Open Enrollment Guide For Plan Year 2010

I. B. E. W. - Local 77

October 1 – <u>October 23, 2009</u>

Look for a summary of 2010 plan changes on page 4.

City of Seattle
Personnel Department

Letter from Mark M. McDermott, Personnel Director

October 2009

Dear Members of the International Brotherhood of Electrical Workers Local 77:

Open Enrollment is your opportunity to review upcoming program changes, assess your coverage needs for next year and make your benefits changes for the coming year.

Current benefits will be maintained with minimal changes for January 1, 2010. Please read through the Guide to be aware of dependent tax status verification changes, plan design and monthly contribution requirements before you make choices for 2010. Also note the City's Open Enrollment period this year is **October 1 – October 23, 2009**, ending earlier than in previous years. Changes you make on or before October 23, 2009 will be effective January 1, 2010.

Read the Plan Changes section of the Guide (page 4) for 2010 modifications. Please take the next few weeks to review your family's insurance needs so that you can update your coverages appropriately during open enrollment. Go through your family's health and dependent care expenses. Consider (re)enrolling in a flexible spending account (FSA) program to save money.

Benefits staff and plan providers will be available to answer questions at the benefits fairs in October. You can also contact your department's benefits representative. If you do not make any changes, your current coverage will continue in 2010, except for the FSA. To continue having a Health Care and/or Dependent Care FSA, you must re-enroll.

Sincerely,

Mark M. McDermott
Personnel Director

If you have difficulty understanding the information in this Guide

Help is available if you have trouble reading or understanding this Guide. If the problem you have is not addressed below, please call the City Benefits Unit at 206-615-1340 so we can provide the assistance you need.

- **English is Your Second Language?** If English is not your native language, translators are available to help you. Many City employees have volunteered to translate for fellow employees. To find someone who "speaks your language" click here http://inweb/LanguageBank/LB_Lookup.asp. Inside the light blue box, click the arrow next to the white box and find the language you speak. Click the GO button. You will find a list of employees who speak that language. If the "Translate" box contains a "Y," that person will translate for you. Call and find a time he/she is available; make an appointment with the City Benefits Unit (206-615-1340) and bring that person with you. Together we'll help you understand your City benefits.

  If you do not have access to a computer, ask your Department's HR/Benefits representative to help you, or call the Benefits Unit at 206-615-1340.

- **Hearing Impaired?** If you use a TDD, the City provides translation services. Call 7-1-1 or 1-800-833-6384 on your TDD. You will be connected with the Washington Relay Service. Give them the number of the party you wish to call. They will call the person for you, then translate information from your TDD to the person you are calling.

- **Visually Impaired?** This Guide is available in a larger font. To request an electronic copy, contact the Benefits Unit at 206-615-1340.

- **Would rather *hear* the information than *read* it?** If your understanding is improved by having someone read or paraphrase information for you, you are invited to attend a benefits orientation. Orientations cover all City benefits and provide ample time for questions. You can meet with the presenter after the session if you have additional questions or questions you would like to ask confidentially. Orientations are held every week - call 206-615-1340 to sign up.

If you have further questions or concerns or would like to speak to someone confidentially, call the Benefits Unit (206-615-1340).

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Changes You Can Make During Open Enrollment

Important note: If you have dependents age over age 18 on your plan, you will receive a request for tax status verification. The City will impute income on the value of their benefits if you don't verify that your dependent is a tax dependent. The City will verify this twice a year, starting in the fall of 2009. See page 5.

Make changes through Employee Self-Service at http://selfservice.ci.seattle.wa.us/

Medical coverage

- ☐ Change plans
- ☐ Add or drop a family member

Dental coverage

- ☐ Change plans
- ☐ Add or drop a family member

Vision coverage

- ☐ Add or drop a family member

Supplemental Long Term Disability coverage*

- ☐ Enroll in or drop Supplemental LTD

Life insurance*

- ☐ Change beneficiary designation
- ☐ Add or drop Basic Life or Limited Basic Life coverage
- ☐ Change your Basic Life to Limited Basic Life (or vice versa)
- ☐ Add or increase your Supplemental coverage if you have Basic Life
- ☐ Drop or decrease your Supplemental coverage
- ☐ Add or increase Supplemental coverage for family members (To do so you must have Basic & Supplemental Life)
- ☐ Drop or decrease Supplemental coverage for family members

*A Medical History Statement is required if adding or increasing coverage.

Long Term Care insurance
(You can apply at any time, although you are guaranteed coverage only if you apply during the first 60 days of your hire date.)

