents. You may use SPS contributions towards medical coverage. Effective November 1, 2014, the plan year will change to November.
- **Health Care and Dependent Care Flexible Spending Accounts (FSAs):** Open Enrollment is generally from mid-November to early December for an effective date of January 1. This is the only time for most employees to elect to participate or discontinue participation. You must re-apply each year to participate in the FSA program. This plan is not eligible for SPS contributions.
- **Voluntary Short Term Disability:** Open Enrollment is generally mid-February to early March for an effective date of April 1. This is the only time for most eligible employees to elect to participate. You must re-apply each year to participate in the Voluntary Short Term Disability program. This plan is not eligible for SPS contributions.

Coverage for Dependents

Dependents are defined as:

- A legally married spouse
- Children under age 26 whether natural, stepchildren, adopted or those legally placed for adoption
- A domestic partner and his/her dependent children

Legal documentation of adoption and stepchildren is required to prove eligibility as a dependent. In addition, some insurers may require documentation from you to verify the dependent eligibility of spouses, domestic partners, and/or children.

Your dependents may be enrolled for insurance coverage only if you are enrolled as an employee. When enrolled, coverage for eligible dependents becomes effective on the same date as yours, or if they are enrolled under Special Enrollment conditions, on the normal date following proper application.

Eligible dependents are covered under the group dental and vision plans without additional premiums, but employees must complete an Enrollment and Change Form and provide required information about every family member who is to be given vision and dental coverage. Further, employees enrolling a spouse or domestic partner must complete an Affidavit of Marriage or Domestic Partnership. Life and LTD benefits are extended to Domestic Partners (and their children) only if a properly completed Affidavit is on file with SPS.

Medical coverage for dependents is provided if the dependents meet the eligibility requirements and are properly enrolled on your medical plan within 30 calendar days of employment, or during the annual Open Enrollment period. Dependents not previously covered under your medical plan may also have Special Enrollment Rights. (See *Special Enrollment Rights*)

New Dependents

Here are some key items regarding new dependents:

- Newborns are covered from birth, and adopted or step-children from the date of placement, but they must be enrolled in your plan within 60 days of the birth or placement to continue coverage on the medical plan.
- New spouses or domestic partners and their children are eligible for insurance on the first of the month following date of marriage/formation of a domestic partnership, but must be enrolled in your plan within 30 days of the marriage/formation of the domestic partnership.

Any monthly premium costs resulting from the addition of new dependents will generally be effective the first of the month following the date of eligibility or the Qualifying Event.

Overage Dependents and Incapacity

Medical, dental and vision coverage can be continued for an unmarried dependent child over age 26 who is incapacitated or developmentally disabled and chiefly dependent on you for support. You must verify that the child is eligible and submit such evidence as required by the plan insurer (usually within 30 calendar days of the dependent's 26th birthday). Evidence of continued dependency and incapacity may be required

periodically. Coverage may continue for the duration of the incapacity provided the condition existed before age 26 and the coverage does not terminate for any reason.

Special Provisions for Substitutes

Certificated Substitute Teachers who work 60 consecutive work days in the same assignment become eligible to participate in the medical, dental and vision plans only (but not Life or LTD insurance) for a minimum period of three months.

Classified Substitute SAEOPs' or Parapros' health benefits eligibility is the same as for Certificated Substitute Teachers, except SAEOPs and Parapros retain SPS plan benefits eligibility for a minimum of two months.

SPS contributions may continue beyond these two- or three-month periods, on a month-to-month basis, if the same assignment continues without a break in service. However, the rules regarding continuation of health benefits differ based on the assignment and other circumstances. In no circumstances will benefits continue beyond September 30th of each year. Eligibility for benefits must be earned each school year by working 60 consecutive days in the same assignment.

Once a substitute becomes eligible for benefits, actual coverage begins following proper enrollment, in the same manner and time frames as apply for new hires or other newly eligible employees. (See *When Coverage Begins*)

Senior Substitutes are not eligible for SPS contributions but are eligible to purchase medical coverage (or a package of medical, dental, and vision) through self-pay via payroll deduction. Self-pay for life or LTD insurance is not allowed in this circumstance. "Senior Substitute" status is determined by the SPS Human Resources Department. After notification of senior substitute status, senior substitutes will be eligible to enroll at the next medical plan Open Enrollment period. Contact the Benefits Helpline at (206) 957-7066 for more information.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance coverage, you may be able to enroll yourself or your dependents in an SPS plan if you experience an involuntary loss of that other coverage. If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted. To enroll, your completed enrollment request must be received by SPS within 30 days after your other coverage ends. When possible, enrollment in the SPS medical plans will always be such that there is no break in coverage. If the request is received after 30 days from the loss of coverage, you will not be allowed to enroll until the next Open Enrollment period.

In the cases of marriage/formation of a domestic partnership, if the request is received within 30 days of the marriage, enrollment is effective on the first day of the calendar month following the date of the Qualifying Event.

In the case of birth, adoption or placement for adoption, if the enrollment request is received within 60 days of the birth, adoption or placement for adoption, enrollment is effective on the date of the birth or placement for adoption. Otherwise, you will not be allowed to enroll until the next Open Enrollment.

Coordination of Benefits

The Washington State Insurance Commissioner's Office has adopted rules governing coordination of benefits, when someone is covered by two group policies at the same time.

In coordinating benefits, one plan is determined to have primary responsibility for payment of health care benefits. Other plans will then provide reduced benefits so that the total payments made under the combined coverage will not exceed 100 percent of the covered expenses.

It is your responsibility to advise your health care provider of dual coverage. In addition, it is important for you to promptly respond to any written request from your benefits carriers for information concerning coordination of benefits.

Because of the high cost of medical coverage, it may not be to your financial advantage to cover your dependents on a SPS-sponsored plan if your dependents have coverage elsewhere. In addition, if both parents are employees of SPS, only one parent, not both, may insure each child.

Leaves of Absence and Benefits

There are many types of employment leave. If you go on an approved leave from SPS, you will receive a letter from Human Resources designating the type of leave, how long it will last, and other information relevant to your leave.

Depending on the circumstances of your leave (and perhaps the terms of your Collective Bargaining Agreement), contributions for benefits may continue for all or part of your leave. More information is available through Human Resources.

If you are going on leave because you are having a baby, please review the SPS Benefits Helpline Advisor "Having a Baby? Frequently Asked Questions Regarding Leaves and Benefits," which addresses issues specific to pregnancy and maternity leave. (See www.OurPasswordPage.com, password "sps", use the category 'Helpline Bulletins'.)

What Types of Leave Are There?

Child Care Leave:
Certain bargaining agreements allow for Child Care Leave. This provides time during the 12 months following birth (or placement for adoption) to care for your new child. Child Care Leave itself is always an Unpaid Leave, but if you also qualify for FMLA/FLA, where SPS contributions could continue for up to 12 weeks. If your Child Care Leave goes past the end of FMLA period, SPS contributions to plan benefit premiums will end, and you will become eligible to self-pay the cost of your benefits. A letter will be mailed to your home address with

instructions and information about the self-pay system. (See *The Self-Pay Program*)

Washington State Family Care Act (FCA):
FCA allows employees to use available sick leave or other paid time off to care for a sick child with a routine illness; a spouse, parent, parent-in-law or grandparent with a serious or emergency health condition; or an adult child with a disability. SPS contributions for benefits continue during this paid leave.

Sabbatical:
For approved sabbaticals, employees may stay on SPS benefits. Classified sabbaticals are fully paid and employees receive their normal SPS contribution for benefits. Certificated sabbaticals are funded at 50% - employees receive a half-time salary and half of the normal SPS contribution for benefits.

If you are on sabbatical and if the cost of your benefits exceeds the SPS contribution amount, you must continue to pay any premium share no later than 30 days following the due date in order to maintain your coverage.

Approved Leaves for Education, Travel, Etc.:
These types of leave are generally unpaid and SPS contributions for benefits will generally not be available. You would be able to continue your benefits through self-pay, for a maximum of 12 months. (See *The Self-Pay Program*)

Family Medical Leave Act (FMLA):
FMLA provides up to 12 weeks each year of unpaid, job-protected leave to employees who need to care for themselves or certain family members in the event of birth, adoption, or a serious health condition.

Employees are eligible for FMLA leave if they have been employed by SPS for at least one year and have worked 1,250 hours or more in the most recent 12 months.

FMLA leave can be paid leave or unpaid leave. SPS requires that employees first use any available paid or shared leave while on FMLA. Whether it is paid or unpaid leave, SPS would continue its contribution for your benefits for the approved time, but in no case longer than 12 weeks.

Your share of the monthly premiums, if any, would have to continue as well. If your paycheck for any given month is not sufficient to cover the cost of your premium share, you will need to pay SPS your share within 30 days following the due date in order to maintain your coverage.

If your approved leave goes past the end of the 12-week FMLA period, SPS contributions would end unless you remained in paid leave status.

Benefits During a Paid Leave
A "paid leave" occurs when you continue to get paid while on leave, or through the use of paid vacation, sick time, or donated leave. As long as you are still being paid while on a District-approved leave and are enrolled for benefits when the leave began, an SPS contribution toward the cost of your employee benefits would continue. If you shared in the cost of your benefits through a payroll deduction, your deduction for your benefits would continue as well.

Benefits During an Unpaid Leave
If your pay ends while you are still on leave, your status will change to unpaid leave status and SPS contributions for benefits, generally will end as well. (There are some exceptions to this rule – See FMLA or FCA.) In this case, you will be given the opportunity to continue coverage on a "self-pay" basis.

When Do SPS Contributions for Benefits End?
If your unpaid leave status begins on or before the 15th of the month, SPS contributions cease at the end of that same month. If your unpaid leave status begins after the 15th of the month, SPS contributions cease at the end of the following month. When SPS contributions for benefits end, you will have to pay the entire monthly cost yourself to maintain your coverage.

The Self-Pay Program
In most cases, when SPS contributions for your benefits end, a letter is sent to your home address offering you the opportunity to continue your coverage by self-paying the premium for your benefits. You can continue your benefits by self-paying the full premium for as long as your approved leave continues, but not longer than 12 consecutive months. After the self-pay period ends, COBRA eligibility begins. The COBRA period is usually 18 months, but can be longer in some cases.

What Should I Do When I Return From Leave?
If you received SPS contributions for benefits throughout your leave and maintain your benefits; upon your return to employment, no action is required on your part to continue your benefits. However, if you have been on self-pay or COBRA, or if you have allowed your benefits to lapse, you must complete a new Enrollment and Change Form and submit it to Human Resources within 30 days of your return to work to reinstate your coverage as an active employee. Otherwise, you may not be able to enroll until the next Open Enrollment.

Changing Your Coverage

In order to make a change to your election outside your initial eligibility period or the annual Open Enrollment period, you must submit an Enrollment and Change Form within 30 calendar days of a **Qualifying Event** or within 60 days following birth, adoption or placement for adoption. An election change must be on account of and correspond with a change in status that affects eligibility for coverage under an SPS plan.

The following events are examples of Qualifying Events:

- There is a change in the number of dependents (examples: a new birth, a death, marriage/formation of a domestic partnership, adoption or placement for adoption, divorce or legal separation).
- There is an involuntary loss of other group coverage for an employee or dependent. (This does not include voluntary individual coverage and the employee must submit valid documentation from the former plan sponsor to verify.)
- A court orders the employee or dependent to provide coverage of dependents.

- A change in employment status causes a significantly different financial cost (generally, this means a change is costs of $50 or more).

In all cases, the requested change must be consistent with the change in status. Some insurers have varying rules, so please call the Benefits Helpline at (206) 957-7066 for details.

Cancellation of Coverage

Generally, you may cancel your medical coverage or drop dependents from coverage only at the annual Open Enrollment period or if you experience a Qualifying Event. Contact the Benefits Helpline at (206) 957-7066 for specific instructions concerning procedures for canceling coverage.

If you do not cancel coverage within the proper time frames following a Qualifying Event, you may not be able to cancel coverage until the next Open Enrollment period. A cancellation request must be received by Human Resources by the 20th of the month in order for the cancellation to be effective the first of the following month (use the Enrollment and Change Form).

