Seattle Public Schools

Employee Benefits Guidebook

For the Benefits Plan Year of
November 1, 2018 to October 31, 2019

Updated as of September 1, 2018

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, SPS benefit policies, or plans; 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 toll free at (800) 946-7066.

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 November 1, 2018 to October 31, 2019

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	**Kaiser Foundation Health Plan of Washington** 601 Union Street, Suite 3100 Seattle, WA 98101	(206) 901-4636 (888) 901-4636	-	via website	M - F 8 to 5 PST	kp.org/wa
Medical Plans	**Kaiser Foundation Health Plan of Washington Options, Inc** 601 Union Street, Suite 3100 Seattle, WA 98101	(206) 901-4636 (888) 901-4636	-	via website	M - F 8 to 5 PST	kp.org/wa
Dental Plans	**Delta Dental of Washington** 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)	**Navia Benefit Solutions** PO Box 53250 Bellevue, WA 98015-3250	(425) 452-3500 (800) 669-3539	(425) 451-7002	customerservice @naviabenefits.com	M - F 5 to 5 PST	naviabenefits.com
Health Savings Account (HSA)	**Avidia Bank/Navia Benefit Solutions** PO Box 53250 Bellevue, WA 98015-3250	(425) 452-3500 (800) 669-3539	(425) 451-7002	customerservice @naviabenefits.com	M - F 5 to 5 PST	naviabenefits.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	-

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 submitted via the NeoGov electronic form submission system or in paper form directly to SPS 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 Delta 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 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.

On paper forms, please print legibly. Return all paper forms to SPS 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 in September for an effective date of November 1. This is the only time for most employees to change medical plans, or add or drop dependents. SPS contributions are applied to mandatory coverage first (dental, vision, life insurance, and long term disability), the remainder, if any, is then put towards medical coverage.

- **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. 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.
- With the qualifying event of birth (or adoption) the new dependent's coverage, as well as any other family members, will become effective on the newborn's DOB (or the day the child is placed with subscriber for the purpose of adoption). Premium will be charged for the first full month following birth or adoption.

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

Substitutes 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.

SPS contributions may continue beyond this three-month period, on a month-to-month basis, if the substitute continues in same assignment continues without a break in service. The rules regarding continuation of health benefits after the assignments ends differ based on bargaining agreement, the assignment and other circumstances.

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*)

Self-Pay 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. Eligibility is determined by the SPS Human Resources Department. After notification of eligibility, these substitutes will be eligible to enroll at the next medical plan Open Enrollment period, and pay applicable premiums through payroll deduction. 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 yourself or your dependents on a SPS-sponsored plan if you or your dependents have coverage elsewhere. In addition, if both parents are employees of SPS, only one parent, not both, may insure each child. But these children may not have dual medical coverage through SPS-sponsored plans.

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, 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 that is $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

You may only cancel your medical coverage or drop dependents from coverage 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 that 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 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.

Coverage for COBRA beneficiaries who reach age 65 will end on the last day of the month that they attain age 65.

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 Delta Dental of Washington retiree coverage, call (206) 522-1300.

Patient Protection Disclosure

SPS offers two medical plans (the KPWA HMO 500 and KPWA HMO Classic plans) that require the designation of primary care provider by participants and beneficiaries.

If you enroll in an HMO plan, Kaiser Permanente of WA 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 the 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 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

Nikki Turpin
COBRA Administrator
(206) 957-7075

Health Plan Rates

For the Plan Year November 1, 2018 to October 31, 2019

All 2018-2019 plan year premiums shown below are in effect until October 31, 2019.
Below, within each category of enrollment, plans are sorted from least to most expensive monthly premium.

EMPLOYEE ONLY	
KPWA Access Basic	$535.08
KPWA Access HDHP	541.69
KPWA HMO 500	595.76
KPWA Access Value	663.34
KPWA HMO Classic	691.46
KPWA Access Plus	694.18
KPWA Access Century	769.47

EMPLOYEE AND SP/DP*	
KPWA Access Basic	$1,037.28
KPWA Access HDHP	1,050.10
KPWA HMO 500	1,154.91
KPWA Access Value	1,285.92
KPWA HMO Classic	1,340.43
KPWA Access Plus	1,345.71
KPWA Access Century	1,461.99

EMPLOYEE WITH ONE CHILD	
KPWA Access Basic	$747.68
KPWA Access HDHP	756.92
KPWA HMO 500	832.47
KPWA Access Value	926.90
KPWA HMO Classic	966.20
KPWA Access Plus	970.01
KPWA Access Century	1,000.31

EMPLOYEE WITH TWO OR MORE CHILDREN	
KPWA Access Basic	$747.68
KPWA Access HDHP	756.92
KPWA HMO 500	832.47
KPWA Access Value	926.90
KPWA HMO Classic	966.20
KPWA Access Plus	970.01
KPWA Access Century	1,385.04

EMPLOYEE, SP/DP*, AND ONE CHILD	
KPWA Access Basic	$1,205.86
KPWA Access HDHP	1,265.33
KPWA HMO 500	1,391.62
KPWA Access Value	1,549.49
KPWA HMO Classic	1,615.17
KPWA Access Plus	1,621.54
KPWA Access Century	1,769.77

EMPLOYEE, SP/DP*, & MORE THAN ONE CHILD	
KPWA Access Basic	$1,205.86
KPWA Access HDHP	1,265.33
KPWA HMO 500	1,391.62
KPWA Access Value	1,549.49
KPWA HMO Classic	1,615.17
KPWA Access Plus	1,621.54
KPWA Access Century	1,923.67

*"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 with Delta Dental of WA

Delta Incentive Plan (#0195) $78.50

Delta Value Plan (#0295) $65.50

VISION PLAN

Policy # SS

NBN Vision Plan $8.50

Important medical plan policy numbers:

KPWA Access Century Plan #6290000

KPWA HMO 500 Plan #1450600

KPWA Access Plus Plan #6514100

KPWA Access HDHP Plan #6416800

KPWA Access HDHP Family Plan #6416900

KPWA HMO Classic #1664800

KPWA Access Value Plan #6514000

KPWA Access Basic Plan #6513900

Basic Life and LTD Rates

The Standard Insurance Company

Monthly Costs for November 1, 2018 to October 31, 2019

Basic Annual Earnings			Monthly Cost
Less than $5,000 per year			$0.00
$5,000	but less than	$6,000	$4.27
$6,000	but less than	$7,000	$4.81
$7,000	but less than	$8,000	$5.55
$8,000	but less than	$9,000	$6.09
$9,000	but less than	$10,000	$6.83
$10,000	but less than	$11,000	$7.37
$11,000	but less than	$12,000	$8.11
$12,000	but less than	$13,000	$8.65
$13,000	but less than	$14,000	$9.39
$14,000	but less than	$15,000	$9.93
$15,000	but less than	$16,000	$10.67
$16,000	but less than	$17,000	$11.21
$17,000	but less than	$18,000	$11.95
$18,000	but less than	$19,000	$12.49
$19,000	but less than	$20,000	$13.23
$20,000	but less than	$21,000	$13.76
$21,000	but less than	$22,000	$14.51
$22,000	but less than	$23,000	$15.04
$23,000	but less than	$24,000	$15.79
$24,000	but less than	$25,000	$16.32
$25,000	but less than	$26,000	$17.07
$26,000	but less than	$27,000	$17.60
$27,000	but less than	$28,000	$18.35
$28,000	but less than	$29,000	$18.88
$29,000	but less than	$30,000	$19.63
$30,000	but less than	$31,000	$20.16
$31,000	but less than	$32,000	$20.90
$32,000	but less than	$33,000	$21.44
$33,000	but less than	$34,000	$22.18
$34,000	but less than	$35,000	$22.72
$35,000	but less than	$36,000	$23.46
$36,000	but less than	$37,000	$24.00
$37,000	but less than	$38,000	$24.74
$38,000	but less than	$39,000	$25.28
$39,000	but less than	$40,000	$26.02
$40,000	but less than	$41,000	$26.56
$41,000	but less than	$42,000	$27.30
$42,000	but less than	$43,000	$27.84
$43,000	but less than	$44,000	$28.58
$44,000	but less than	$45,000	$29.12
$45,000	but less than	$46,000	$29.86
$46,000	but less than	$47,000	$30.40
$47,000	but less than	$48,000	$31.14
$48,000	but less than	$49,000	$31.68
$49,000	but less than	$50,000	$32.42
$50,000	but less than	$51,000	$32.95
$51,000	but less than	$52,000	$33.70
$52,000	but less than	$53,000	$34.23
$53,000	but less than	$54,000	$34.98
$54,000	but less than	$55,000	$35.51
$55,000	but less than	$56,000	$36.26
$56,000	but less than	$57,000	$36.79
$57,000	but less than	$58,000	$37.54
$58,000	but less than	$59,000	$38.07
$59,000	but less than	$60,000	$38.82
$60,000	but less than	$61,000	$39.35
$61,000	but less than	$62,000	$40.09
$62,000	but less than	$63,000	$40.63
$63,000	but less than	$64,000	$41.37
$64,000	but less than	$65,000	$41.91
$65,000	but less than	$66,000	$42.65
$66,000	but less than	$67,000	$43.19
$67,000	but less than	$68,000	$43.93
$68,000	but less than	$69,000	$44.47
$69,000	but less than	$70,000	$45.21
$70,000	but less than	$71,000	$45.75
$71,000	but less than	$72,000	$46.49
$72,000	but less than	$73,000	$47.03
$73,000	but less than	$74,000	$47.77
$74,000	but less than	$75,000	$48.31
$75,000	but less than	$76,000	$49.05
$76,000	but less than	$77,000	$49.59
$77,000	but less than	$78,000	$50.33
$78,000	but less than	$79,000	$50.87
$79,000	but less than	$80,000	$51.61
$80,000	but less than	$81,000	$52.14
$81,000	but less than	$82,000	$52.89
$82,000	but less than	$83,000	$53.42
$83,000	but less than	$84,000	$54.17
$84,000	but less than	$85,000	$54.70
$85,000	but less than	$86,000	$55.45
$86,000	but less than	$87,000	$55.98
$87,000	but less than	$88,000	$56.73
$88,000	but less than	$89,000	$57.26
$89,000	but less than	$90,000	$58.01
$90,000	but less than	$91,000	$58.54
$91,000	but less than	$92,000	$59.28
$92,000	but less than	$93,000	$59.82
$93,000	but less than	$94,000	$60.56
$94,000	but less than	$95,000	$61.10
$95,000	but less than	$96,000	$61.84
$96,000	but less than	$97,000	$62.38
More than $97,000 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 November 1, 2018 to October 31, 2019

Seattle Public Schools provides a monthly benefits 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 the benefits you choose.

The Monthly District Contribution beginning November 1, 2018
(The District Contribution may be adjusted up or down later in the year.)

Certificated:	Fully Funded.....	$928.00
Classified:	Fully Funded.....	$971.00

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

Certificated: Your FTE status _____ x $928.00 = $_____ (*Your monthly District contribution*)

Classified: Your FTE status _____ x $971.00 = $_____ (*Your monthly District contribution*)

Calculate Your Monthly Benefits Costs

A. Enter your Monthly District Contribution	$_____	Your District Contribution is based on your FTE status.
B. Enter your Basic Life & LTD Premium	($_____)	Coverage is mandatory. Enter the premium associated with your annual salary from page 11.
C. Calculate your Remaining District Contribution (Your "Health Flex Dollars")	$_____	Subtract your Life & LTD Premium from your District Contribution. The remaining amount is available for vision, dental, and medical coverage.
D. Your Vision Plan Premium	($_____)	Coverage is mandatory. The NBN Vision plan premium is a family premium.
E. Enter your Dental Premium	($_____)	Coverage is mandatory. Choose either the Incentive Plan or the Value Plan for you and your family.
F. Enter your Medical Premium	($_____)	Enter the premium for your chosen plan. See the rates page, and be sure you review the plan comparison.
G. Subtotal: Add together your Vision, Dental, and Medical Premiums (D+E+F)	$_____	Subtotal: If this is less than your available Health Flex Dollars (line C), you will have no payroll deduction.
H. Your Monthly Payroll Deduction (if any)	$_____	If your Subtotal on Line G is greater than your Health Flex Dollars on Line C, subtract G from C.

If the combined cost of your health benefits is more than your Health Flex Dollars, the difference will be automatically deducted from your paycheck on a pre-tax basis. Pre-tax treatment does not apply to premiums for a domestic partner who is not your tax dependent.

Benefits and District Contributions

The District Contribution may be used for the following basic benefits only: Basic Life and AD&D Insurance, Long Term Disability Insurance, Dental, Vision, and Medical. As mandated by the ACA, your available Health Flex Dollars may not be used for flexible spending accounts, health savings accounts, voluntary life insurance, voluntary short term disability insurance, voluntary 403(b) retirements plans, or state pension plans (DRS). Unspent benefits dollars are returned to the pool and redistributed to help offset health plan premiums for employees who cover families.

Dental Plans

Delta Dental of Washington (DDWA)

Plan Name	Incentive Plan (the default plan option)
Plan Number	#0195
Annual Deductible	$0 per Calendar Year
Annual Benefit Maximum	$2,500 per Calendar Year (Preventive care no longer counts against this figure)

	In Network	Out of Network	Out of State
PPO Providers	Delta Dental PPO Network	Delta Dental 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 DDWA 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 benefit, you must have your provider submit the remaining portion of your bill to the plan for secondary coverage.

Dental Plans

Delta Dental of Washington (DDWA)

Plan Name	Value Plan
Plan Number	#0295
Annual Deductible	$50 per Calendar Year (Waived for Class I services)
Annual Benefit Maximum	$1,500 per Calendar Year (Preventive care no longer counts against this figure)

	In Network	Out of Network
PPO Providers	Delta Dental PPO Network	Any Other Provider
Class I: Diagnostic and Preventive*	100%	Not covered
Class II: Restorative	80%	Not covered
Crowns and Onlays	50%	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 DDWA 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 enrolls on the DDWA Value Plan and later changes enrollment to the Incentive Plan will be enrolled at the 80% incentive level regardless of prior coverage, or length of enrollment on either plan.