- ☐ Enroll in Long Term Care

Accidental Death & Dismemberment insurance

- ☐ Change beneficiary designation
- ☐ Add or increase your or family coverage
- ☐ Drop or decrease your or family coverage

Flexible Spending Accounts
(Participants must re-enroll every year)

- ☐ Enroll in Dependent Care Flexible Spending Account for 2010
- ☐ Enroll in Health Care Flexible Spending Account for 2010

Deferred Compensation Savings Plan
(Make changes any time during the year)

- ☐ Change beneficiary designation
- ☐ Enroll or increase contribution
- ☐ Stop or decrease contribution
- ☐ Add or increase Regular Catch-up contribution (for those within 3 years of retirement)
- ☐ Add or increase Age 50+ Catch-up contribution (for those who will be at least 50 on or before 12/31/2010).

Your Responsibilities

- Update your address, telephone number and emergency contact through Employee Self-Service at http://selfservice.ci.seattle.wa.us/
- Review your paycheck deductions frequently. See your HR representative with questions.
- Update family status change through your department's HR/Benefit Representative.

Open Enrollment is Here!

Between **October 1 and October 23**, you can make changes to your benefits coverages and add or drop dependents (see checklist on page 2). You must re-enroll if you wish to have a health care and/or dependent care Flexible Spending Account in 2010. Even if you do not wish to make any changes, we encourage you to go on line and review/update your beneficiary information.

Make changes online through Employee Self- Service (ESS) at http:selfservice.ci.seattle.wa.us/. You can make changes as often as you want until 5:00 pm on October 23; the most recent changes will be saved**Beneficiary updates made via Employee Self-Service are effective immediately**. If you do not have access to ESS, fill out forms and turn them in to your department's HR representative **by October 23**.

If you submit a paper enrollment form and then decide to also make changes on line, be aware that the paper form you submit will be entered by your department's benefits representative **after** open enrollment is over. This means the changes on the paper form will take precedence over on line changes. Therefore, if you submit a paper form with changes and wish to make further changes, use another paper form with a later completion date.

Benefits Fairs

Seasonal flu shots will be available at all fairs. These are **not** for the H1N1 ("swine") flu.

- **Aetna Preventive, SPOG Traditional and Group Health members** - shots are free at all flu shot clinics when you bring your medical card (covered by your preventive care benefit under these plans).
- **All Fire Fighters Local 27, Local 77 and Most Traditional members** may purchase flu shots for $25 by check **only**. Cash will **not** be accepted.

Benefits Fairs Schedule

Downtown Fair **Wednesday, October 7** 9:30 am - 2:30 pm	City Hall - Bertha Knight Landes Conference Room 600 4th Avenue | 98104 (Enter at 5th and Cherry)
South Seattle Fair **Tuesday, October 13** 7:30 am - 10:30 am	Rainier Community Center 4600 – 38th Avenue South | 98118
North Seattle Fair **Thursday, October 15** 7:30 am - 10:30 am	Bitter Lake Community Center 13035 Linden Avenue North | 98133

In addition to the Benefits Fairs, flu shots will be offered at many City worksites, see: http://personnelweb/Content/inWeb/benefits/pubs/calendar.pdf .

2010 Plan Changes

Basic Group Term Life

- **Monthly Premium**
  - Monthly premium decreased approximately 20% to $.066 per $1,000 of coverage. (Coverage amount is equal to your annual salary, rounded up to the next $1,000 increment, multiplied by 1.5.) See page 17 for plan details.

Dependent Tax Status Verification

To properly administer the health plans, the City is verifying the IRS tax status of all non-spouse dependents over age 18. Employees that are covering a dependent reaching age 19 or over during 2010 will receive a letter at home requesting verification of IRS dependent tax status.

The City will continue to provide medical, dental and vision coverage to all dependents up to the age of 25, but must treat the coverage for IRS and non-IRS dependent children differently:

- Dependents that meet the IRS definition of a Qualifying Child or Relative may continue health coverage without being taxed on the value of the benefit.

- Dependents that DO NOT meet the IRS definition of a Qualifying Child or Relative may continue health coverage, but employees will be taxed on the value of the medical, dental and vision coverage. The value of the coverage will appear under “Earnings”, as line item “Hlth Care Allow”, to generate the appropriate tax. The same amount will appear under “Deductions”, as line item “Hlth Care Offst”, which reverses the “Earnings” once the tax amount has been calculated. In 2009, the monthly imputed income for a child is $176.24. In the 28% tax bracket, an additional $49.35 is taken out in taxes.

See IRS dependent definition on page 5.