When Coverage Ends

Loss of coverage can occur for several reasons:

- Your employment terminates
- You go on an unpaid leave
- You change to another job that is not eligible for benefits
- You have a reduction in hours causes you to lose eligibility for benefits

If you lose your eligibility on or before the 15th of the month, your coverage will cease at the end of that month. However, if you lose eligibility after the 15th of the month, your coverage will cease at the end of the next month following your change.

If you are a school-year employee and you terminate employment at the completion of your scheduled work year, your coverage will continue through the summer months and end on September 30th (or on July 31st for employees represented by PASS).

COBRA Continuation of Health Benefits

COBRA provides certain employees and dependents the right to temporary continuation of health benefits at group rates. For the purposes of COBRA, health benefits include SPS group medical, dental, vision, and Flexible Spending Accounts.

COBRA coverage, however, is only available when coverage is lost due to certain specific 'COBRA Qualifying Events'. COBRA Qualifying Events for employees include voluntary or involuntary termination of employment for reasons other than gross misconduct, and a reduction in the number of hours of employment. For dependents it also includes the covered employee's becoming entitled to Medicare, death, divorce or legal separation, and for children, loss of dependent child status under the plan rules.

To be eligible for COBRA coverage, you must have been enrolled in an SPS health plan when a COBRA Qualifying Event occurs and the health plan must continue to be offered to active SPS employees.

For more information regarding your COBRA rights and responsibilities see the ***COBRA General Notice*** on the following page and on the Benefits Website at www.OurPasswordPage.com (password "sps"), or call the Benefits Helpline at (206) 957-7066.

Coverage for Retired Employees

Retiree plans are available to eligible retirees through the Washington State Public Employee Benefits Board (PEBB) and are administered by the Washington State Health Care Authority. Call 1 (800) 200-1004 for information. In addition, you may want to consider purchasing individual medical coverage separately. Contact the Benefits Helpline at (206) 957-7066 for information. For Washington Dental Service retiree coverage, call (206) 522-1300.

Patient Protection Disclosure

SPS offers one medical plan (the GHC $500 Plan) that requires the designation of primary care providers by participants or beneficiaries.

If you enroll in the GHC $500 Plan, Group Health Cooperative generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the appropriate network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, please visit the 'Providers' link at the employee benefits website at www.OurPasswordPage.com (password "sps"), or call the Benefits Helpline at (206) 957-7066.

You do not need prior authorization from any of the group health plans offered by SPS or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

The information provided here is for informative purposes only. If there are discrepancies between this document and actual plan contracts, the plan contracts will prevail.

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

**** Continuation Coverage Rights Under COBRA****

Introduction
You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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

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

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

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator Contact Information
Sprague Israel Giles, Inc.
SPS Benefits Administrator
1501 4th Avenue, Suite #730
Seattle, WA 98101-1637
(206) 957-7066

Melissa Sodano
COBRA Administrator
(206) 957-7075

Categories	GHO HDHP 1500 Group #6416800	GHC 500 Group #1450600	GHO OPTIONS Group #6290000	GHO ALLIANT PLUS Group #5667500	KPS VALUE PPO Group #22233	KPS CLASSIC PPO Group #22165	PREMERA PLAN 2 Group #80000207
Annual Deductible	Individual deductible: $1,500 shared in and out of network Family deductible: $3,000 shared in and out of network	$500 per person $1,500 max per family (Fourth quarter carryover applies.)	In Network (GHC): No deductible. Out-of-Network: $200 per person $400 max per family	In Network (GHC): $100 per person. $300 max per family Out-of-Network: $200 per person $600 max per family	Per contract year: Participating: $200 per person with $600 max per family Non-Participating: $1,000 per person $3,000 max per family	Per contract year: $100 per person $300 max per family	$200 per person $600 max per family
Coinsurance, when applicable	In-network: 100% Out-of-network: 80%	In-network: 80% No coverage out of network, except for emergencies	In-network: 100% Out-of-network: 80%	In-network: 90% Out-of-network: 80%	Participating: 80% Non-participating: 50%	Participating: 80% Non-participating: 60%	In-network: 80% Out-of-network: 60%
Your Annual Out of Pocket Expense Limit	In and out-of-network: Individual limit: $5,100 Family limit: $10,200	$2,000 max per person $6,000 max per family	In Network: $2,000 max per person $6,000 max per family Out-of-Network: $2,000 max per person $6,000 max per family	In Network: $1,500 max per person $4,500 max per family Out-of-Network: $3,000 max per person $9,000 max per family	Per contract year: Participating: $2,500 max per person $7,500 max per family Non-participating: $10,000 max per person $30,000 max per family	Per contract year: Participating: $1,500 max per person $4,500 max per family Non-participating: $3,000 max per person $9,000 max per family	Share In and Out-of-Network: $1,500 max per person $4,500 family max (includes deductible)
What DOES NOT Apply to the Out of Pocket Expense Limit?	Nothing - ALL covered services apply to the out-of-pocket expense limit.	Deductible and copays do not apply	Out-of-Network deductible and copays do not apply	Deductible and copays do not apply	Deductible, copays, and audio benefits do not apply	Deductible, copays, and audio benefits do not apply	Copays do not apply
Access to Care; Referrals and Pre-Authorizations	In Network: Your PCP directs your care. Self-referral to most specialists is allowed at Group Health Medical Centers. Out-of-Network: Self-referrals are allowed.	Your Primary Care Physician (PCP) directs your care. Wide range of self-referrals to specialists is allowed at Group Health Medical Centers.	In Network: Your PCP directs your care. Self-referral to most specialists is allowed at Group Health Medical Centers. Out-of-Network: Self-referrals are allowed.	In Network: Your PCP directs your care. Self-referral to most specialists is allowed at Group Health Medical Centers, Virginia Mason, The Everett Clinic. Out-of-Network: Self-referrals are allowed.	Self-referrals are allowed. Pre-authorization is required for certain services.	Self-referrals are allowed. Pre-authorization is required for certain services.	Self-referrals are allowed. Pre-authorization is required for certain services.
Rules for Out of Area Care	Out-of-Network: Subject to deductible then paid at 80%. To avoid balance billing for services that exceed the allowed amount, see First Choice or First Health providers. www.GHC.org www.FCHN.com	ER Care at non-GHC facilities subject to $75 copay (waived if admitted), subject to deductible then paid at 80%. Must notify GHC within 24 hours of inpatient admission. www.GHC.org	Out-of-Network: Subject to $200 deductible then paid at 80%. To avoid balance billing for services that exceed the allowed amount, see First Choice or First Health providers. www.GHC.org www.FCHN.com	Out-of-Network: Subject to $200 deductible then paid at 80%. To avoid balance billing for services that exceed the allowed amount, see First Choice or First Health providers. www.GHC.org www.FCHN.com	Participating Provider benefits available nationwide through the Multiplan network of providers. Emergency care is covered Worldwide. www.KPSHealthPlans.com www.FCHN.com www.Multiplan.com	Participating Provider benefits available nationwide through the Multiplan network of providers. Emergency care is covered Worldwide. KPSHealthPlans.com www.FCHN.com www.Multiplan.com	In-Network benefits available nationwide through BlueCard Program. Coverage available Worldwide. For information, call (800) 810-2583. www.Premera.com www.BCBS.com

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1. **Physician Visits in Office & Clinic**	In and out-of-network: $20 copay and deductible apply, then 100% In-network 80% Out-of-Network	The first four office visits per calendar year are covered with a $20 copayment. Subsequent visits are $20 per visit, subject to the deductible, and covered at 80%.	In Network: $25 copay per visit Out-of-Network: Subject to $200 deductible then paid at 80%. No copay.	Deductible and coinsurance waived In and Out-of-Network: $25 copay per visit	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 50%.	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 60%.	Deductible waived In-Network: $25 copay Out-of-Network: $30 copay
2. **Diagnostic Testing**	In and out-of-network: Deductible applies, then 100% In-network 80% Out-of-Network	The first $500 of lab and x-ray services is covered at 100%. Once the first $500 has been used, deductible applies then coverage is at 80%.	In Network: Covered in full. Out-of-Network: Subject to deductible and paid at 80%.	In and out-of-network: Deductible applies, then 90% In-network 80% Out-of-Network	Deductible applies, then 80% Participating 50% Non-Participating	Deductible applies, then 80% Participating 60% Non-Participating	Deductible applies, then 80% In-Network 60% Out-of-Network
3. **Inpatient Hospital Room and Board, and Ancillaries**	In and out-of-network: Deductible applies, then 100% In-network 80% Out-of-Network	Deductible then covered at 80%	$200 copay per day, for up to 3 days per admission In-Network: Covered in full after copay. Out-of-Network: Deductible applies, then Paid at 80% after copay.	Deductible applies, then $200 copay per day up to 3 days per admission, then 90% In-network, 80% Out-of-Network	Deductible applies, then $300 copay per day to $900 max per person per admission, then 80% Participating, 50% Non-Participating.	Deductible applies, then $200 copay per day to $1000 max per person per admission, then 80% Participating, 60% Non-Participating.	Deductible applies, then Inpatient copay: $150 per day to $450 maximum per person, per calendar year. In-Network 80% Out-of-Network 60%
4. **Prescription Drugs & Insulin (Unless Otherwise Specified)**	In and out-of-network: Deductible applies, then In Network: Formulary Generic: $15 Formulary Brand : $30 Non-Form. Brand: $50 Certain preventive medications (determined by GHO) are covered in full In-Network Out-of-Network: Formulary Generic: $20 Formulary Brand: $35 Non-form. Brand $55	Value Generic: $4 Formulary Generic: $8 Formulary Brand: $25 Non-Formulary: Not covered	In Network: Value Generic: $4 Formulary Generic: $8 Formulary Brand: $25 Non-Form. Brand: $50 Out-of-Network: Formulary Generic: $13 Formulary Brand: $30 Non-form. Brand $55	At GH, VM, or Everett Clinic Pharmacy: Value Generic: $4 Formulary Generic: $8 Formulary Brand: $25 Non-Form. Brand: $50 Out-of-Network: Formulary Generic: $13 Formulary Brand: $30 Non-form. Brand $55	Tier 1: $15 copay Tier 2: $25 copay Tier 3: $50 copay A three month supply for two copays.	Tier 1: $10 copay Tier 2: $30 copay Tier 3: 50% with $100 maximum copayment A three month supply for one copay, for Tier 1 and Tier 2 Drugs only.	Up to a 34 day supply: Generic: $10 copay Preferred Brand: $20 copay Non-Preferred: $35 copay