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 benefit, 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, if not already a multiple of $1,000 to a maximum of $2,500,000.
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 or which causes a coma within 365 days of the injury you may be entitled to certain additional benefits.
Accelerated Death Benefit	If you qualify for waiver of premium and become terminally ill with a life expectancy of less 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 properly utilized seat-belt.
Conversion Privilege	If your insurance terminates or reduces for any reason other than a failure to pay premium or the payment of an accelerated death benefit, 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 per person, whichever is less.
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.

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.

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 up to $16,667; 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	-To Social Security Normal Retirement Age or 30 months, whichever is longer
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 a pre-existing conditions exclusion only on the assisted living benefit. There is no limitation of coverage for pre-existing conditions on the base LTD benefits.
Total Disability Required?	No, partial disability can be paid (call Helpline for details)
Waiver of Premium	Yes
Survivor Benefit	3 x gross 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.

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

Medical Plans

Summary of How Medical Networks Work

Eligibility

All benefits-eligible employees (as specified in the General Enrollment and Eligibility Information) may join a medical plan if applying appropriately. Only one of the medical plans can be selected and dependents must join the plan of the employee. This coverage is voluntary—you may waive medical coverage if you so desire. If you do nothing, you will be waived from any medical plan coverage and can then only join during the annual Open Enrollment period, unless you experience a Qualifying Event.

Premium Contributions

If the total premiums for the combination of your mandatory coverages (dental, vision, basic life and long term disability) combined with the medical premiums for your chosen plan exceed the District Contribution for benefits, the remaining premium will be withheld from your paycheck on a pre-tax basis. Premiums for domestic partners and their children will be withheld on an after-tax basis, unless you notify us that they are your tax dependents.

Types of Medical Plans

Health Maintenance Organization (HMO)	HMOs usually require that you select a Primary Care Provider (PCP) from their list of providers. Some services require a referral from your PCP, but Kaiser Permanente allows you to self-refer to a wide variety of specialists. No benefits are available outside the network without a referral and approval, except for medical emergencies.
Preferred Provider Organization (PPO)	PPOs contract with otherwise independent providers, clinics, and hospitals. If you choose to receive your care through a preferred provider (called In-Network care), your plan will pay a higher percentage of the billed charges. If you choose to go to a non-preferred provider (Out-of-Network care), the plan will pay a lower percentage of the charges, and it is possible that you may be balance-billed for any amounts that exceed the approved amounts.

Medical Plans

HMO Plans: **KPWA HMO 500** **KPWA HMO Classic**	Plan members may use the Kaiser Permanente of Washington health care network (KP.org/wa). Emergency care is always covered as In-Network care at any hospital, in accordance with the Affordable Care Act requirements, even for HMO plan members.
PPO Plans: **KPWA Access Basic** **KPWA Access HDHP** **KPWA Access Value** **KPWA Access Plus** **KPWA Access Century**	Plan members may use the Kaiser Permanente of Washington health care network (KP.org/wa). In addition, plan members may use the Kaiser Access PPO network (KP.org/wa) or the First Choice Health Network (FCHN.com) in WA, AK, ID, OR, and MT. Nationally, outside of those five states, plan members have access to the First Health / Coventry PPO network (FirstHealth.com). For information on coverage when travelling internationally, please contact Kaiser Permanente customer service at 1 (888) 901-4636.

For detailed plan information, including plan booklets with exclusions and limitations, visit the Benefits Website at www.OurPasswordPage.com (use the code 'sps' to gain access). See the 'Providers' section for ways to locate In-Network care for whichever plan you select.

Categories	KPWA HMO 500 Group #1450600	KPWA Classic HMO Group #1664800	KPWA Access Basic Group #6513900	KPWA Access HDHP 1500 Group #6416800	KPWA Access Value Group # 6514000	KPWA Access Plus Group #6514100	KPWA Access Century Group #6290000
Which Providers are In-Network?	**In-Network:** Kaiser Permanente of WA (KPWA) providers **Out-of-Network:** NO COVERAGE except for Emergencies		**In-Network:** KPWA providers, KPWA Access PPO providers, First Choice Health Network (FCHN) PPO providers, and First Health PPO providers **Out-of-Network:** All others				
Annual Deductible	$500 per person $1,500 max per family (Fourth quarter carryover applies)	$100 per person $200 max per family (Fourth quarter carryover applies)	**In-Network:** $1,000 per person $2,000 max per family **Out-of-Network:** $2,000 per person $4,000 max per family (Fourth quarter carryover applies)	**In-Network:** $1,500 Individual $3,000 Family **Out-of-Network:** $3,000 Individual $6,000 Family (all family members pay toward same shared family deductible)	**In-Network:** $500 per person $1,500 max per family **Out-of-Network:** $1,000 per person $3,000 max per family (Fourth quarter carryover applies)	**In-Network:** $250 per person $750 max per family **Out-of-Network:** $500 per person $1,500 max per family (Fourth quarter carryover applies)	**In-Network:** $200 per person $400 max per family **Out-of-Network:** $400 per person $800 max per family (Fourth quarter carryover applies)
Coinsurance <u>you pay</u>, when applicable	In-network: 20% Out-of-network: Not covered, except for emergencies	In-network: 0% Out-of-network: Not covered, except for emergencies	In-network: 20% Out-of-network: 50%	In-network: 10% (5% at Kaiser) Out-of-network: 50%	In-network: 20% Out-of-network: 50%	In-network: 20% Out-of-network: 50%	In-network: 0% Out-of-network: 40%
Your Annual Out-of-Pocket Expense Limit (The maximum amount you paid for covered services.)	$2,500 per person $7,500 max per family	$2,000 per person $4,000 max per family	**In-Network:** $5,000 per person $10,000 max per family **Out-of-Network:** Unlimited	**In-Network:** $3,500 per person $7,000 per family **Out-of-Network:** $7,000 per person $14,000 per family (all family members pay toward same shared maximum)	**In-Network:** $3,000 per person $9,000 max per family **Out-of-Network:** $6,000 per person $18,000 max per family	**In-Network:** $3,000 per person $9,000 max per family **Out-of-Network:** $6,000 per person $18,000 max per family	**In-Network:** $2,500 per person $5,000 max per family **Out-of-Network:** $5,000 per person $10,000 max per family
What DOES NOT Apply to the Out of Pocket Expense Limit?	Your costs for all covered services apply to the out-of-pocket expense limit						
Access to Care; Referrals and Pre-Authorizations	Your Primary Care Physician (PCP) directs your care. Wide range of self-referrals to specialists is allowed within Kaiser Permanente Medical Centers.		Self-referrals are allowed. Pre-authorization is required for certain services				
Rules for Out of Area Care	Outside of the KPWA service area there is coverage anywhere for medically necessary urgent or emergency care, subject to the ER cost share		In-network benefits are available in WA, OR, ID, MT, and AK through the FCHN, or nationally through the First Health PPO network. First Choice Health Network: www.fchn.com First Health Network: www.firsthealth.com				

This is a comparison of benefit and not a contract. Should there be any discrepancy between this document and the contract, the contract will prevail. Prepared by Sprague Israel Giles, Inc. 8/23/2018