	IRS Dependent Definition*	
Age	**Qualifying Child:**	**Qualifying Relative:**
18 and under	• Specific relationship • Reside with employee for more than half the year, AND • Provide half or less of their own support	• Specific relationship • Live with employee all year • Have gross income of less than $3500 AND • Provide more than half of their own support
18 to 21	Same as 18 and under, AND • Full-time student, OR • Disabled	Same as above
21 to 23	Same as 18 and under, AND • Full-time student, OR • Disabled	Same as above
23 to 24	Same as 18 and under, AND • Disabled	Same as above
24 to 25	Same as 18 and under, AND • Disabled	Same as above
25 and over	Same as 18 and under, AND • Disabled	Same as above

* See IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information) for full information.

Enrollment Options

The plan and dependent coverage elections you make now are for the 2010 plan year. According to IRS Section 125 regulations, you cannot change your dependent election outside of open enrollment period unless you have a qualifying change in family status. Your enrollment options for 2010 and the consequences of your decision are described below.

ACCEPT medical coverage for yourself and eligible family members by making changes through Employee Self-Service or completing and submitting a Health Care Benefit Election Form. If you do not make changes, your plans will remain the same, and you will pay the designated premium amount.

DECLINE medical coverage for yourself and/or family members (you may not decline dental or vision coverage).

- If you have no other medical insurance, you will NOT be eligible to enroll in a medical plan until the next annual Open Enrollment unless you have a qualifying change in family status as defined in the Change in Family Status/Dependent Eligibility section. Enrollment must take place within 31 days.
- If you have other medical coverage (you may not decline dental or vision coverage) and lose your other coverage, you may enroll in a City medical plan within 31 days of the loss of the other coverage upon providing proof of continuous medical coverage.
- If you have a qualifying change in family status, you may enroll or dis-enroll your eligible dependents within 31 days (or 60 days for a newborn or newly adopted child) of that change.
- If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical, dental, or vision coverage through the City under the federal COBRA law subsequently. However, if you retire you will be eligible to enroll in a City retiree medical plan.

Premium Sharing

The table below shows your monthly premium contributions for 2010. Premium contributions will be divided into two equal payments and taken from the first two paychecks of the month before the actual month of coverage. (For example, premium contributions taken from your December paychecks are for January coverage.) Your premium contributions will be deducted on a pre-tax basis.

2010 Monthly Medical Premiums for I.B.E.W. Local 77 Represented City Employees

Medical Plan	Employee's Premium Contribution	City-paid Premium Amount	Total Monthly Premium Amount
City of Seattle Preventive	$58.18	$1105.49	$1163.67
City of Seattle Traditional	$58.94	$1120.13	$1179.07
Group Health Standard	$50.16	$953.13	$1003.33

Domestic Partner/Same-Sex Spouse and Age 19-24 Year Old Child (Non-IRS Tax Dependent) Coverage Information

Taxable Benefit Amount (Coverage Value)

If your domestic partner/same-sex spouse, your age 19-24 year old children and/or your partner's non-IRS tax dependent's children do not qualify as your IRS tax dependents, you will also be taxed on the City-paid **value** of their medical, dental and vision coverage as required by IRS regulations. The following amounts will be listed on your paycheck as taxable income and are subject to federal income and Social Security tax withholding. These values have been adjusted to reflect the premium amounts taken after-tax (as explained above) so you are not taxed twice.

Coverage Value with Washington Dental Services Coverage

2010 Monthly Taxable Values of City Coverage Provided to: Your Non-IRS Tax Dependent Domestic Partner/Same-Sex Spouse, Your Age 19-24 Year Old Non-IRS Tax Dependent Child, or Your Domestic Partner's Non-IRS Tax Dependent's Child		
Type of Coverage	**Domestic Partner/ Same-Sex Spouse Taxable Amount**	**Taxable Amount Per Child**
Preventive Plan	$574.61	$229.84
Traditional Plan	$582.21	$232.88
GH Standard Plan	$520.54	$208.21
WDS Coverage	$ 60.74	$ 36.44
Vision Coverage	$ 4.31	$ 2.59
Total Taxable Value With WDS & VSP		
Preventive Plan	$639.66	$268.87
Traditional Plan	$647.26	$271.91
GH Standard Plan	$585.59	$247.24