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5. Mail Order Prescription Drugs & Insulin (Unless Otherwise Specified)	Up to a 90-day supply. Three times retail copay amounts apply if obtained through GHC mail service program. Formulary drugs only	Up to a 90-day supply. Regular copay amounts apply minus a $5 discount per 30-day supply or refill if obtained through GHC mail service program. Formulary drugs only	Up to a 90-day supply. Regular copay amounts apply minus a $5 discount per 30-day supply or refill if obtained through GHC mail service program. Formulary drugs only	Up to a 90-day supply. Regular copay amounts apply minus a $5 discount per 30-day supply or refill if obtained through GHC mail service program. Formulary drugs only	Up to a three month supply for two copays.	Tier 1 and Tier 2 Drugs Only: Up to a three month supply for one copay	Up to a 100 day supply for 1 copay.
6. Preventive Care, Well-Baby Care	In-Network: Covered in full according to the well-care schedule. Out-of-Network: Covered in full, not subject to deductible or coinsurance.	Covered in full when in accordance with the well-care schedule.	In-Network: Covered in full according to the well-care schedule. Out-of-Network: Covered at 80% after deductible is satisfied.	In-Network: Covered in full according to the well-care schedule. Out-of-Network: $25 copay, deductible waived. Routine mammograms covered at 80% after deductible.	Participating: Paid at 100% Non Participating: Paid at 50%, deductible waived.	Participating: Paid at 100% Non Participating: Paid at 60%, deductible waived.	In-Network covered in full deductible waived. Out-of-Network, constant 80% after deductible.
7. Routine Vision Exam	In Network: $20 copay and deductible apply, then covered 100%. Vision exam allowed once every 12 months. Out-of-Network: Not covered.	Vision exam allowed once every 12 months. $20 copay with deductible and coinsurance waived.	In Network: $25 copay. Vision exam allowed once every 12 months. Out-of-Network: Not covered.	In Network: $25 copay. Vision exam allowed once every 12 months. Out-of-Network: Not covered.	Routine vision exams not covered.	Routine vision exams not covered.	Routine vision exams not covered.
8. Routine Hearing Exam & Hearing Hardware	In and out-of-network: $20 copay and deductible applies, then 100% In-network 80% Out-of-Network Hearing exam allowed to determine hearing loss. No hardware coverage.	Hearing Exams to determine hearing loss: $20 copay per visit then deductible then covered at 80%. No hardware coverage.	In Network: $25 copay. Hearing exam allowed to determine hearing loss. No hardware coverage. Out-of-Network: Routine hearing exams subject to deductible and paid at 80%.	In and Out-of-Network: $25 copay. Hearing exam allowed to determine hearing loss. No hardware coverage.	Hearing exams and hardware paid at 80% participating, 50% non-participating up to $125 maximum per contract year. Subject to deductible. Does not apply to OOP Expense limit.	Hearing exams and hardware paid at 80% participating, 60% non-participating up to $125 maximum per contract year. Subject to deductible. Does not apply to OOP Expense limit.	Hearing exams and hardware paid at a constant 80% up to $400 maximum every 3 consecutive calendar years. Subject to deductible.
9. Chiropractors; Manipulations Of Spine And Extremities	In and out-of-network: $20 copay and deductible applies, then 100% In-network 80% Out-of-Network Limited to 10 visits per calendar year.	Self-referrals to GHC providers. $20 copay per visit then deductible then covered at 80% to maximum of 10 visits per calendar year.	In Network: $25 copay per visit, deductible waived Out-of-Network: Subject to $200 deductible then paid at 80%. No copay. Limited to 10 visits per calendar year.	Deductible waived In and Out-of-Network: $25 copay per visit Limited to 10 visits per calendar year.	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 50%. Limited to 24 visits per contract year.	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 60%. Limited to 24 visits per contract year.	Deductible waived In-Network: $25 copay Out-of-Network: $30 copay Unlimited Visits.

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10. **Acupuncture**	In Network: $20 copay, deductible, then covered 100%. Limited to 8 visits per diagnosis per calendar year. Out-of-Network: $20 copay, deductible then paid at 80%. Visit limit subject to medical necessity.	$20 copay per visit then deductible then covered at 80%. Self-referrals to GHC providers for up to 8 visit per diagnosis per calendar year. Additional visits require plan approval.	In Network: $25 copay per visit. Limited to 8 visits per diagnosis per calendar year Out-of-Network: Subject to $200 deductible then paid at 80%. No copay. Visit limit subject to medical necessity.	In and Out-of-Network: $25 copay per visit. Deductible and coinsurance waived. In-Network: Limited to 8 visits per diagnosis per calendar year Out-of-Network: Visit limit subject to medical necessity.	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 50%. Limited to 12 visits per calendar year.	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 60%. Limited to 12 visits per calendar year.	Deductible waived In-Network: $25 copay Out-of-Network: $30 copay Limited to 12 visits per calendar year.
11. **Naturopathic Care**	In-network: $20 copay, deductible, then covered 100%. Self-referrals to GHC providers for up to 3 visit per diagnosis per calendar year. Additional visits available with referral. Out-of-Network: $20 copay, deductible then paid at 80%.	$20 copay per visit then deductible then covered at 80%. Self-referrals to GHC providers for up to 3 visit per diagnosis per calendar year. Additional visits require plan approval.	In-network: $25 copay per visit. Self-referrals to GHC providers for up to 3 visit per diagnosis per calendar year. Additional visits available with referral. Out-of-Network: Subject to $200 deductible then paid at 80%. No copay.	Deductible and coinsurance waived In and Out-of-Network: $25 copay per visit In-network: Self-referrals to GHC providers for up to 3 visit per diagnosis per calendar year. Additional visits available with referral.	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 50%	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 60%	Deductible waived In-Network: $25 copay Out-of-Network: $30 copay
12. **Obstetrics; Initial Newborn Care; Facility and Professional Services** (newborns covered first 3 weeks after birth)	In and out-of-network: Deductible applies, then 100% In-network 80% Out-of-Network Note: Family deductible applies on date of birth if baby is added to insurance plan.	Inpatient: Deductible then covered at 80% Outpatient: $20 copay then deductible then covered at 80%.	$200 copay per day, for up to 3 days per admission In-Network: Covered in full after copay. Out-of-Network: Subject to deductible then paid at 80% after copay.	Subject to deductible and inpatient copay. In Network: Deductible and then covered at 90% Out-of-Network: Deductible then covered at 80%.	Outpatient: Routine OB office visits covered in full. Inpatient: See inpatient hospital, room and board. Newborns: Well-baby nursing care not subject to deductible. 80% par, 50% non-par.	Outpatient: Routine OB office visits covered in full. Inpatient: See inpatient hospital, room and board. Newborns: Well-baby nursing care not subject to deductible. 80% par, 60% non-par.	In-Network 80%, Out-of-Network 60%. Subject to inpatient hospital or outpatient surgery copay and deductible.
13. **Ground and Air Ambulance**	In and out-of-network: Deductible applies, then 100% In-network 80% Out-of-Network	80% (Deductible waived.) Non-emergent inter-facility transfer covered at 80%. Hospital-to-hospital ground transfers covered in full.	Emergency ambulance covered at 80%. Non-emergent inter-facility transfer covered at 80%, except hospital-to-hospital ground transfers covered in full.	Emergency ambulance covered at 80%.	Deductible applies, then covered at 80% Ground - unlimited. Air - $5,000 max per trip.	Deductible applies, then covered at 80% Ground - unlimited. Air - $5,000 max per trip.	80% of allowable charges. Subject to deductible.
14. **Emergency Room Use, in and out of Service Area**	Deductible applies, then covered 100%	$75 copay per visit, waived if admitted, then deductible then covered at 80%.	In-Network: $100 copay per visit at GHC, waived if admitted. Out-of-Network: $100 copay, waived if admitted.	$100 copay, waived if admitted. Deductible and coinsurance apply.	$100 emergency room copay, waived if admitted. After copay, paid at 80%.	$100 emergency room copay, waived if admitted. After copay, paid at 80%.	$75 emergency room copay, waived if admitted. After copay and deductible, paid at 80% of allowable charges.

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15. Outpatient Physical, Speech, Occupational & Licensed Massage Therapy	In and out-of-network: $20 copay and deductible applies, then 100% In-network 80% Out-of-Network Combined limit is 60 visits per calendar year for inpatient and outpatient visits.	$20 copay per visit then deductible then covered at 80% to 60 visits combined for all conditions per calendar year.	In Network: $25 copay Out-of-Network: Subject to deductible then paid at 80%. Combined limit is 60 visits per calendar year for inpatient and outpatient visits.	In and Out-of-Network: $25 copay per visit. Limited to 60 visits combined for all conditions per calendar year.	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 50% Limited to 45 visits per calendar year	Deductible waived Participating Providers: $25 copay per visit Non Participating: $25 copay, then 60% Limited to 45 visits per calendar year	Physical Therapy: In-network: 80% after deductible Out-of-network: 60% after deductible. No limit Other Therapies: Deductible waived. In-network: $25 copay Out-of-Network: $30 copay. Limited to 45 visits per cal. year
16. Inpatient Occupational, Speech & Physical Therapy	In and out-of-network: Deductible applies, then 100% In-network 80% Out-of-Network Combined limit is 60 days per calendar year for network and out-of-network days.	Deductible then covered at 80% up to 60 days per calendar year for all therapies combined.	In-Network: Covered in full after inpatient copay. Out-of-Network: Subject to deductible then paid at 80% after inpatient copay. Combined limit is 60 days per calendar year for network and out-of-network days.	Subject to inpatient copay. In Network: Deductible and then covered at 90% Out-of-Network: Deductible then covered at 80% Combined limit is 60 days per cal. year for network and out-of-network days.	Subject to deductible and inpatient copay. 80% Participating 50% Non-Participating. 120 days maximum per contract year.	Subject to deductible and inpatient copay. 80% Participating 60% Non-Participating. 120 days maximum per contract year.	In-Network 80%, Out-of-Network 60%. Limit: 120 days each calendar year. Subject to inpatient copayment and deductible.
17. Outpatient Day Surgery, Surgery Centers	In and out-of-network: $20 copay and deductible applies, then 100% In-network 80% Out-of-Network	$20 copay then deductible then covered at 80%.	In Network: $100 copay per visit. Out-of-Network: $100 copay. Subject to deductible then paid at 80%	In and Out-of-Network: $100 copay per visit. Subject to deductible and coinsurance.	Deductible applies, then $150 copay per surgery; 80% Participating, 50% Non-Participating	Deductible applies, then $200 copay per surgery; 80% Participating, 60% Non-Participating	Deductible applies, then $100 copay per surgery; In-Network 80%, Out-of-Network 60%
18. Mental Health Care - Inpatient and Outpatient	Inpatient: In and out-of-network: Deductible applies, then 100% In-network 80% Out-of-Network Outpatient: In and out-of-network: $20 copay and deductible applies, then 100% In-network, 80% Out-of-Network	Inpatient: Deductible, then covered at 80%. Outpatient: $20 copay then deductible then covered at 80%.	Inpatient: $200 copay per day, for up to 3 days per admission In-Network: Covered in full after copay. Out-of-Network: Deductible applies, then paid at 80% after copay. Outpatient: In-Network: $25 copay per visit. Out-of-Network: Subject to deductible then paid at 80%.	Inpatient: Deductible applies, then $200 copay up to 3 days per admission, then 90% In-network or 80% Out-of-Network. Outpatient: In-Network: $25 copay per visit. Deductible and coinsurance waived.	Inpatient: Deductible applies, then $300 copay per day to $900 max per person per admission, then 80% Participating or 50% Non-Participating. Outpatient: Participating Providers: $25 copay, then 100%. Non-Participating: $25 copay, then 50%. Not subject to deductible.	Inpatient: Ded applies, then $200 copay per day to $1000 max per person per admission, then 80% Participating, 60% Non-Participating. Outpatient: Participating Providers: $25 copay, then 100%. Non-Participating: $25 copay, then 50%. Not subject to ded.	Inpatient: Ded applies, then copay of $150 per day to $450 maximum per person, per calendar year. Then coinsurance of In-Network 80% or Out-of-Network 60%. Outpatient: $25 copay In-Network or $30 copay Out-of-Network. Not subject to ded.
19. Diabetes Supplies	Insulin, needles, syringes & lancets covered under Prescription Drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies covered under devices, equipment and supplies covered at 50%.	Insulin, needles, syringes & lancets covered under Rx Drugs. External insulin pumps, monitors, testing reagents and supplies covered under devices, equipment and supplies covered at 80%.	Insulin, needles, syringes & lancets covered under Rx Drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies covered under devices, equipment and supplies covered at 80%.	Insulin, needles, syringes & lancets covered under Prescription Drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies covered under devices, equipment and supplies covered at 80%.	Testing strips, insulin agents, syringes & lancets covered under Prescription Benefit. Other supplies are paid under Durable Medical Equipment & Supplies Benefit. Diabetic education: $25 copay, deductible waived.	Testing strips, insulin agents, syringes & lancets covered under Rx Benefit. Other supplies are paid under Durable Medical Equipment & Supplies Benefit. Diabetic education: $25 copay, ded waived.	Covered as any other medical condition. Diabetes Education: In-Network 100%, deductible waived, Out-of-Network 60% after deductible. Insulin/Diabetic Supplies: See Prescription Drugs.