Categories	KPWA HMO 500 Group #1450600	KPWA Classic HMO Group #1664800	KPWA Access Basic Group #6513900	KPWA Access HDHP 1500 Group #6416800	KPWA Access Value Group # 6514000	KPWA Access Plus Group #6514100	KPWA Access Century Group #6290000
1. Physician Visits in Office & Clinic	The first four office visits per member per calendar year are covered with a $25 copay per visit. Subsequent visits are $25 per visit, subject to the deductible, then you pay 20% coinsurance	**In-Network:** $15 copay per visit **Out-of-Network:** No coverage	**In-Network:** $35 copay per visit ($25 at KPWA), deductible applies, then you pay 20% coinsurance **Out-of-Network:** Deductible applies, then you pay 50% coinsurance	**In and out-of-Network:** Deductible applies, then you pay **At KPWA:** 5% **In-Network:** 10% **Out-of-network:** 50%	**In-Network:** $30 copay per visit ($20 at KPWA) **Out-of-Network:** Deductible applies, then you pay 50% coinsurance	**In-Network:** $25 copay per visit ($15 at KPWA) **Out-of-Network:** No copay but deductible applies, then you pay 50% coinsurance	**In-Network:** $25 copay per visit ($15 at KPWA) **Out-of-Network:** No copay but deductible applies, then you pay 40% coinsurance
2. Diagnostic Testing	The first $500 of lab and x-ray services is covered at 100%. Once the first $500 has been used, deductible applies then you pay 20% coinsurance	0% coinsurance	**In-Network:** Deductible applies, then you pay 20% coinsurance **Out-of-Network:** Deductible applies, then you pay 50% coinsurance	**In-Network:** Deductible applies, then you pay 10% coinsurance **Out-of-Network:** Deductible applies, then you pay 50% coinsurance	**In-Network:** Deductible applies, then you pay 20% coinsurance **Out-of-Network:** Deductible applies, then you pay 50% coinsurance	**In-Network:** Deductible applies, then you pay 20% coinsurance **Out-of-Network:** Deductible applies, then you pay 50% coinsurance	**In-Network:** Deductible applies, then you pay 0% coinsurance **Out-of-Network:** Deductible applies, then you pay 40% coinsurance
3. Preventive Care, Well-Baby Care	Covered in full when according to the KPWA well-care schedule		**In-Network:** Covered in full according to the well-care schedule **Out-of-Network:** Deductible applies, then 50% coinsurance	**In-Network:** Covered in full according to the well-care schedule **Out-of-Network:** Deductible applies, then 50% coinsurance	**In-Network:** Covered in full according to the well-care schedule **Out-of-Network:** Deductible applies, then 50% coinsurance	**In-Network:** Covered in full according to the well-care schedule. **Out-of-Network:** Deductible applies, then 50% coinsurance	**In-Network:** Covered in full according to the well-care schedule **Out-of-Network:** Deductible applies, then 40% coinsurance
4. Inpatient Hospital Room and Board, and Ancillaries	Deductible applies, then you pay 20% coinsurance	$200 copay per day for up to 3 days per admission. Deductible applies, then you pay 0% coinsurance	**In and Out-of-Network:** $200 copay per day for up to 5 days per admission. Deductible applies, then you pay **In-Network:** 20% **Out-of-Network:** 50%	Deductible applies, then you pay **In-Network:** 10% **Out-of-Network:** 50%	$200 copay per day, for up to 3 days per admission Deductible applies, then you pay **In-Network:** 20% **Out-of-Network:** 50%	$200 copay per admission. Deductible applies, then you pay **In-Network:** 20% **Out-of-Network:** 50%	$200 copay per day, for up to 3 days per admission Deductible applies, then you pay **In-Network:** 0% **Out-of-Network:** 40%

Categories	KPWA HMO 500 Group #1450600	KPWA Classic HMO Group #1664800	KPWA Access Basic Group #6513900	KPWA Access HDHP 1500 Group #6416800	KPWA Access Value Group # 6514000	KPWA Access Plus Group #6514100	KPWA Access Century Group #6290000
5. Prescription Drugs & Insulin (Unless Otherwise Specified) Access PPO plans use the Optum Rx Pharmacy PPO network	Value Generic: $4 Preferred Generic: $8 Preferred Brand: $25 Non-preferred: Not covered		**In-Network:** Value Generic: $5 Pref Generic: $10 Pref Brand: $40 Non-pref Brand: 50% Pref brand drugs are $10 less when obtained from a KPWA pharmacy. 1st fill for value-based drugs can be obtained at any pharmacy **Out-of-Network:** Not covered	**In-Network:** Ded applies, then: Preferred Gen: $10 Pref Brand : $35 ($30 at KPWA) Non-pref Brand: $70 ($65 at KPWA) Certain preventive meds (by KPWA) are covered in full **Out-of-Network:** Not covered	**In-Network:** Pref Generic: $20 Pref Brand: $35 Non-pref Brand: $55 Preferred and Non-preferred drugs are $5 less when obtained from a KPWA pharmacy. **Out-of-Network:** Not covered	**In-Network:** Pref Generic: $5 Pref Brand: $35 Non-pref: $70 Pref brand drugs are $5 less and Non-pref drugs are $10 less from a KPWA pharmacy. **Out-of-Network:** Not covered	**In-Network:** Pref Generic: $10 Pref Brand: $35 Non-pref: $70 Preferred brand and non-preferred drugs are $5 less from a KPWA pharmacy. **Out-of-Network:** Not covered
6. Mail Order Prescription Drugs & Insulin (unless otherwise specified)	**KPWA Mail Order Service:** Regular copay amounts apply minus a $5 discount per 30-day supply or refill, up to a 90-day supply		**KPWA Mail Order Service:** 2x the KPWA pharmacy cost share for a 90 day supply of medications				
7. Routine Vision Exam (One visit per 12 months)	$25 copay, deductible and coinsurance waived. No hardware coverage	$15 copay. No hardware coverage	**In and Out-of-Network:** Covered at 100% No hardware coverage				
8. Routine Hearing Exam & Hearing Hardware	For exam, see (#1) Physician Visits, one exam per year. Hardware is covered up to $1,000 per ear per 36 months			For exam, see (#1) Physician Visits, one exam per year. No hardware coverage	For exam, see (#1) Physician Visits, one exam per year. Hardware is covered up to $1,000 per ear per 36 months		
9. Chiropractors, manipulation of spine and extremities	See (#1) Physician Visits. No visit limit						
10. Acupuncture	See (#1) Physician Visits. 12 visits per calendar year						