Coverage Value with Dental Health Services Coverage

2010 Monthly Taxable Values of City Coverage Provided to: Your Non-IRS Tax Dependent Domestic Partner/Same-Sex Spouse, Your Age 19-24 Year Old Non-IRS Tax Dependent Child, or Your Domestic Partner's Non-IRS Tax Dependent's Child		
Type of Coverage	**Domestic Partner/ Same-Sex Spouse Taxable Amount**	**Taxable Amount Per Child**
Preventive Plan	$574.61	$229.84
Traditional Plan	$582.21	$232.88
GH Standard Plan	$520.54	$208.21
DHS Coverage	$ 67.94	$ 40.77
Vision Coverage	$ 4.31	$ 2.59
Total Taxable Value With DHS		
Preventive Plan	$646.86	$273.20
Traditional Plan	$654.46	$276.24
GH Standard Plan	$592.79	$251.57

Changing Your Plan Choices Outside of Open Enrollment

You may only make changes to your benefits elections outside the open enrollment period, if family status changes occur in your family. The changes you can make depend on (must be consistent with) the status change. Call your department's HR representative, or the Central Benefits Unit (206-615-1340) for more information.

Changes in family status are defined as:

• Birth, adoption, placement of a child, or legal guardianship.

• Loss of a child, spouse, or domestic partner's eligibility under another health plan.

• Marriage or formation of a domestic partnership.

• Divorce, termination of a domestic partnership, or legal separation.

Eligible Dependents

You must be enrolled before you can enroll your dependents. Dependents eligible to be covered under the City's benefit programs are:

• Your spouse or domestic partner.

• Your biological or adopted children, your spouse or domestic partner's children, or any child for whom you are the legal guardian. The child must be unmarried, under age 25, and live with you.

To cover a spouse/domestic partner, you must complete an Affidavit of Marriage/Domestic Partnership, available from your HR or Payroll Representative and on line at http://personnelweb.ci.seattle.wa.us/Content/inWeb/benefits/pubs/dp_affmarriage.doc. You may need to provide proof of legal guardianship for dependent children.

If the premiums for a domestic partner, same-sex spouse, child over age 18 or partner's child are taken after taxes, you may drop a domestic partner, same-sex spouse or child over age 18 any time (without a change in family status) if he/she is not claimed as your IRS tax dependent.

Medical, Dental and Vision Coverage

Benefits Highlights

The following plan highlights will help you compare plan features and decide which plan best fits your needs. The tables are not a complete description of benefits – see the plan booklets for exclusions, limitations and additional information. [1]

[1] If there is a discrepancy between the information here and in booklets, the booklet information will apply.

2010 Medical Benefits Highlights – I.B.E.W. Local 77

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp.

Group Health Cooperative (GHC)	City of Seattle Traditional Plan		City of Seattle Preventive Plan	
	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
Deductible (per calendar year)				
No deductible	$100 per person $300 per family	$150 per person $450 per family	Does not apply	$250 per person $750 per family
Annual Out of Pocket Maximum (OOP Max) Excludes deductible, if applicable. Aetna Copays do not apply towards OOP Max.				
$750 per person, $1,500 per family	$200 per person. Applies to 20% coinsurance	$1,200 per person. Applies to 40% coinsurance *	$500 per person $1,000 per family (applies to emergency room copays)	$3,000 per person $6,000 per family Most costs paid in full after out-of-pocket maximum is paid.*
Maximum Lifetime Benefits Payable				
None	$1,000,000		$1,000,000	$1,000,000
Hospital Copay				
Paid at 100%	Paid at 100%	Paid at 100%	Paid at 100%	Paid at 100%
Hospital Pre-admission Authorization				
Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
Choice of Providers				
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists.	Paid at 80% Outside the service area: Any licensed, qualified provider. Expenses paid based on Reasonable and Customary (R&C)* charges. You pay the difference between R&C and billed charges.	Paid at 60%	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.
COVERED EXPENSES				
Acupuncture				
Paid at 100% after $5 copay. Self-referred up to 8 visits per condition per calendar year. Additional visits with PCP referral.	Paid at 80% Maximum of 12 visits per calendar year.	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Alcohol/Drug Abuse Treatment				
Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay	Paid at 80% for inpatient and outpatient	Paid at 80% for inpatient and outpatient	Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay	Inpatient: Paid at 70% Outpatient: Paid at 70%