Categories	GHO HDHP 1500 Group #6416800	GHC 500 Group #1450600	GHO OPTIONS Group #6290000	GHO ALLIANT PLUS Group #5667500	KPS VALUE PPO Group #22233	KPS CLASSIC PPO Group #22165	PREMERA PLAN 2 Group #80000207
20. **Skilled Nursing Facility Care**	In and out-of-network: Deductible applies, then 100% In-network 80% Out-of-Network Combined limit of 60 days per calendar year.	Deductible then covered at 80% up to 60 days per calendar year.	In Network: Covered in full. Out-of-Network: Subject to deductible then paid at 80%. Combined limit of 60 days per calendar year.	In Network: Deductible and then covered at 90% Out-of-Network: Deductible then covered at 80%.	$50 copay per admission, then 80% Participating, 50% Non-Participating, in lieu of hospitalization.	$50 copay per admission, then 100% Participating, 60% Non-Participating, in lieu of hospitalization.	$50 copay per calendar year, then 100% of allowable charges after deductible. Subject to plan limitations.
21. **Neurodevelopmental Therapies (for children age 6 and under)**	Inpatient: Deductible applies, then 100% In-network 80% Out-of-Network Combined limit of 60 days per calendar year Outpatient: $20 copay and deductible applies, then 100% In-network 80% Out-of-Network Combined limit of 60 visits per calendar year.	Inpatient: Deductible then 80% up to 60 days per calendar year. Outpatient: $20 copay then deductible then 80% up to 60 visits per calendar year.	In Network: Inpatient covered in full after inpatient copays. Outpatient: $25 copay Out-of-Network, Inpatient or Outpatient: Covered at 80% after deductible and copays. Combined limit of 60 inpatient days per calendar year, and 60 outpatient visits per calendar year.	Subject to deductible and inpatient copay. In Network: Deductible and then covered at 90% Out-of-Network: Deductible then covered at 80% Combined limit of 60 inpatient days per calendar year, and 60 outpatient visits per calendar year.	Deductible applies, then Speech, physical, occupational therapies: 80% Participating 50% Non-Participating.	Deductible applies, then Speech, physical, occupational therapies: 80% Participating 60% Non-Participating.	Inpatient: In-Network 80%, Out-of-Network 60%. Up to 120 days each calendar year. Subject to inpatient copay and deductible. Outpatient: Up to 45 visits each calendar year. In-Network: $25 copay per visit. Out-of-Network: $30 copay per visit. Not subject to deductible.
22. **TMJ Disorder**	Covered subject to applicable outpatient copay, deductible and coinsurance. Combined limit of $1,000 per calendar year with a lifetime maximum of $5,000.	$20 copay per visit then deductible then covered at 80%. Limited to $1,000 per calendar year with a lifetime maximum of $5,000. GHC referral required.	Covered subject to applicable inpatient and outpatient copays, deductible and coinsurance. Combined limit of $1,000 per calendar year with a lifetime maximum of $5,000.	Covered subject to applicable inpatient and outpatient copays, deductible and coinsurance. Combined limit of $1,000 per calendar year with a lifetime maximum of $5,000.	Not covered.	Not covered.	Deductible applies. Non-surgical treatment paid at constant 50% of allowable charges up to a lifetime max. of $1,000. Surgical Treatment – In-Network 80%, Out-of-Network 60%.
23. **Durable Medical Equipment, Supplies, and Prostheses**	Deductible applies, then covered 50%	Covered at 80%. Deductible waived.	In Network: Covered at 80%. Out-of-Network: Covered at 80% after deductible.	In Network: Covered at 80%; deductible waived Out-of-Network: Covered at 80% after deductible.	Deductible applies, then 80% Participating 50% Non-Participating.	Deductible applies, then 80% Participating 60% Non-Participating.	In-Network 80%, Out-of-Network 60%. Subject to deductible.
24. **Home Health Care**	In and out-of-network: Deductible applies, then 100% In-network 80% Out-of-Network. No visit limit.	Covered in full. No visit limit.	In Network: Covered in full. No visit limit. Out-of-Network: Subject to deductible then paid at 80%. No visit limit.	In Network: Covered in full. No visit limit. Out-of-Network: Subject to deductible then paid at 80%. No visit limit.	Prior authorization required. 130 visits maximum per contract year. 80% Participating 50% Non-Participating.	Prior authorization required. 130 visits maximum per contract year. 80% Participating 60% Non-Participating.	$50 copay per calendar year, then skilled care paid at 100% of allowable charges after deductible (Custodial care not covered.) Subject to plan limitations.

Health Savings Account (HSA)
For GHO HDHP 1500 Enrollees

Health Care Bank through Flex-Plan Services, Inc.

Eligibility	Only employees enrolled in the GHO HDHP 1500 may open and contribute to a Health Savings Account (HSA).
Limits on Eligibility	1. If you are covered by any other health insurance policy that is not considered an HDHP, you are not eligible to contribute to a HSA. 2. If you are covered by Medicare, you cannot contribute to a HSA. 3. If you participate in an FSA, HRA or VEBA through your employer or your spouse's employer, you cannot contribute to a HSA.
Summary of Account	A Health Savings Account (HSA) works with a High Deductible Plan (HDHP) and lets you set aside a portion of your paycheck—before taxes—into the account to help you pay for eligible medical expenses.
HSA Features	1. Employee-owned: money in the account is yours and stays with you even if you change jobs. Even if you are no longer covered by an HDHP, your account stays active and you can use remaining funds for eligible medical expenses. 2. Reduces taxable income: money is tax-free when you put it in and when you take it out to cover qualified medical expenses. 3. Grows with you: if you maintain a minimum balance of $2,000, you may invest additional funds in select mutual funds. 4. Helps you plan for the future: after you turn 65, or if you become disabled, your HSA becomes similar to a regular IRA. At that point, withdrawals you use for non-eligible expenses will be taxed at your regular incomes tax rate but won't incur additional penalties.
How to Enroll in and Use Your HSA	1. After you enroll in the GHO HDHP 1500, you will receive an email with instructions for accessing a secure web portal, where you can set up your account with HealthCare Bank, a division of State Bank and Trust, and choose your monthly tax-free contribution to your HSA through SPS payroll. You can use the portal to change your contribution, track your account balance, and view your investment accounts. 2. You will be given a Benny Card that you can use at the point of sale to pay for approved medical expenses. You can also request distributions online for any purchases not made with your Benny Card. Payments will be made based on the available funds in your account.
Eligible Expenses	Health care expenses incurred by you, your spouse, and your children can be reimbursed from your HSA if the expenses are for the diagnosis, care, mitigation, treatment or prevention of disease or for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses solely for cosmetic reasons are generally not considered expenses for medical care. A more complete list of eligible expenses is available on the benefits website and a full list can be found in IRS Publication 502.

This is only a summary of your benefits, the plan contract will prevail if there are any discrepancies. Please consult your benefits booklet for a detailed description.

Health Savings Account (HSA)
For GHO HDHP 1500 Enrollees

Health Care Bank through Flex-Plan Services, Inc.

Reimbursement of Qualified Medical Expenses	1. You do not have to submit receipts to receive your reimbursement. However you need to keep receipts and documentation for each year's federal tax return. 2. You can make a withdrawal at any time, so long as the medical expense was incurred after you enrolled in the HSA. Reimbursements for qualified medical expenses are tax-free. 3. You may also make withdrawals for health expenses for a spouse or children not covered under your HDHP.
Using an HSA with FSA	As long as the FSA (Flexible Spending Account) is limited to dental, vision and/or preventive care expenses, you can have an FSA with the HSA. This type of FSA is typically called a Limited Purpose FSA.
Using an HSA with an HRA or VEBA	Three types of HRAs will work alongside an HSA: 1. An HRA that is limited to dental, vision and or preventive care expenses (just like a Limited Purpose FSA). 2. An HRA that is set up to only reimburse expenses after the HDHP deductible is met. 3. A Retiree HRA that can only reimburse once an individual retires. With a Retiree HRA, an individual is no longer eligible to contribute to their HSA after retirement, once they have access to their Retiree HRA funds.
Maximum Contributions and Timing	For the 2013 tax year, the maximum allowable contribution is $3,250 for single enrollment and $6,450 for family enrollment. In order to contribute the maximum allowable contribution for 2013, you must remain enrolled on the HDHP for all 12 months of 2013. Otherwise, contributions must be prorated for each month you were actually enrolled on the HDHP. Excess contributions must be fixed and are subject to penalties. The 2014 maximum allowable contributions have not yet been determinated by the IRS. HSA contributions must be made by your tax return date for the tax year, not including extensions.
Required Tax Filing	You will need to keep receipts and documentation and are also required to report contributions and distributions on IRS Form 8889, attached to Form 1040. HealthCare Bank will provide necessary information to plan participants after the tax year is complete.
More Information	This is just a brief description of some of the rules surrounding HDHPs and HSAs. For additional information, visit www.flex-plan.com, consult IRS Publication 969 or your tax advisor.

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Dental Plans

Washington Dental Service (WDS)

Plan Name	WDS Incentive Plan (the default plan option)
Plan Number	195
Annual Deductible	$0 per Calendar Year
Annual Benefit Maximum	$2,500 per Calendar Year

	In Network	Out of Network	Out of State
PPO Providers	Delta Preferred Network	Delta Premier Network	National Delta Directory
Class I: Diagnostic and Preventive*	70% - 100%	70% - 100%	70% - 100%
Class II: Restorative*	70% - 100%	70% - 100%	70% - 100%
Crowns and Onlays*	70% - 100%	50%	70% - 100%
Class III: Major	50%	50%	50%
Orthodontia	Not Covered		
Predetermination of Benefits Recommended For:	All Extensive Procedures (This is done so that you can know what kind of cost-sharing you may be responsible for prior to actually receiving the dental services you and your dentist are planning)		
Check Your Benefits	www.deltadentalwa.com You may register here to check plan coverage and eligible benefits by entering your WDS subscriber identification number and last name at this site.		
More Information	Visit the Benefits Website at www.ourpasswordpage.com (password is "sps") or call the Benefits Helpline at (206) 957-7066 or toll free at (800) 946-7066.		

*Incentive eligible procedures: the first year of coverage, 70% of covered benefits are paid for Class I and Class II services. The 70% payment level increases 10% yearly, provided you utilize plan benefits at least once each benefit period. The maximum benefits for Class I and Class II services would be 100% after three years. Failure to use plan benefits once each benefit period causes your payment level to drop by 10% from the previous year's coverage, but never below the original 70%. Each eligible employee and each eligible dependent has individual incentive levels. An incentive level transfer form can be obtained from Human Resources or online at www.ourpasswordpage.com (password: sps).

Note: The SPS Dental Plan allows Coordination of Benefits for those employees that have dual coverage under a spouse or domestic partner who is also employed by SPS. To take advantage of this new benefit enhancement you must have your provider submit the remaining portion of your bill to the plan for secondary coverage.

Dental Plans

Washington Dental Service (WDS)

Plan Name	WDS Value Plan
Plan Number	195
Annual Deductible	$50 per Calendar Year (Waived for Class I services)
Annual Benefit Maximum	$1,500 per Calendar Year

	In Network	Out of Network
PPO Providers	Delta Preferred Network	Any Other Provider
Class I: Diagnostic and Preventive*	100%	Not covered
Class II: Restorative	80%	Not covered
Crowns and Onlays	Covered as Class III	Not covered
Class III: Major	50%	Not covered
Orthodontia	Not Covered	
Predetermination of Benefits Recommended For:	All Extensive Procedures (This is done so that you can know what kind of cost-sharing you may be responsible for prior to actually receiving the dental services you and your dentist are planning)	
Check Your Benefits	www.deltadentalwa.com You may register at the above website to check plan coverage and eligible benefits by entering your WDS subscriber identification number and last name at this site.	
More Information	Visit the Benefits Website at www.ourpasswordpage.com (password is "sps") or call the Benefits Helpline at (206) 957-7066 or toll free at (800) 946-7066.	

Incentive level note: any SPS employee that transfers from the WDS Value Plan to the WDS Incentive Plan will begin at the 80% incentive level upon moving to the WDS Incentive Plan rather than the normal 70%. Other than this one exception, the participation in the WDS Value Plan does not count as credit toward the incentive level plan's incentive level.

Note: The SPS Dental Plans allow Coordination of Benefits for those employees that have dual coverage under a partner who is also employed by SPS. To take advantage of this new benefit enhancement you must have your provider submit the remaining portion of your bill to the plan for secondary coverage.