Categories	KPWA HMO 500 Group #1450600	KPWA Classic HMO Group #1664800	KPWA Access Basic Group #6513900	KPWA Access HDHP 1500 Group #6416800	KPWA Access Value Group # 6514000	KPWA Access Plus Group #6514100	KPWA Access Century Group #6290000
11. Naturopathic Care	See (#1) Physician Visits. Self-referrals to KPWA providers for up to 3 visits per diagnosis per calendar year		See (#1) Physician Visits. No visit limits				
12. Obstetrics; Initial Newborn Care; Facility and Professional Services (newborns covered first 3 weeks after birth)	For inpatient care, see (#4) Inpatient Hospitalization. For outpatient care, see (#1) Office Visits or (#15) Outpatient Services, depending on services as billed. Note: Newborns have their own deductibles/coinsurance/etc., if baby is added to insurance plan.						
13. Ambulance Services	Deductible waived. You pay 20% coinsurance		**In and Out-of-Network:** Deductible applies, then you pay 20% coinsurance	**In and Out-of-Network:** Deductible applies, then you pay 10% coinsurance	**In and Out-of-Network:** Deductible applies, then you pay 20% coinsurance		Covered in full
14. Emergency Room In and out of Service Area (copays waived if admitted)	$150 copay Deductible applies, then you pay 20% coinsurance	$100 copay Deductible applies, then you pay 0%	$250 copay Deductible applies, then you pay 20% coinsurance	No copay. Deductible applies, then you pay 10% coinsurance	$250 copay Deductible applies, then you pay 20% coinsurance	$150 copay Deductible applies, then you pay 20% coinsurance	$100 copay Deductible applies, then you pay 0%
15. Outpatient Day Surgery, Surgery Centers	$25 copay Deductible applies, then you pay 20% coinsurance	$15 copay Deductible and coinsurance do not apply	Deductible applies, then you pay **In-Network:** 20% **Out-of-Network:** 50%	Deductible applies, then you pay **In-Network:** 10% **Out-of-Network:** 50%	Deductible applies, then you pay **In-Network:** 20% **Out-of-Network:** 50%	Deductible applies, then you pay **In-Network:** 20% **Out-of-Network:** 50%	**In-Network:** $25 copay **Out-of-Network:** Deductible applies, then you pay 40%
16. Bariatric Surgery	Covered at cost shares when clinical criteria is met. Pre-authorization by KPWA is required.						
17. Rehabilition: Outpatient Occupational, Speech, Massage & Physical Therapy	See (#1) Physician Visits. Limited to 45 visits per calendar year		See (#1) Physician Visits. Combined limit (in and out-of-network) is 45 days per calendar year				
18. Durable Medical Equipment, Supplies, and Prostheses	Deductible and coinsurance apply. Orthotic devices covered up to $600 per calendar year. Exclusions apply, see plan contract for details.						

Voluntary Life Insurance Plan

The Standard Insurance Company

If you are a benefits eligible 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). Your initial eligibility 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?
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 by an additional 15% at age 75.

You may also purchase up to half of 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 newly eligible employee, you can buy up to $70,000 of coverage with no medical questions on yourself, up to $30,000 for spouses or domestic partners, and $10,000 per child. If you apply for any amounts above these guaranteed issue limits, you do have to complete a Medical History Statement for Standard Insurance Company, who reserves the right to deny coverage for the extra amounts. Additionally, if you were eligible under the prior plan but not insured, or if your coverage previously ended because you did not pay premium or because you converted your life insurance, you do need to complete a Medical History Statement for Standard Insurance Company. The Medical History Statement is available at the Benefits Website (see below) or by calling the Benefits Helpline at (206) 957-7066. (*NOTE: This guaranteed issue is a one-time opportunity. You must enroll within 31 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, and are under Social Security Normal Retirement Age on the date you become disabled, your life insurance 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 plan booklet, also available on the Benefits Website or upon request to the Benefits Helpline (see below).

When Is Coverage Effective?
Your enrollment form must be signed and dated within 30 days of the date you become eligible for benefits. If your enrollment form is received by 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. To do this, you will need to contact The Standard Insurance Company directly at 1 (888) 937-4783.

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 can be found at the back of this booklet or online at the District's Employee Benefits Website (see below).

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.

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, reduced by deductible income, 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.

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.

Healthcare and Dependent Care FSA Plans

Navia Benefit Solutions, 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 = $2,650 (minimum election of $50 per year) 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. **Rollover Provision:** Unused Health Care FSA balances up to $500 will be rolled over to the subsequent plan year, as long as you participate in the plan again. You must claim all funds by the end of the plan year's run-out period. Funds in excess of $500 left in the plan cannot be refunded to you; this is referred to as the Use-it or Lose-it rule.
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 Navia Benefits at www.NaviaBenefitSolutions.com.

Please remember: **Other than the new Rollover provision described above, it is important to know that this plan is a USE IT OR LOSE IT plan for health and dependent care.**
Please plan appropriately when calculating your annual deductions.

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 KPWA Access HDHP Enrollees

Avidia Bank through Navia Benefit Solutions, Inc.

Eligibility	Only employees enrolled in the KPWA Access HDHP may open and contribute to a Health Savings Account (HSA) via SPS payroll deduction.
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 a 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	* 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. * Reduces taxable income: money is tax-free when you put it in and when you take it out to cover qualified medical expenses. * Grows with you: if you maintain a certain balance, you may invest additional funds in select mutual funds, see Avidia Bank for details. * 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	After you enroll in the KPWA Access HDHP you will receive an email with instructions for accessing a secure web portal, where you can set up your account with Avidia Bank, 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. You will be given a linked debit 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 debit card. Payments will be made based on the available funds in your account.
Eligible Expenses	Health care expenses incurred by you, your legal spouse, and your dependent 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 KPWA Access HDHP Enrollees

Avidia Bank through Navia Benefit Solutions, Inc.

Reimbursement of Qualified Medical Expenses	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. 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. 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 a 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 2018 tax year, the maximum allowable contribution is $3,450 for single enrollment and $6,850 for family enrollment. In order to contribute the maximum allowable contribution for 2018, you must remain enrolled on the HDHP for all 12 months of 2018. 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 2019 maximum allowable contributions are $3,500 for single enrollment and $6,900 for family enrollment. 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. Avidia 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.NaviaBenefits.com, consult IRS Publication 969 or your tax advisor.

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.

Frequently Asked Employee Benefits Questions

1. **Can I add or drop my medical coverage mid-year?**
   You can make changes to your coverage during the annual Open Enrollment period. Otherwise, changes to your enrollment can only be made within 30 or 60 days of a "qualifying event". Examples of some qualifying events include birth, death, divorce, marriage, involuntary loss of group coverage, or becoming newly eligible for other group coverage; please refer to the **General Eligibility and Enrollment Information** section of this booklet for more detailed information.

2. **If I want the change in my enrollment to appear on my next paycheck, what is the submission deadline?**
   Outside of Open Enrollment, all changes or enrollments need to be to the Payroll Department by the payroll deadline for the month prior to the insurance effective date. Payroll deadlines are posted on the **administrative calendar found at SeattleSchools.org** During Open Enrollment, please refer to the current year's Open Enrollment announcement for specific dates and deadlines.

3. **When will I receive insurance cards?**
   Generally, you will receive a card within one to two weeks from your insurance effective date. This wait may be significantly longer during and after Open Enrollment due to the volume of changes the insurance companies are handling. If you are not making changes to your coverage at Open Enrollment, you may not receive new cards (as the current card will still be valid).

   You and your covered dependents (e.g., spouse, domestic partner, child) will receive ID cards from your medical insurance carrier. Delta Dental of WA and NBN Vision, however, **do not** issue ID cards.

4. **What do I need to do if I haven't received an insurance card and I need to access my benefits?**
   All of our insurance companies allow employees to access benefits as of their effective date, once they are enrolled. Once enrollment has occurred, updates to the carriers can take up to ten days, so if you need coverage right away after you have enrolled, please contact the Benefits Helpline at (206) 957-7066.