Vision Plan

Northwest Benefit Network (NBN)

Plan ID Number	SS
Annual Deductible	$0 per Calendar Year
Exam Copay	$0
Materials Copay	$10

	In Network	Out of Network
Vision Network	NBN Panel Providers	Non-Panel Providers
Vision Exam		
Time Limit	One exam every 365 days from date of last like service	
Payment Limit	Paid at 100%	Up to $35 reimbursement
Frames		
Time Limit	One pair every 730 days from date of last like service	
Payment Limit	Paid at 100% of allowed	Up to $30 reimbursement
Lenses		
Time Limit	One pair of lenses every 365 days from date of last like service	
Payment Limits		
Single	Paid at 100% of allowed	$30
Bifocal	Paid at 100% of allowed	$40
Trifocal	Paid at 100% of allowed	$45
Lenticular	Paid at 100% of allowed	$90
Elective Contact Lenses		
Payment Limit	$175	$90
Time Limit	Exam, fitting and contact lenses, in lieu of all other services, every 365 days from date of last like service	
Medically Necessary Contacts		
Payment Limit	Paid at 100% of allowed	$200
Time Limit	One pair of contacts every 365 days from date of last like service	
To Find an In Network Providers	Visit the NW Administrators website at NWAdmin.com and use the “Search NBN Vision Providers” link in the lower left side of the home page.	
More Information	Visit the Benefits Website at www.ourpasswordpage.com (password is “sps”) or call the Benefits Helpline at (206) 957-7066 or toll free at (800) 946-7066.	

Note: The SPS Vision Plan allows Coordination of Benefits for those employees that have dual coverage under a spouse or domestic partner who is also employed by SPS. To take advantage of this new benefit enhancement you must have your provider submit the remaining portion of your bill to the plan under the secondary coverage

Basic Life and AD&D Insurance Plan

The Standard Insurance Company

Plan Type	Basic Life and AD&D Insurance
Plan Number	353414

Coverage Amounts	150% of annual base earnings rounded to the next higher $1,000
Life Reduction Formula	Life insurance amounts will reduce to: - 65% of original benefit at age 70 and - 50% of original benefit at age 75
Accidental Death and Dismemberment (AD&D)	If you sustain an accidental Bodily Injury which results in loss of life, sight, or limb within 365 days of the injury you are entitled to certain additional benefits.
Accelerated Death Benefit	If you become terminally ill and are not expected to live more than 24 months, you may request up to 75% of your life insurance amount to a maximum of $500,000. A doctor must certify your condition in order to qualify for this benefit. The death benefit will be reduced by any benefits already paid under this option.
Seat Belt Benefit	An additional Accidental Death Benefit of equal to your AD&D benefit (up to a maximum of $50,000) will be paid out if you die as a result of an automobile accident and you were wearing a seatbelt.
Conversion Privilege	If your insurance terminates because your employment terminates, you may be entitled to convert all or part of your Group Life Insurance to an Individual Life Policy without submitting evidence of insurability.
Coverage for Dependents	Spouses, domestic partners and each child are covered for at least one -half the amount of your life insurance or $4,000, whichever is less per person.
More Information	Visit the Benefits Website at www.ourpasswordpage.com (password is “sps”) or call the Benefits Helpline at (206) 957-7066 or toll free at (800) 946-7066.

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Long Term Disability Plan

The Standard Insurance Company

Plan Type	Long Term Disability (LTD) Insurance
Plan Number	353414

Percentage Paid	60% of covered monthly earnings; reduced by certain other sources of income including Social Security, other disability income, and income from part-time employment.
Monthly Benefit Maximum	$10,000
Benefits Waiting Period	45 calendar days
Benefit Duration	The maximum benefit period is determined by your age at the start of disability as follows: **Age Disabled** — **Benefits Payable Until/for...** Prior to Age 62 — -To 65, or Social Security Normal Retirement Age, or 42 months, whichever is longer Age 62 — -To Social Security Normal Retirement Age, or 42 months, whichever is longer Age 63 — -To Social Security Normal Retirement Age or 36 months, whichever is longer Age 64 — -30 months Age 65 — -24 months Age 66 — -21 months Age 67 — -18 months Age 68 — -15 months Age 69 and over — -12 months
Own Occupation Period	2 years
Pre-Existing Conditions	There is no limitation of coverage for pre-existing conditions
Total Disability Required?	No, partial disability can be paid (call Helpline for details)
Waiver of Premium	Yes
Survivor Benefit	3 x monthly LTD benefit
Assisted Living Benefit	Yes
Chemical Dependency	24 month lifetime limitation
Mental & Nervous Disability	24 month limitation per period of disability unless confined
More Information	Visit the Benefits Website at www.ourpasswordpage.com (password is “sps”) or call the Benefits Helpline at (206) 957-7066 or toll free at (800) 946-7066.

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Voluntary Life Insurance Plan

The Standard Insurance Company

As a newly hired employee you may purchase Voluntary Term Life insurance in addition to the group term life insurance automatically provided by SPS (equal to 150% of your annual base salary). This new hire period is the only opportunity to purchase this extra life insurance with no health questions asked, up to certain limits.

How Much Additional Life Insurance Can I Purchase Through This Voluntary Program?
For yourself: The minimum amount you may purchase is $20,000; the maximum is $500,000, but no more than 6-times your annual base salary. For example, if your base annual salary is $40,000, then you can purchase up to $240,000. However, the benefit reductions related to age that are in the District's mandatory life insurance plan apply to this Voluntary Life Insurance coverage as well, for both you and your dependents – the benefit is reduced by 35% at age 70 and 50% at age 75.

For family members: If you buy coverage for yourself, then you may also purchase up to half your amount for your spouse or domestic partner and/or fixed amount for your children. For example, if you buy $140,000 for yourself, you can buy up to $70,000 for your partner or spouse. Also, you can buy either $5,000 or $10,000 for your dependent children up to age 25.

Do I Have to Answer Any Medical Questions?
It depends on how much you apply for. As a new employee, the insurance company guarantees that you can buy up to $70,000 of coverage with no medical questions. For your spouse or domestic partner, coverage is guaranteed up to $30,000. For children, it is $10,000. If you apply for any amounts above these limits, you do have to complete health forms to Standard Insurance Company, who reserves the right to deny coverage for the extra amounts.
NOTE: This guaranteed issue is a one-time opportunity. You must enroll within 30 days of when you first become eligible in order to take advantage of the guarantee. Otherwise, when you apply for any amount of voluntary life insurance, you will have to complete the health questionnaire for all amounts.

Are There Other Benefits?
The plan includes a Waiver of Premium feature. If you are approved to receive Long Term Disability benefits from the SPS plan, your voluntary life coverage, including any coverage for family members, will continue without any premium payments. There is also an Accelerated Benefit provision that would allow you to receive up to 75% of your life insurance benefit if you become terminally ill, have a life expectancy of less than 12 months, and meet other eligibility requirements. Other benefits are listed in the full booklet.

When Is Coverage Effective?
Your enrollment form must be signed and dated within 30 days of the date you become eligible for coverage. If your enrollment form is received in Human Resources by the 20th of the month, any guaranteed coverage would begin on the first of the next month. If your enrollment form is received after the 20th of the month, coverage will begin on the first day of the second following month for non-Guaranteed Issue amounts.

What Happens To My Coverage If I Leave Seattle Public Schools?
If you leave the District, you may have the opportunity to keep the insurance that you purchase at special group trust rates, for up to two years, or until you become eligible for another employer's group life insurance plan, whichever occurs first. Or, you can convert coverage to an individual whole life policy.

How Can I Apply for Additional Voluntary Life Insurance Coverage and How Much Will It Cost?
In order to apply for additional life insurance coverage through the District's voluntary life insurance program, you will need to complete and submit the Voluntary Term Life Insurance Enrollment Form. This form is located at the back of this booklet and can always be found at the District's Employee Benefits Website (see below). The formula used to determine the premium can be found on the Enrollment Form.

Resources
You can find more information, summaries and forms posted on the Employee Benefits Website located at www.ourpasswordpage.com (password is "sps") or obtain them by calling the Benefits Helpline at (206) 957-7066 or toll free at (866) 946-7066.

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Voluntary Short Term Disability Plan

The Standard Insurance Company

As a newly hired employee you are eligible to enroll in the Seattle Public Schools' Voluntary Short Term Disability insurance program. Because this coverage is voluntary, you will not be enrolled unless you complete the enrollment section on the VSTD form. Please read this material carefully.

What is Voluntary Short Term Disability (VSTD) Insurance?
Some people call this "paycheck insurance." If you are sick or disabled, this voluntary insurance can provide income to you for up to six weeks. This may be important to newer employees who may not have enough sick leave yet, because the District's Long Term Disability (LTD) insurance does not provide any income until after a 45-day waiting period. This VSTD insurance can fill that income gap. It can cover you when you would have no sick pay during the 45-day wait for LTD benefits.

What Are The Benefits?
The plan pays up to 60% of your weekly base salary, with a maximum of $1,500 payable per week, for covered sicknesses or injuries that are not work-related. Benefits are payable after three days of disability, or after you have used all of your accumulated sick leave, whichever is later. Benefits may continue until LTD benefits begin, or until you are no longer disabled, whichever occurs first.

The plan is designed so that it will not pay in addition to other benefits paid for the same disability. In the unlikely event that you do receive other disability, retirement or unemployment compensation benefits these payments would reduce your VSTD benefit. The plan will pay a minimum benefit of $25 per week.

When Is Coverage Effective?
Your enrollment form must be signed and dated within 30 days of the date you become eligible for coverage. If your enrollment form is received in HR by the 20th of the month, coverage begins on the first of the next month. If your enrollment form is received after the 20th of the month, coverage will begin on the first day of the second following month. If you become insured, you will receive a group insurance certificate containing a detailed description of the policy's coverage provisions.

Monthly Premiums and Your Plan Year Commitment
Your monthly premium is determined by multiplying your annual base salary by one of three rates, which are determined by the amount of sick leave you have. There is a small table on the VSTD form where you can calculate your own monthly cost. When you enroll, you are committing to pay the premiums throughout the plan year, which ends on March 31 each year. There is no opportunity to discontinue coverage prior to that date unless your employment terminates.

Enrollment Requirements
To purchase this coverage, complete the VSTD enrollment form within 30 days of your hire date and submit it to Human Resources. You will not have another opportunity to enroll until the beginning of the new plan year, which begins April 1 of each year. Each year you must meet the eligibility requirements. This VSTD plan is offered every April only to benefit-eligible employees who have accumulated sick leave balances of less than 33 work days as of December 31, of the previous year.

Coverage If You Leave Seattle Public Schools
There is no opportunity to continue coverage if you terminate employment from Seattle Public Schools. Also, coverage ends upon the termination of your employment and no premiums are payable after that time.

Does The Plan Have Any Exclusions?
Yes, disabilities arising from the following causes are not covered: your involvement in any employment for wage or profit; war, acts of war, or substantial armed or military conflict; committing or attempting to commit an assault or felony; active participation in a violent disorder or riot; an intentionally self-inflicted injury, while sane or insane; loss of a professional or occupational license or certification.

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Healthcare and Dependent Care FSA Plans

Flex-Plan Services, Inc.

Eligibility	All Benefits Eligible Employees
Benefit Plans	1. Health Care Flexible Spending Account 2. Dependent Care Flexible Spending Account
Annual Benefits Limitation	1. Health Care Maximum = $2,500 2. Dependent Care Maximum = $5,000
Plan Year	January 1 through December 31
Termination of Participation During the Plan Year	Pre-tax contributions cease at termination of employment. Claims for reimbursements may be submitted for services incurred on or before your termination date.
Dependent Care Expenses	Dependent care expenses are eligible if they enable you or your spouse to be gainfully employed. These expenses can also be reimbursed through the plan if your spouse is disabled or a full-time student.
Medical Related Expenses	Most health care expenses incurred by you and your family not covered by a health insurance plan, such as deductibles and copays, are eligible for reimbursement. See IRC Sec. 213(d). Reimbursement for certain categories of over-the-counter drugs such as allergy medications, antacids, pain relievers, cold medicines, prenatal vitamins only taken in preparation for or during pregnancy, and other drugs used “to alleviate or treat personal injuries or sickness” is allowed with a prescription from a physician.
Time Frame to File Claims	You should submit reimbursement claims during the Plan Year, but in no event later than 90 days after the end of a Plan Year. Any claims submitted after that time will not be considered.
Permitted Changes to Plan Contributions	Qualified change in family or employment status. Please call the Benefits Helpline if you have questions at (206) 957-7066.
More Information	Visit Flex-Plan Services at www.flex-plan.com.

This is only a summary of your benefits, the plan contract will prevail if there are any discrepancies. Please consult your benefits booklet for a detailed description.

403(b) Tax Sheltered Annuity Plans

Carruth Compliance Consulting, Inc.

Carruth Compliance Consulting, Inc.	Carruth Compliance Consulting, Inc. (CCC) provides compliance and plan administration services to Seattle Public Schools, and provides employees with the information they need to take advantage of this tax deferred retirement savings plan.
Information for Employees	CCC provides educational information about advantages of tax deferred savings in general, along with links to websites that provide useful commentary and tools. SPS policies, practices, and procedures are available online, along with enrollment steps, Salary Reduction Agreement forms, and instructions for changing investment companies or contribution amounts. CCC monitors contributions for IRS compliance.
Am I Eligible To Participate?	Yes, if you receive a paycheck for services provided to Seattle Public Schools, then you are eligible to sign up for elective deferrals into the Seattle Public Schools 403(b) Plan.
Why Should I Use This Plan?	There are many ways to save for retirement, including Individual Retirement Accounts (IRAs), your employer's 403(b) plan, deferred compensation, not to mention your own personal investment and savings. Some approaches are tax deferred and others are not. See the Seattle Public Schools section of the CCC website to read about the advantages of **tax deferred savings** and some of the unique features of 403(b) plans.
What Are My Investment Options?	Seattle Public Schools maintains a substantial list of investment companies (vendors) and registered representatives (agents). The Seattle Public Schools section of the CCC website provides information about current vendors available to you and their investment products. Also, if you are interested in an investment company or product that is not currently on the vendor list, information about how this company can be added is provided.
Plan Document for Seattle Public Schools	If you'd like to review the Seattle Public Schools 403(b) Plan Document that governs 403(b) policies for Employees of Seattle Public Schools, you may do so at www.ncompliance.com/guest_employerplandoc.aspx?EmployerID=64.
Questions?	CCC staff members welcome email messages (preferred) or telephone calls with questions about the Seattle Public Schools 403(b) Plan. Contact information for CCC is available at www.ncompliance.com/contact.aspx.
Seattle Public Schools 403(b) Website Access	1. Go to www.ncompliance.com 2. Click on the button labeled “Employee Entrance” 3. Scroll down and click the link “Seattle Public Schools - WA”

This is only a summary of your benefits, the plan contract will prevail if there are any discrepancies. Please consult your benefits booklet for a detailed description.

Health Plan Rates

For the Plan Year October 1, 2013 to October 31, 2014

Premera Plan 2 premiums do not change until November 1, 2013.
All 2013 Open Enrollment premiums are in effect until October 31, 2014.

EMPLOYEE ONLY	
GHO HDHP 1500	$396.27
GHC 500	498.52
GHO Alliant Plus	579.57
GHO Options	587.81
KPS Value Plan	611.42
KPS Classic Plan	628.78
Premera Plan 2	858.30

EMPLOYEE AND SP/DP*	
GHO HDHP 1500	$768.75
GHC 500	946.14
GHO Options	1,093.65
GHO Alliant Plus	1,124.64
KPS Value Plan	1,185.25
KPS Classic Plan	1,238.31
Premera Plan 2	1,574.85

EMPLOYEE WITH ONE CHILD	
GHO HDHP 1500	$553.95
GHC 500	683.32
GHO Options	774.30
GHO Alliant Plus	810.17
KPS Value Plan	854.37
KPS Classic Plan	892.59
Premera Plan 2	1,147.35

EMPLOYEE WITH TWO OR MORE CHILDREN	
GHO HDHP 1500	$553.95
GHC 500	683.32
GHO Alliant Plus	810.17
KPS Value Plan	854.37
KPS Classic Plan	892.59
GHO Options	1,051.25
Premera Plan 2	1,147.35

EMPLOYEE, SP/DP*, AND ONE CHILD	
GHO HDHP 1500	$926.40
GHC 500	1,012.02
GHO Options	1,347.97
GHO Alliant Plus	1,354.89
KPS Value Plan	1,428.20
KPS Classic Plan	1,492.12
Premera Plan 2	1,888.70

EMPLOYEE, SP/DP*, & MORE THAN ONE CHILD	
GHO HDHP 1500	$926.40
GHC 500	1,012.02
GHO Alliant Plus	1,354.89
KPS Value Plan	1,428.20
GHO Options	1,483.62
KPS Classic Plan	1,492.12
Premera Plan 2	1,888.70

*"SP/DP" means spouse or domestic partner

DENTAL AND VISION

All dental and vision plans are full family coverage for the premium amount shown.

DENTAL PLANS

Both Plans are Policy # 195
WDS Incentive Plan $96.00
WDS Value Plan $83.00

VISION PLAN

Policy # SS
NBN Vision Plan . . . . . $ 11.00

Important medical plan policy numbers:

GHO Options Plan #6290000
GHC 500 Plan #1450600
GHO Alliant Plus Plan #5667500
GHO HDHP 1500 Plan #6416800
Premera Plan 2 #8000207
KPS Classic Plan #22165
KPS Value Plan #22233

Basic Life and LTD Rates

The Standard Insurance Company

Monthly Costs for October 1, 2013 to October 31, 2014

Basic Annual Earnings			Monthly Cost
Less than $16,000 per year			$0.00
$16,001	but less than	$17,001	$0.04
$17,001	but less than	$18,001	$0.70
$18,001	but less than	$19,001	$1.18
$19,001	but less than	$20,001	$1.84
$20,001	but less than	$21,001	$2.31
$21,001	but less than	$22,001	$2.98
$22,001	but less than	$23,001	$3.45
$23,001	but less than	$24,001	$4.11
$24,001	but less than	$25,001	$4.59
$25,001	but less than	$26,001	$5.25
$26,001	but less than	$27,001	$5.73
$27,001	but less than	$28,001	$6.39
$28,001	but less than	$29,001	$6.87
$29,001	but less than	$30,001	$7.53
$30,001	but less than	$31,001	$8.01
$31,001	but less than	$32,001	$8.67
$32,001	but less than	$33,001	$9.14
$33,001	but less than	$34,001	$9.81
$34,001	but less than	$35,001	$10.28
$35,001	but less than	$36,001	$10.94
$36,001	but less than	$37,001	$11.42
$37,001	but less than	$38,001	$12.08
$38,001	but less than	$39,001	$12.56
$39,001	but less than	$40,001	$13.22
$40,001	but less than	$41,001	$13.70
$41,001	but less than	$42,001	$14.36
$42,001	but less than	$43,001	$14.84
$43,001	but less than	$44,001	$15.50
$44,001	but less than	$45,001	$15.97
$45,001	but less than	$46,001	$16.64
$46,001	but less than	$47,001	$17.11
$47,001	but less than	$48,001	$17.77
$48,001	but less than	$49,001	$18.25
$49,001	but less than	$50,001	$18.91
$50,001	but less than	$51,001	$21.89
$51,001	but less than	$52,001	$22.55
$52,001	but less than	$53,001	$23.03
$53,001	but less than	$54,001	$23.69
$54,001	but less than	$55,001	$24.17
$55,001	but less than	$56,001	$24.83
$56,001	but less than	$57,001	$25.30
$57,001	but less than	$58,001	$25.97
$58,001	but less than	$59,001	$26.44
$59,001	but less than	$60,001	$27.10
$60,001	but less than	$61,001	$27.58

Basic Annual Earnings			Monthly Cost
$61,001	but less than	$62,001	$28.24
$62,001	but less than	$63,001	$28.72
$63,001	but less than	$64,001	$29.38
$64,001	but less than	$65,001	$29.86
$65,001	but less than	$66,001	$30.52
$66,001	but less than	$67,001	$31.00
$67,001	but less than	$68,001	$31.66
$68,001	but less than	$69,001	$32.13
$69,001	but less than	$70,001	$32.80
$70,001	but less than	$71,001	$33.27
$71,001	but less than	$72,001	$33.93
$72,001	but less than	$73,001	$34.41
$73,001	but less than	$74,001	$35.07
$74,001	but less than	$75,001	$35.55
$75,001	but less than	$76,001	$38.71
$76,001	but less than	$77,001	$39.19
$77,001	but less than	$78,001	$39.85
$78,001	but less than	$79,001	$40.33
$79,001	but less than	$80,001	$40.99
$80,001	but less than	$81,001	$41.46
$81,001	but less than	$82,001	$42.13
$82,001	but less than	$83,001	$42.60
$83,001	but less than	$84,001	$43.26
$84,001	but less than	$85,001	$43.74
$85,001	but less than	$86,001	$44.40
$86,001	but less than	$87,001	$44.88
$87,001	but less than	$88,001	$45.54
$88,001	but less than	$89,001	$46.02
$89,001	but less than	$90,001	$46.68
$90,001	but less than	$91,001	$47.16
$91,001	but less than	$92,001	$47.82
$92,001	but less than	$93,001	$48.29
$93,001	but less than	$94,001	$48.96
$94,001	but less than	$95,001	$49.43
$95,001	but less than	$96,001	$50.09
$96,001	but less than	$97,001	$50.57
$97,001	but less than	$98,001	$51.23
$98,001	but less than	$99,001	$51.71
$99,001	but less than	$100,001	$52.37
$100,001	but less than	$101,001	$55.35
$101,001	but less than	$102,001	$56.01
$102,001	but less than	$103,001	$56.49
$103,001	but less than	$104,001	$57.15
$104,001	but less than	$105,001	$57.62
$105,001	but less than	$106,001	$58.29
More than $106,001 per year			Call 957-7066

These monthly costs reflect a progressive premium subsidy. Call the Benefits Helpline for more information.

Monthly Cost Worksheet

For the Plan Year October 1, 2013 to October 31, 2014

The District provides a monthly benefit contribution that will pay all or part of the cost of your Basic Benefits. Use this worksheet to determine the total monthly cost of your benefits and whether you will have a monthly payroll deduction for these benefits. Enrollment is mandatory and automatic for the dental, vision, and life/long term disability plans, while enrollment in the medical coverage is optional.

The District's Monthly Contribution Allowance for October 1, 2013 is:

Certificated: Fully Funded..... $826.00

Prorated..... Based on FTE*

Classified: Fully Funded..... $833.00

Prorated..... Based on FTE*

***Employees working jobs with prorated benefit contributions:** *Calculate your monthly District contribution. For example, if you work half-time, enter 0.5 as your FTE status. Not all employee groups will have prorated contributions. If you work part-time but your employee group is not subject to proration, use the Fully Funded amount.*

Certificated: Your FTE status _____ x $826.00 = $_____ (*Your monthly District contribution*)

Classified: Your FTE status _____ x $833.00 = $_____ (*Your monthly District contribution*)

Calculate your monthly benefits costs:	**Enrollment**	**Monthly Premium**
Vision:	Required	$ 11.00
Enter Your Dental Rate (See Health Plan Rates page):	Required	$
Enter Your Life/LTD Rate (See Basic Life and LTD Rates page):	Required	$
Enter Your Medical Rate (See Health Plan Rates page):	Optional	$
Total Monthly Cost =		$
Enter your Monthly District Contribution (from above):		$

If your Total Monthly Cost is greater than the District contribution, the difference is what you will pay through payroll deduction. You may want to consider changing to a lower cost medical plan.

Notes:

Dental and Vision - These plans cover you and all your dependents for one monthly premium.

Life and LTD - Your monthly cost for Life and LTD is based on your basic annual earnings (basic annual earnings do not include other income, such as TRI). See the Life/LTD monthly cost table.

Medical - The cost for medical coverage is based on the plan you select and whether you elect to enroll eligible dependents. Be sure to submit the medical enrollment form and an Affidavit of Marriage or Domestic Partnership form (if applicable) within 30 days of your date of hire.

Email benefits@seattleschools.org or call the Benefits Helpline at (206) 957-7066 if you have questions.

Seattle Public Schools 2013-2014

Medical, Dental, and Vision Insurance Plan Enrollment & Change Form

Please print clearly in blue or black ink.
Complete all Sections and read the information on the back page.
You must sign and date the bottom of this form.