   Kaiser Permanents of WA will verify your enrollment once an appointment has been made. Delta Dental of Washington and NBN Vision do not issue ID cards. When you make an initial appointment with a provider, you can supply that provider with your name and Social Security Number. Your provider will then verify your eligibility directly with the insurance company.

5. **When will my newborn be covered?**
   The Erin Act is a State law requiring that a newborn be covered for the first 21 days after birth on the mother's insurance coverage; this coverage is automatic. The parent(s) has 60 days from the date of birth, or the date of adoption of a child, to enroll the child onto a plan. The child is covered from the date of birth, and the first premium charge is normally for the first of the month following the birth date.

6. **When I have to pay upfront for a service that is covered by insurance, how do I submit a claim?**
   Insurance claim forms are available on the Benefits Website, OurPasswordPage.com (password: sps). Copies of these forms are continually being updated by our insurance vendors. You can also find them on your insurance company's website.

   If you do not have access to the internet, please call the Benefits Helpline at (206) 957-7066 or toll free at (800) 946-7066, Mon. – Fri., 8am-5pm PST. The Benefits Specialists at the Helpline will be able to assist you.

7. **How do I submit a reimbursement request for my FSA or HSA?**
   Flexible Spending Plan claim forms are available on the Benefits Website, OurPasswordPage.com (password: sps). For Health Savings Accounts (HSAs), please contact Avidia Bank or Navia Benefit Solutions.

8. How do I make a Short Term or Long Term Disability claim?

You will need to complete and submit claim forms to initiate a claim. The forms can be found on the Benefits Website at OurPasswordPage.com (password: sps). Alternatively, you may contact the SPS Benefits Helpline, where the claims should be filed (they coordinate with The Standard Insurance Company and complete the Employer Statement portion of the claim form). If you need help understanding how these benefits work, you may also call the Benefits Helpline at (206) 957-7066 or toll free at (800) 946-7066, Mon. – Fri., 8am-5pm PST.

9. I am interested in setting up a 403(b) annuity, where do I begin?

Carruth Compliance Consulting is the school district's 403(b) third party annuity administrator. To get a list of the most current approved vendors, please contact them at (877) 222-3090 or online at NCompliance.com. Once you have made a selection from the approved vendor list, you must set up an account and initiate a deferral through Carruth.

10. How do I make changes to the 403(b) annuity I currently defer to through Seattle Public School District payroll deduction?

All changes must be made through Carruth Compliance Consulting. Changes must be made at least two to three working days prior to the payroll deadline in order to be effective on the current month's warrant.

11. I am separating employment from Seattle Public Schools, what happens to my benefits?

Benefits are administered according to instructions from Human Resources. You will be issued a COBRA notice within 30 days of loss of coverage for COBRA covered benefits (Medical, Dental, Vision, and FSA). If you would like assistance in determining your coverage options, please call the Benefits Helpline at (206) 957-7066 or toll free at (800) 946-7066, Mon. – Fri., 8am-5pm PST.

12. Where can I get booklets for my medical and dental plans, or life and LTD insurance certificates?

All health plan booklets and insurance certificates are available on the Benefits Website, located at OurPasswordPage.com (password: sps).

13. I need proof of coverage. Who can I contact for that?

Contact the Customer Service department of your insurance company. Certificates of Creditable Coverage are only available from the insurance provider. Please see The Benefits Contact List in this guidebook for contact information based on the plan you are enrolled in.

14. My name/address has changed. Can I just call the insurance company and update my information?

Address changes: submit an address change form to Human Resources.

Name changes: Please bring your new signed Social Security Card to Human Resources. You will need to complete enrollment forms with your new name and sign them. Do not contact the insurance company directly; they will need to see signed forms before they can make any changes.

15. What optional/voluntary benefit programs may I enroll in?

- Additional Optional Life Insurance
- Health Savings Accounts (for HDHP enrollees only)
- Flexible Spending Plans (Health and Dependent Care)
- 403(b) Tax-sheltered Annuities
- 457(a) Deferred Compensation Plan
- Voluntary Short Term Disability

Please refer to the Cost Worksheet to determine if the deductions listed above are applicable to your bargaining unit. **Information regarding the plans is available in this Booklet, please refer to the Table of Contents for page numbers.**

Important Notices

Required Notices

The following notices are important, describing your rights under various laws and regulations. These documents/information are provided electronically through the Benefits Website. They are found in the 'Required Notices' section of the table on the left-hand side of the page.

Please review these notices carefully:

- ☐ Patient Protection Notice
- ☐ Exchange Notice
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ USERRA Notice
- ☐ HIPAA Notice and Special Enrollment Rights
- ☐ Medicare Part D Creditable Coverage Notice
- ☐ GINA Notice
- ☐ Women's Health and Cancer Rights Notice
- ☐ Family Medical Leave Notice
- ☐ Newborns' and Mothers' Health Protection Notice
- ☐ SPS Notice of Privacy Practices

Certificate of Coverage

In addition, once available, health plan certificates of coverage are made available on the Benefits Website under the category labeled 'Insurance Booklets'. It sometimes may be the case that a booklet for a new plan year is not made available until after the new plan year has begun.

Need Help?

Contact the
BENEFITS HELPLINE
(206) 957-7066 or (800) 946-7066

Visit the BENEFITS WEBSITE
www.ourpasswordpage.com
password: sps

Need Forms?

Enrollment Forms and Instructions

To enroll for your employee benefits, please complete, sign, and return all applicable forms to:
SPS Human Resources at JSCEE MS 33-157.

For Mandatory Coverages Only

- ☐ **SPS Enrollment and Change Form**
  You must complete this form to enroll in medical, dental, and/or vision coverage and to cover dependents on any of these plans. Also use this form to waive medical coverage.

- ☐ **Affidavit of Marriage and Domestic Partnership**
  Complete this form (once per couple) to enroll a spouse or domestic partner on any benefit plan.

- ☐ **Life Insurance Beneficiary Form**
  Because all benefit-eligible employees receive life insurance coverage, complete this form to designate your beneficiary(ies).

For Voluntary Coverages

- ☐ **Voluntary Life Insurance Enrollment Form**
  For eligible employees who wish to enroll, complete and return this form. If you choose to enroll for more than the guarantee issue amount, you must also then obtain and complete the Medical History Statement found on the Benefits Website at OurPasswordPage.com (password: sps).

- ☐ **Voluntary Short Term Disability Enrollment Form**
  Use this form to enroll in the voluntary short term disability insurance plan.

- ☐ **Flexible Spending Account (FSA) Enrollment Form**
  To enroll in either the health care or the dependent care Flexible Spending Plans, you must complete this form during your initial eligibility window.

For Midyear Changes in Coverage

Midyear changes to most benefits are possible, but only during IRS-allowed periods following a Qualifying Event. There are helpful documents posted on the Benefits Website on OurPasswordPage.com (password: sps) summarizing the various Qualifying Events and how they work.

Other plans (such as Voluntary Life Insurance) allow you to change your coverage at any time. But in order to add coverage, you must still submit the Medical History Statement.

Usually, one has 30 days from the date of the Qualifying Event in which to submit a form requesting a change in benefits. The effective date of the change is commonly the first of the month following the date of the Qualifying Event. (An exception is birth/adoption, where one has 60 days to submit a form and the coverage must begin on the day of birth/placement.) Other rules and regulations may apply; and there are many. Please call with questions.