For office use only

Effective Date: _____ / _____ / _____

Entered in SAP: _____ / _____ / _____

Sent to Carrier: _____ / _____ / _____

Completed By: _____

Section 1 - Employee Information

Your Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SSN: _____ – _____ – _____ **Birth Date:** ____ /____ /_____ **Hire Date:** ____ /____ /_____ **Gender:** ☐ Female ☐ Male

SPS Employee ID #: _____ **Email Address:** _____

Section 2 - Check All That Apply

☐ New Enrollment *(e.g., I was just hired, am newly eligible for benefits, or previously waived medical coverage)*

☐ Coverage Change Due to Qualifying Event *(Please see rules on the back, supporting documentation may be required)*

Type of Qualifying Event: _____ Date of Qualifying Event: ____ /____ /_____

Section 3 - Select Your Medical Plan. See the detailed plan comparison and costs sheets. You may waive coverage as well.

☐ GHO HDHP 1500 ☐ GHC 500 ☐ GHO Options ☐ GHO Alliant Plus ☐ KPS Value PPO ☐ KPS Classic PPO ☐ Premera Plan 2

☐ I Waive Coverage: *I waive my right to medical coverage this plan year. I have read and understand my Special Enrollment Rights.*

Section 4 - Select Your Dental Plan. Dental and Vision plans are both mandatory and at no cost to you.

☐ WDS Incentive Plan (default) ☐ WDS Value Plan (new)

*(**Note**: The WDS Incentive Plan is the default dental plan. You must elect the WDS Value Plan to be enrolled on it.)*

Section 5 - List Your Dependents. You must list all dependents. Dental and Vision are full family coverage. Medical coverage is optional.

Enter a ☐ Spouse or ☐ Domestic Partner (also submit an *Affidavit of Marriage or Domestic Partnership*)

				Cover on Medical Plan?
Spouse or Domestic Partner's Name	M / F	SSN	Birth Date	☐ Yes/add ☐ No/drop

Enter Dependent Children, under age 26 or disabled (*documentation required to prove disability*)

1. _____	_____	_____ – _____ – _____	____ /____ /_____	☐ Yes/add ☐ No/drop
2. _____	_____	_____ – _____ – _____	____ /____ /_____	☐ Yes/add ☐ No/drop
3. _____	_____	_____ – _____ – _____	____ /____ /_____	☐ Yes/add ☐ No/drop
4. _____	_____	_____ – _____ – _____	____ /____ /_____	☐ Yes/add ☐ No/drop

Section 6 - Employee's Signature and Statement of Acceptance

My signature below indicates that I have read and understand this enrollment form and other descriptive materials provided. This application is binding on me and cannot be revoked nor can coverage be modified except as permitted by law, regulation, and carrier contract. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. This form supersedes all previous forms I have submitted. An eligible individual not listed on this application will be considered as waiving coverage.

Employee Signature: _____ Date of Signature: _____

Return this form within 30 days of your hire date to: **Human Resources, MS 33-157**
PO Box 34165
Seattle, WA 98124

Visit www.OurPasswordPage.com (password: 'sps') for information.
Call the Benefits Helpline if you have questions: (206) 957-7066.

The Following Companies Provide the Medical, Dental, and Vision Benefits to Seattle Public Schools:

Group Health Cooperative	320 Westlake Avenue N, Suite 100 Seattle, WA 98109	(888) 901-4636
Group Health Options Inc	320 Westlake Avenue N, Suite 100 Seattle, WA 98109	(888) 901-4636
KPS Health Plans	PO Box 34803 Seattle, WA 98124	(800) 552-7114
Premera Blue Cross	PO Box 327 Seattle, WA 98111	(800) 932-9221
Washington Dental Service	PO Box 75688 NG Station Seattle, WA 98175	(800) 554-1907
NBN Vision (self-funded plan)	2323 Eastlake Avenue E Seattle, WA 98102	(800) 732-1123

Special Enrollment Rights and Other Important Information

If you decline medical enrollment at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents under a District medical plan, provided you request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. In addition, if you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a District-sponsored medical plan if you or your dependents lose eligibility for that other coverage of if the employer stopped contributing towards that other coverage. In this event you must request enrollment within 30 days after the other coverage ends or after the employer stops contributing towards the other coverage. However, if you voluntarily end your other medical coverage after declining this District-sponsored coverage, you and your dependents may not be eligible to enroll in this plan until the next Open Enrollment period.

The insurance carriers are responsible for the administration of plans being offered and for confidential data. State and Federal law assures that private health information will be held confidential. Please contact the Benefits Helpline at (206) 957-7066 or the carriers' toll free Member Services Departments listed above if you require further information.

The Effective Date of Coverage

All contract, enrollment, and premium changes to Group Health Cooperative, Group Health Options, KPS Health Plans, Washington Dental Service, and NBN Vision Plans become effective October 1, 2013. **For Premera Blue Cross medical coverage, enrollment changes are effective October 1, 2013 while contract and premium changes are effective November 1, 2013.**

For newly eligible employees: If your hire date is on or before the 15th of the month and your paperwork is received by Human Resources on or before the 20th day of that month, your coverage will begin on the first of the following month. However, if your hire date is after the 15th of the month or your paperwork is received after the 20th day of that month, your coverage will begin on the first of the month following one full calendar month of employment. In all cases you must submit your paperwork within 30 days of your hire date in order to secure coverage.

For Qualifying Event changes: To add a spouse or domestic partner, your enrollment form must be received within 30 days of your marriage or formation of domestic partnership. Coverage will be effective on the first day of the month following the marriage or domestic partnership formation.

To add newborns and newly adopted children, your enrollment form must be received within 60 days of birth, adoption or placement for adoption. Coverage will be retroactive to the date of birth, adoption, or placement for adoption.

For other Qualifying Events, your enrollment form must be received within 30 days of the date of the Qualifying Event. The effective date of coverage changes will generally be the first of the month following the date of the Qualifying Event. Coverage changes will generally have effective dates that ensure there is no lapse is coverage between the SPS plan and another group insurance plan. Some exceptions can apply. Please contact the Benefits Helpline at (206) 957-7066 for details. In all cases, election change requests must be on account of and correspond with a Qualifying Event that affect eligibility for appropriate coverage.

Payroll and Tax Information

Payroll deadlines and employee cost shares:

When election changes are approved and processed before the 20th of the month, any employee cost share changes will appear on your pay warrant on the first of the following month. You are responsible for paying any additional premium share for election changes. If your pay warrant does not have sufficient pay to cover your benefits expenses, you must pay the difference within the next 30 days, or your coverage will be cancelled.

Tax treatment of employee cost shares:

In accordance with the SPS Section 125 plan, if you have any payroll deduction for medical premiums, your share of these premiums will be withheld on a pre-tax basis unless you are covering a domestic partner who is not your income tax dependent or if you request in writing to pay tax on these expenses. Contact the Benefits Helpline at (206) 957-7066 for more information.

SEATTLE PUBLIC SCHOOLS

Return to Human Resources, MS 33-157
Call the Benefits Helpline at (206) 957-7066 for assistance

Affidavit of Marriage or Domestic Partnership

A. Marriage:

Employee ID #: _____

I, _____, certify that I and_____
(Print name of employee) *(Print name of spouse)*

were legally married on _____/_____/_____.

Signatures required in Section C

B. Domestic Partnership:

Employee ID #: _____

I, _____, certify that I and_____
(Print name of employee) *(Print name of Domestic Partner)*

established a domestic partnership beginning on _____/_____/_____ and that we:

1. Share the same regular and permanent residence;
2. Have a close personal relationship;
3. Are jointly responsible for the "basic living expenses" as defined below;
4. Are not married to anyone;
5. Are each eighteen (18) years of age or older;
6. Are not related by blood as close as would bar marriage;
7. Were mentally competent to consent to a contract when the domestic partnership began;
8. Are each other's sole domestic partners and are responsible for each other's common welfare.

"Basic living expenses" means the cost of basic food, shelter, and any other expenses of the common household. You and your domestic partner agree that you are both responsible for them, but need not contribute jointly or equally.

Is Your Domestic Partner a Tax Dependent?
Be sure to complete the Certification of Tax Status **on the other side**

Signatures required in Section C

C. Signature (Required for all):

By signing below, you are stating that:

I understand that this Affidavit shall be terminated upon the death of my spouse or domestic partner or by a change of circumstances attested to in this affidavit. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I certify under penalty of perjury, under the laws of the state of Washington, that the foregoing is true and correct. I understand that willful falsification of information on this declaration may lead to disciplinary action, up to and including discharge from employment and/or disenrollment from SPS coverage. I agree to notify Human Resources if there is any change in the circumstances attested to in this declaration within 30 days of the change.

For Employees Enrolling Domestic Partners or Children of Domestic Partners: I understand that the fair market value of the benefits my employer provides for my domestic partner (or my domestic partner's eligible dependent children) will be added to my taxable income, unless I certify that my partner and/or children are my IRS Section 152 tax dependents on page 2 of this document. Should my domestic partnership end, I understand that another Affidavit of Domestic Partnership cannot be filed within 90 days after a request for termination of domestic partnership.

We declare, under penalty of perjury, that the foregoing information provided by us is true and correct and that all provisions of this statement have been met.

_____ _____
Signature of Employee Signature of Spouse or Domestic Partner

_____/_____/_____ _____/_____/_____
Date Date

Certification of Tax Status for Domestic Partnership:

Complete this section if your domestic partner or the children of your domestic partner are your dependents on your federal tax forms. If you have any questions about the tax aspect of this, talk to a tax accountant or other competent tax advisor.

Employee Name: _____ Employee ID #: _____

Any premium contribution that an employee pays for a domestic partner's health coverage or for the partner's eligible dependent children will be made with after-tax dollars, unless the domestic partner and/or children of the domestic partner are the employee's dependents according to Internal Revenue Code Section 152. The employee must certify the tax status of these individuals by checking the appropriate boxes below. Seattle Public Schools assumes no responsibility for the certification, which is entirely the responsibility of the employee. Consult with your tax advisor regarding your specific circumstances.

A. I declare that:

☐ Yes, my domestic partner is my Internal Revenue Code Section 152 tax dependent.

☐ No, my domestic partner is not my Internal Revenue Code Section 152 tax dependent. As a result, I understand that the fair market value of the benefits my employer provides for my partner will be added to my taxable income.

If applicable, name the child or children of your Domestic Partner whom you will also cover on your SPS employee benefits and check the appropriate box below:

Child or children:

_____

_____

B. I certify that:

☐ Yes, my domestic partner's child(ren) is/are my Internal Revenue Code Section 152 tax dependent(s).

☐ No, my domestic partner's child(ren) are not my Internal Revenue Code Section 152 tax dependent(s). As a result, I understand that the fair market value of the benefits my employer provides for them will be added to my taxable income.

C. Signature:

_____ _____

Employee Signature **Date**

Return to Human Resources, MS 33-157
Call the Benefits Helpline at (206) 957-7066 for assistance

Call the SPS Benefits Helpline at (206) 957-7066 for assistance. Forms, benefits information and convenient links can be found at www.ourpasswordpage.com (password: sps).

Basic Life and AD&D Insurance
Beneficiary Form
The Standard Insurance Company

Information About You:

Name	Birth Date	Employee ID #

Work Location and Occupation	Soc. Sec. Number

Life Insurance Beneficiary Designation:

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designations below. If additional beneficiaries are to be named, complete a second form. Your designations will apply to the Group Term Life, Accidental Death, and any Additional Life coverage you purchase through Seattle Public Schools. This form is not valid unless signed, dated, and delivered to your employer during your lifetime.

Primary Beneficiaries:

Full Name	Relationship	Percent Share*
Address	**Birth Date**	**Soc. Sec. Number**
Full Name	Relationship	Percent Share*
Address	Birth Date	Soc. Sec. Number

Contingent Beneficiaries:

Full Name	Relationship	Percent Share*
Address	Birth Date	Soc. Sec. Number
Full Name	Relationship	Percent Share*
Address	Birth Date	Soc. Sec. Number
Full Name	Relationship	Percent Share*
Address	Birth Date	Soc. Sec. Number

* If percentage shares are not given, they will be equal.