For a detailed discussion, please call the Benefits Helpline at (206) 957-7066 or toll free at 1 (800) 946-7066 any time from M - F 8am to 5pm.

SPS Medical, Dental and Vision Initial Enrollment Form

For Newly Eligible Employees Only

1. Please print clearly in blue or black ink.
2. Complete all sections and read the information on the back page.
3. You must sign/date the bottom of this form and submit as directed.

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 Hire / Re-hire Enrollment *(e.g., I was just hired, or re-hired, and am now or will be a benefit-eligible employee of SPS)*

☐ Newly Eligible for Benefits *(e.g., I just began a benefit-eligible position(s), but am not a new hire with SPS)*

Benefit-eligible Position: _____ Start Date of Eligible Position: _____

Section 3 - Select Your Medical Plan

You may waive coverage as well. See the detailed plan comparison and cost sheets.

☐ KPWA Access Century *#6290000*	☐ KPWA Access Plus *#6514100*	☐ KPWA Access Value *#6514000*	☐ KPWA Access Basic *#6513900*
☐ KPWA Access HDHP *#6416800*	☐ KPWA HMO 500 *#1450600*	☐ KPWA HMO Classic *#1664800*	☐ I Waive Coverage*

**I waive my right to medical coverage this plan year. I have read and understand my Special Enrollment rights on the second page of this form.*

Section 4 - Select Your Dental Plan

Employee Only enrollment is mandatory. See dental comparison and costs.

Delta Dental of Washington: ☐ Incentive Plan (**default**) ☐ Value Plan

Section 5 - Enroll Family Members

For each eligible dependent*, provide all requested information and check boxes to select coverage.

	Dependent Name	M / F	Social Security Number	Birth Date	Medical Coverage		Dental and Vision	
					Yes	No	Yes	No
Spouse/DP			- -	/ /	☐	☐	☐	☐
Child 1			- -	/ /	☐	☐	☐	☐
Child 2			- -	/ /	☐	☐	☐	☐
Child 3			- -	/ /	☐	☐	☐	☐
Child 4			- -	/ /	☐	☐	☐	☐

*Please submit an *Affidavit of Marriage or Domestic Partnership* for new or newly enrolling spouses/partners. Dependent children may be covered up to age 26 (or over age 26, if totally disabled and covered continuously; proof of disability will be required).

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, or 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: _____

Please return this form to: Human Resources, MS 33-157
PO Box 34165
Seattle, WA 98124

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

Kaiser Foundation Health Plan of Washington	601 Union Street, Suite 3100 Seattle, WA 98101	(888) 901-4636
Kaiser Foundation Health Plan of Washington Options Inc	601 Union Street, Suite 3100 Seattle, WA 98101	(888) 901-4636
Delta Dental of Washington	400 Fairview Ave N, Suite 800 Seattle, WA 98109	(800) 554-1907
NBN Vision (self-funded plan)	2323 Eastlake Avenue E Seattle, WA 98102	(800) 732-1123

Find information about these insurance carriers at http://www.insurance.wa.gov/consumertoolkit/Start.aspx

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, or adoption (or placement for adoption), you may be able to enroll yourself and your dependents under a District 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 medical plan if you or your dependents lose eligibility for that other coverage or if the employer stopped contributing towards that other group plan. 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 its confidential data. State and Federal law requires 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 for information.

The Effective Date of Coverage

For newly eligible employees: If your hire date is on or before the 15th of the month and your paperwork is received by SPS 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: Please use the "SPS Medical, Dental and Vision Midyear Change Form" to request changes to your coverage. This form can be found at SPS Human Resources, online at the Benefits Website, or by contacting the Benefits Helpline at (206) 957-7066.

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 in 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 affects eligibility for corresponding coverage.

For Open Enrollment changes: Open Enrollment occurs once per year. Any contract, premium, and enrollment changes to Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options, Inc., Delta Dental of Washington, and NBN Vision Plans become effective November 1.

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 provisions, 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.

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

"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.

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: _____

Voluntary Life Insurance Enrollment and Change Form

Coverage underwritten by Standard Insurance Company

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

For office use only

Effective Date: _____ / _____ / _____

Entered in SAP: _____ / _____ / _____

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 the Option Below that Best Fits Your Situation

☐ New Enrollment *(e.g., I was just hired, re-hired, or am otherwise newly eligible for benefits)*

☐ Coverage Change Request for Current Employee *(I previously waived coverage or I want to change my current coverage amount)*

☐ Cancellation Request *(to cancel your current voluntary life insurance coverage, check here and proceed directly to Section 8)*

Section 3 - How to Calculate Your Monthly Premiums

For Employee or Spouse / Domestic Partner coverage, please use the rate that matches the employee's current age. Then divide the amount you elect below by 1,000. Multiply this figure by your Rate from the rate table immediately below. For example, a 45 year old employee electing $100,000 of coverage would cost $20 per month: $100,000 / 1,000 = $100. $100 x $0.20 = $20.00 per month.

Rates per $1,000						
	Age < 25 $ 0.05	Age 30-34 $ 0.08	Age 40-44 $ 0.12	Age 50-54 $ 0.30	Age 60-64 $ 0.67	Age 70-74 $ 2.06
	Age 25-29 $ 0.06	Age 35-39 $ 0.09	Age 45-49 $ 0.20	Age 55-59 $ 0.51	Age 65-69 $ 1.27	Age 75 + $ 2.06

Section 4 - Elect Your Employee Voluntary Life Insurance Amount and Enter Your Premium

☐ $20,000 (minimum)	☐ $30,000	☐ $40,000	☐ $50,000	☐ $60,000
☐ $70,000 (Guaranteed Issue max)	☐ Custom Amount*: $		**Monthly Premium**: $	

**The minimum is $20,000. Elections may be in increments of $10,000 to a maximum of $500,000. The Guaranteed Issue (GI) amount for newly eligible employees is a maximum of $70,000. If the Guarantee Issue does not apply to your election (if you are not a newly eligible employee, if your coverage has previously terminated because you did not pay premium or converted your insurance, or if are requesting an amount greater than $70,000), you must also complete the Medical History Statement.*

Section 5 - Elect Your Spouse / Domestic Partner Amount and Enter Your Premium

To elect, you must first enroll in Employee coverage.

☐ $10,000 (minimum)	☐ $30,000 (GI)	☐ Custom Amount**: $	**Monthly Premium**: $

***Spouse/Partner coverage must be a minimum of $10,000, in increments of $10,000, to a maximum of $250,000, not to exceed 50% of your Employee election you have made in Section 4. The Guarantee Issue amount for spouses/partners is $30,000. The Medical History Statement may be required.*

Section 6 - Make Your Child/Children Coverage Elections

Coverage is for each child under age 26, premium is for all children together.

☐ $5,000 benefit per child, **$1.00** per family per month	☐ $10,000 benefit per child, **$2.00** per family per month

Section 7 - Provide Dependent Information

List all dependents you wish to cover, additional children may be added on the back page.

	Dependent Name	M / F	Social Security Number	Birth Date
Spouse/DP			- -	/ /
Child 1			- -	/ /
Child 2			- -	/ /

Section 8 - Employee's Signature

I agree to the Statement of Acceptance on the back of this form. Further, 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 insurability that is satisfactory to Standard Insurance Company but the request may be denied.

Employee Signature: _____ Date of Signature: _____

Please return this form 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 Life and Disability Insurance Coverage to Seattle Public Schools

Standard Insurance Company	1100 SW 6th Avenue Portland, OR 97204	(800) 348-3226

The Effective Date of Coverage

For newly eligible employees: If your hire date is on or before the 15th of the month and your paperwork is received by SPS 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. For non-guaranteed coverage, your insurance will become effective on the date Standard Insurance Company approves your Medical History Statement.

For coverage changes: Guarantee Issue is only available to newly eligible employees. If you wish to add or increase your voluntary life insurance after your initial eligibility period, your election must be approved by Standard Insurance Company. An approved application for coverage will become effective on the date that Standard Insurance Company approves your Medical History Statement.

If you wish to reduce your election or cancel your voluntary life coverage, your coverage change will generally be effective on the first day of the month following the receipt of the change form by SPS Human Resources.

Beneficiary Information

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. Special instructions regarding benefit payments or changes to beneficiary designations should be submitted, in writing, to Human Resources.

If you would like to update your beneficiary information, please complete the Life Insurance Beneficiary Form at Human Resources or posted online at the Benefits Website at www.OurPasswordPage.com (password 'sps') and submit as instructed on the form. If you need help locating or completing this form, please call the Benefits Helpline at (206) 957-7066 or 1 (800) 946-7066.

Payroll and Tax Information

Guaranteed Issue and payroll: If you enroll for an amount greater than the Guaranteed Issue amount, your payroll deduction will reflect only the premium for the Guaranteed Issue amount until such time as Standard Insurance Company approves your Medical History Statement. At that time, the additional premium will be added to your deduction amount on the first of the month following the date of your approval. Please contact the Benefits Helpline at (206) 957-7066 with questions about this process.

Payroll deadlines and employee cost shares: When elections or 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 directly to the SPS Payroll Department within the next 30 days, or your coverage will be cancelled.

Tax treatment of voluntary life insurance premiums: In accordance with the tax code, voluntary life insurance premiums are always paid with after-tax dollars. Contact the Benefits Helpline at (206) 957-7066 for more information.

Statement of Acceptance

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 Spouse / Domestic Partner coverage, I hereby certify that I have filed an Affidavit of Marriage or Domestic Partnership with Human Resources. I acknowledge that coverage for children will only continue up to age 26. I have read the information above and agree to the terms stated. I understand that according to the terms of the SPS voluntary life insurance contract, the benefit amount reduces by 35% at age 70 and 50% at age 75. I acknowledge that all information provided on this form is subject to the terms of the contract and in the case of any discrepancies, the contract shall prevail.

Provide Additional Dependent Information

	Dependent Name	M / F	Social Security Number	Birth Date
Child 3			- -	/ /
Child 4			- -	/ /
Child 5			- -	/ /
Child 6			- -	/ /
Child 7			- -	/ /

Voluntary New Employee
STD Enrollment Form

The Standard Insurance Company

Plan Year: April 1 through March 31

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**.**

Please note, enrolling in this coverage as a new hire guarantees coverage on this plan for the remainder of the current plan year until the end of the coming month of March. A new plan year begins every April 1st and all participants must re-enroll at that time for continued coverage.

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 SPS Human Resources: JSCEE MS 33-157 PO Box 34165 Seattle WA 98124

SEA

Seattle School District – Flexible Spending Arrangement Enrollment Form

Plan Year: 1/1/2018-12/31/2018
Last Day to Submit Claims: 3/31/2019

navia benefit solutions

Employee Information – Please write legibly to ensure proper enrollment

Last Name, First Name	SSN / Employee ID #

Home Address (Street, City, State, Zip Code)

Date of Birth	Phone Number	Email Address	Effective Date

Benefit Elections

Section 125 Benefit	Yes/No	Annual Election	# of Paychecks	Paycheck Deduction
Health Care FSA Minimum of $50.00 per plan year Maximum of $2,600.00 per plan year	❑ Yes ❑ No	$_____	____	$_____
Limited Health Care FSA Minimum of $50.00 per plan year Maximum of $2,600.00 per plan year *For Health Savings Account (HSA) participants. The LHCFSA only reimburses dental, orthodontia, vision and preventive care expenses*	❑ Yes ❑ No	$_____	____	$_____
Day Care FSA Minimum of $50.00 per plan year Maximum of $5,000.00 per plan year (or $2,500 if you're married and filing taxes separately)	❑ Yes ❑ No	$_____	____	$_____
Premium Conversion The group insurance premiums you pay through your paycheck are automatically deducted pre-tax. Premium contributions toward domestic partner coverage will be deducted post-tax unless they qualify as a tax dependent.				Automatic

Debit Card & Direct Deposit

Navia Debit Card – You may use the card to pay for expenses directly from the funds in your Health Care FSA or Limited Health Care FSA. There is no cost for the initial card. The cards are valid for 3 year periods; if you've previously received the card then it will be reloaded with your new election. You must provide a valid email address to use the card.	Automatic

Direct Deposit – Reimbursements are electronically deposited into your bank account. If you've previously signed up for direct deposit with Navia your information will remain on file and you do not need to complete this section.	❑ Yes ❑ No	❑ Checking ❑ Savings	Account #: _____ Routing #:

Signature

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 non-qualifying 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.

❑ **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

Employee Signature	Date
X	

Completed Enrollment Forms must be returned to: MS 33-157

Please see the reverse side 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. After the run-out period is complete, unused Day Care FSA balances will be forfeited; this is referred to as the Use-it or Lose-it rule. Unused Health Care FSA balances up to $500 will be rolled over to the subsequent plan year. Any Health Care FSA funds in excess of $500 will be forfeited. In order to receive carryover you must re-enroll in the following plan year or have a remaining balance in excess of the plan minimum.

Claim Runout Period

- The claim runout period allows you to submit claims after the end of the plan year. Claims received after this period will be denied.

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. If you enroll in the plan after open enrollment then please divide your annual election by the remaining deductions in the plan year.

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.

Debit Card

- If you elect to use the card please keep in mind that you may still need to submit supporting documentation to verify that a charge is eligible. You will be notified via email if you have a charge that requires documentation. You can check your account online to view any outstanding charges or contact customer service.
- If you use the card for an ineligible expense or do not substantiate a charge within 75 days of receiving the first request for substantiation your card may be temporarily suspended to prevent further use. The IRS provides the participant with 2 methods for correcting an ineligible or unsubstantiated charge: a) repay the plan for the amount of the expense, or b) request the substitution or offset of future out of pocket expenses. If neither option "a" nor "b" is successful the final option illustrated by the IRS permits the employer to deduct the ineligible expense from the participant's wages or other compensation consistent with federal and state law.
- You will receive one card by default but you can request additional cards for a fee of $5/card. This fee also applies for reissues of any lost, stolen, or otherwise misplaced cards. The $5 fee will be deducted from your FSA balance.

Electronic Disclosure Notice

- By providing your email address you consent to receive email communications from Navia, agents, and subcontractors regarding the Plan.
- If you no longer wish to receive information electronically, you may withdraw consent at any time at no cost. To withdraw consent, please contact Navia.
- 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.