_____ ____/____/____

Employee Signature Date

Return to:
JSCEE Human Resources
MS 33-157
PO Box 34165
Seattle, WA 98124

SPS to complete:
Effective Date of Coverage: _____

Processed by: _____

New Hire Voluntary Life
Enrollment and Beneficiary Form

The Standard Insurance Company

As a newly hired employee you are eligible to purchase Voluntary Term Life insurance with up to $70,000 per employee and $30,000 per spouse/domestic partner of Guaranteed Issue coverage. This voluntary coverage would be in addition to the group term life insurance automatically provided by the District – which is equal to 150% of your annual base salary. This is your only opportunity to purchase up to the Guaranteed Issue amount with no health questions asked – read below for limitations. Please read this material carefully.

Enrolling for Voluntary Term Life Insurance

Last	First	Middle	Date of Birth
Address			Employee ID Number
City	State	Zip	Annual Base Salary

Monthly Premium Calculation: Rate Table and Your Monthly Costs

Rates per $1,000	Age < 25 $ 0.05 Age 25–29 $ 0.06	Age 30 – 34 $0.08 Age 35 – 39 $0.09	Age 40 – 44 $0.12 Age 45 – 49 $0.20	Age 50 – 54 $0.30 Age 55 – 59 $0.51	Age 60 – 64 $0.67 Age 65 – 69 $1.27 *Age 70 + $ 2.06

Person to be Insured		**Maximum Available**	**Monthly Rates (based on your age, from table above)**	**Amount To Be Purchased (in $10,000 increments)**	**Your Monthly Cost[1]**	**Medical History Statement Attached [2]**
Employee		6 times annual base salary	$ _____	$_____	$_____	***Required for more than $70,000 for employee or $30,000 for partner***
Spouse or Domestic Partner		Half of employee amount	Same as employee	$_____	$_____	
Children: choose	either	$5,000		$5,000	$1.00 / month	Circle only one amount ⇦
	or	$10,000		$10,000	$2.00 / month	

(1) To calculate Your Cost: Divide Amount Purchased by $1,000, then multiply by Rate. **Example for a 40-year old**: $250,000 ÷ 1,000 = $250. $250 x $0.12 = $30.00 monthly cost.

(2) Each employee applying for more than $70,000 and spouse/domestic partner applying for more than $30,000 must complete a Medical History Statement form and submit it with this application. A Medical History Statement can be found online at **www.ourpasswordpage.com** (password: sps) or call the **Benefits Helpline**: (206) 957-7066 or (800) 946-7066, or send an email to **benefits@seattleschools.org.**
***Note that the benefits above are reduced by 35% at age 70 and 50% at age 75.

SIGNATURE REQUIRED

I understand that if I decline coverage for myself or eligible dependents now, but wish to purchase coverage in the future, I will be required to provide evidence of good health that is satisfactory to Standard Insurance Company and that my request for coverage may be denied. I understand that I will be personally paying for this coverage and authorize Seattle Public Schools to make the appropriate payroll deductions from my wages. If I have applied for Domestic Partner coverage, I have filed a Declaration of Marriage or Domestic Partnership with Human Resources. **You must sign and return this form within 30 days of your employment eligibility date to be eligible for Guaranteed Issue coverage. The effective date of this coverage is the same as the effective date of your District-paid benefits.**

Check one: _____ I ELECT to enroll for coverage _____ I DECLINE to enroll

Signature: _____ **Date:** _____

Please complete the reverse side of this enrollment form to record your beneficiary information.

Voluntary Term Life Insurance Beneficiary Designation

It is preferable that you name both **primary** and **secondary** beneficiaries. Please indicate each beneficiary's full name, address, social security number, relationship (or "Not Related"), date of birth and distribution percentage. If you name more than one beneficiary with unequal shares, please show the percentage to be paid to each beneficiary, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

Standard Insurance Company automatically considers a District employee to be the primary beneficiary of any benefits payable due to the loss of a spouse/domestic partner or child.

This beneficiary designation will apply to your Voluntary Term Life coverage. Special instructions regarding benefit payments or changes to beneficiary designations should be submitted, in writing, to Human Resources.

If you need assistance, contact the **Benefits Helpline** at (206) 957-7066, (800) 946-7066 or benefits@seattleschools.org.

Employee Information

Last	First	Middle	Date of Birth
Address			Employee ID Number
City	State	Zip	Annual Base Salary

Beneficiary Information

	%	Full Name	Address	SSN	Relationship	Date of Birth
Primary						
Secondary						

Signature: _____ **Date:** _____

If You Need More Information or Assistance

- **Important Questions & Answers** about Voluntary Term Life insurance coverage can be found on the back of this page.
- Contact Seattle Public Schools' **Benefits Helpline** at (206) 957-7066 or (800) 946-7066, or **benefits@seattleschools.org**
- Look on the web at: **www.OurPasswordPage.com** (Password: sps)

Return this form to Human Resources: JSCEE MS 33-157 PO Box 34165 Seattle WA 98124

You must sign/return this form within 30 days of your employment eligibility date to be eligible for Guaranteed Issue coverage.

Voluntary New Employee
STD Enrollment Form

The Standard Insurance Company

As a newly hired employee you are eligible to enroll in the Seattle Public Schools' Voluntary Short Term Disability insurance program. Because this coverage is voluntary, you will not be enrolled unless you complete the enrollment section below and submit this form within 30 days of your benefits eligibility date (usually your hire date). Please read this material carefully.

To Purchase Voluntary Short Term Disability Insurance, Complete the Following Sections

1. Information About You

Last	First	MI		Date of Birth
Address				SPS Employee ID Number
City	State	Zip		Home Phone Number

2. Calculate Your Monthly Premium

(i.e., multiply your annual salary by .000458)

Your base annual salary **Multiplied by**

$_____ **.000458** **Equals your monthly cost: $_____**

(Examples: $24,000 x .000458 = $10.99 a month; $32,000 x .000458 = $14.66 a month)

Transferring in with Sick Leave? **Do you already have Accumulated Sick Leave?**

If you are transferring sick leave from another district or have accumulated sick leave already from previous employment, this **may make you ineligible to receive benefits**. Call the **Benefits Helpline** at (206) 957-7066 or (800) 946-7066 for more information.

3. Check the Box to Indicate Your Election, Read This Important Information and Sign Below

☐ **I elect coverage,** and understand that I will be personally paying for this coverage. I authorize Seattle Public Schools to make the appropriate payroll deductions from my wages until the next plan year beginning April 1. I understand that I cannot revoke my election or discontinue my payroll deduction prior to that time**.**

☐ **I decline to enroll,** and understand I will not be allowed to enroll unless I am determined to be eligible during the next annual open enrollment period**.**

You must sign and return this form within 30 days of your employment eligibility date to be eligible for coverage.

Signature: _____ **Date:**_____

Return this form to Human Resources: JSCEE MS 33-157 PO Box 34165 Seattle WA 98124

You must sign and return this form within 30 days of your employment eligibility date to be eligible for coverage.

SEA

SEATTLE PUBLIC SCHOOLS

FLEXIBLE SPENDING ARRANGEMENT ENROLLMENT FORM

FOR PLAN YEAR JANUARY 1, 2013 *through* DECEMBER 31, 2013

Section I – Employee Information

Last Name, First Name	Employee ID#	Employee SSN

Address City St Zip

Email DOB (MM-DD-YYYY) **If outside open enrollment: Effective Date**

Instructions

1. Complete Section I — Employee Information. Fill this section out completely to ensure proper enrollment.
2. Complete Section II — Elections. Indicate the benefits you will enroll in and the per plan year and per paycheck deduction amounts.
3. Complete Section III — Signature. Return the enrollment form to the appropriate contact by the specified deadline.

Premium Conversion The group insurance premiums you pay through your paycheck are taken pretax *Premium contributions toward domestic partner coverage will be deducted post-tax unless they qualify as a tax dependent.*	Automatic

Section II – Elections

Benefit	Yes/No	Annual Election	# Paychecks	Paycheck Deduction
Health Care FSA Maximum of $2,500.00 per plan year	❑ Yes ❑ No	$_____ per plan year	_____	$_____ per paycheck
Limited Health Care FSA **(For Health Savings Account (HSA) Participants. The Limited FSA reimburses only dental, vision & preventive expenses.)** Maximum of $2,500.00 per plan year	❑ Yes ❑ No	$_____ per plan year	_____	$_____ per paycheck
Day Care FSA Maximum of $5,000.00 per plan year ($2,500 if married, filing separately)	❑ Yes ❑ No	$_____ per plan year	_____	$_____ per paycheck
Direct Deposit Reimbursements are electronically deposited into your bank account.	❑ Yes ❑ No	❑ Checking ❑ Savings	**Routing #**_____ **Account #**_____	

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for qualifying day care expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above.

Section III – Signature

❑ YES, the above benefits have been explained to me and I elect to participate as indicated.

❑ NO, the above benefits have been explained to me and I decline participation.

X _____ _____

Employee Signature **Date**

Completed enrollment form must be returned to: **Mailstop 33-157 (within 30 days of your hire date)**

Please see the reverse for important information regarding the above benefits.

Additional Information

- **Premium Conversion:**
  - If the enrollment status is marked as 'AUTOMATIC', you must notify your employer in writing to decline enrollment in this benefit. Premium Conversion is subject to the change in status rules and is considered an election equal to the amount of your premium deductions.

- **Health Care Flexible Spending Arrangement ("Health Care FSA"):**
  - Reimbursement will only be available for qualifying medical care expenses as set forth in the Plan Document and Section 213 of the Internal Revenue Code. It is your responsibility to check the eligibility of an expense prior to enrollment.
  - Group Medical Plan Premiums cannot be reimbursed through the Health Care FSA and will be deducted pre-tax through the Premium Conversion Plan. Therefore, do not include the cost of premiums in your FSA annual election amount.

- **Limited Health Care Flexible Spending Arrangement ("Limited Health Care FSA"):**
  - If you participate in a Health Savings Account (HSA) then you may not participate in the regular Health Care FSA. The limited Health Care FSA is available for reimbursement of dental, vision, and orthodontia expenses only. See your Summary Plan Description for more information.

- **Day Care Flexible Spending Arrangement ("Day Care FSA")**
  - Reimbursement will be available only for qualifying day care expenses as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description.
  - Participation in a Day Care FSA will require you to complete tax form 2441 when filing federal taxes. If your plan includes a Grace Period any amounts carried forward or forfeited during a taxable year should be entered in Line 13 of Form 2441. If you or your spouse is a full-time student, please consult IRS Publication 503.
  - If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the $5,000 calendar year limit mandated by the IRS.

- **Use-It or Lose-It**
  - You must claim all elected funds by the end of the run-out period. Money left in the plan after the end of the run-out period cannot be refunded to you; this is referred to as the Use-it or Lose-it rule.

Lost Checks and Reissues

- Lost or stale dated FSA checks can be reissued 10 business days after the original check date. There is a $25.00 check reissue fee. The check reissue request will require at least one business day to process.

- Any fees associated with presenting a canceled check will be deducted from your FSA as well as the face value of the check.

Direct Deposit

- All electronic funds transfers (EFT) will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account.

- Returned items due to incorrect banking information will be assessed a $10.00 fee that will be deducted from your FSA balance.

Deductions

- FSA deductions will be deducted from your paycheck evenly throughout the plan year. You must indicate an annual election and a per paycheck deduction on your enrollment form.

Change in Status

- All elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in status. Please consult the plan document or summary plan description for a list of qualifying events.

- In the event of a change in status the change in election must be necessitated by and consistent with the change in status and the change must be acceptable under IRS Regulations.

Eligibility

- Independent contractors and self employed individuals are not eligible to participate in the Plan. Self employed individuals include: Sole Proprietors of their own business; General Partners in a general partnership and General Partners in a limited partnership; Limited Partners of partnerships with guaranteed payments; more than 2% Shareholders of an S corporation as well as the spouse, children, parents and grandparents of a more than 2% Shareholder; and non-employee Members of an LLC. It is your responsibility to determine your eligibility.

- Expenses must be incurred during the plan year and while you are an active participant in the plan. Any expense incurred prior to your effective date or after your termination date cannot be reimbursed.

Electronic Disclosure Notice

- By providing your email address you consent to receive email communications from Flex-Plan, agents, and subcontractors regarding the Plan.

- If you no longer wish to receive information electronically, you may withdraw consent at anytime at no cost. To withdraw consent, please contact Flex-Plan.

- You have a right to receive a paper version of an electronically furnished document at no cost.

- To access documents you must have Adobe Reader. A link to download this software will be provided with all electronic documents provided.