Contraceptives				
For contraceptive drugs and devices, see Prescription Drug benefit	Oral contraceptive drugs: see Prescription Drug benefit. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: not covered. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: see Prescription Drug benefit. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: not covered. Contraceptive devices and other prescription contraceptive products covered as medical benefit.
Durable Medical Equipment				
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 100%	Paid at 70%
	Maximum benefit unlimited for in-network and out-of-network combined.		Maximum benefit unlimited for in-network and out-of-network combined.	
Emergency Medical Care				
➢ **Urgent Care Clinic**				
Paid at 100% after $5 copay	Paid at 80%	Paid at 80%	Paid at 100%	Paid at 70%
➢ **Emergency Room (copays waived if admitted)**				
GHC facility: Paid at 100% after $50 copay (waived if admitted) Non-GHC facility: Paid at 100% after $100 deductible (waived if admitted)	Paid at 80%.	Paid the same as in-network except if it's non-emergency, then it's 60%	Paid at 100% after $50 copay (waived if admitted.) Urgent Care paid at 100% after $35 copay.	Paid the same as in-network except if it's non-emergency, then it's 70% after $50 copay. (waived if admitted).
➢ **Ambulance**				
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary.		Ground ambulance paid at 100% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Hospital Inpatient				
Paid at 100% .	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Hospital Outpatient				
Paid at 100% after $5 copay	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Hospice				
Paid at 100% when authorized	Paid at 90%. Lifetime maximum of $10,000 or 6 months, whichever is greater. 14 day inpatient limit per 6 month period. 120 hour limitation for skilled nursing care.		Paid at 100% Maximum of 6 months for inpatient and outpatient combined.	Not covered
Maternity Care (delivery & related hospital)				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maternity Care (prenatal and postpartum)				
Paid at 100% after $5 copay	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Mental Health Care (inpatient)				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%

Mental Health Care (outpatient)				
Paid at 100% after $5 copay per individual, family or couple session. Copays apply to the annual out-of-pocket maximum.	Paid at 80%. Expenses apply to the annual out-of-pocket coinsurance maximum.	Paid at 60% Expenses apply to the annual out-of-pocket coinsurance maximum.	Paid at 100% after $5 copay Copays do not apply to the annual out-of-pocket maximum	Paid at 70% Coinsurance applies to the annual out-of-pocket maximum.
Physician Office Visit				
$5 copay	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Prescription Drugs (retail)				
For a 30-day supply: $5 copay. Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 34-day supply or 100 unit supply (whichever is greater): $8 copay. You pay the difference between generic and name-brand. Oral contraceptives are covered. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit. Copays do not apply to out-of-pocket maximum. Non-formulary drugs not covered.	Not covered	For a 31-day supply: Generic: $5 copay Preferred brand: $10 copay Non-preferred drugs: $25 copay Oral contraceptives are covered. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit. Copays do not apply to out-of-pocket maximum.	Not covered
Prescription Drugs (mail order)				
3x $5 copay per 90-day supply	For a 90-day supply: $16 copay. Non-formulary drugs are not covered	Not covered	For a 90-day supply: Generic: $10 copay Preferred brand: $20 copay Non-preferred drugs: $50 copay	Not covered
Preventive Care				
Paid at 100% for preventive care visits, most immunizations, hearing exams, eye exams and mammograms.	Paid at 100% (deductible waived) Maximum of $300 per calendar year. Mammograms paid at 80%.	Paid at 60% for mammograms, deductible waived.	Paid at 100% for periodic check-ups, well child care, immunizations, well woman care and mammograms.	Paid at 70% for well woman care and mammograms. No other preventive services covered.
Rehabilitation Services (inpatient)				
Paid at 100% Maximum of 60 days per condition per calendar year for all types of rehabilitation.	Paid at 80% Maximum of $50,000 per condition per calendar year for preferred and participating services combined.	Paid at 60%	Paid at 100%	Paid at 70%
Rehabilitation Services (outpatient)				
Paid at 100% after $5 copay Maximum of 60 days per condition per calendar year for all types of rehabilitation.	Paid at 80% Coinsurance does not apply to out-of-pocket maximum. Maximum calendar year benefit of $2,000.		Paid at 100% after $5 copay Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits per calendar year for each of the above listed benefits for in-network and out-of-network combined.	Paid at 70%

Skilled Nursing Facility		
Paid at 100%; 60 day maximum per calendar year (in addition to coverage in lieu of hospitalization)	Paid at 80% Maximum of 90 days per calendar year	Paid at 100% Paid at 70% Maximum of 120 days per calendar year for in-network and out-of-network combined
Smoking Cessation		
Paid at 100% for individual/group sessions through Free and Clear. Nicotine replacement therapy included in Prescription Drugs benefit. No copay on all smoking cessation prescription drugs.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail. Not covered	Not covered
Spinal Manipulations		
Paid at 100% after $5 copay. Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 80% Maximum of 10 visits per calendar year	Paid at 100% after $5 copay. Paid at 70% Maximum of 20 visits per calendar year for in-network and out-of-network combined
Sterilization Procedures		
Vasectomy and tubal ligation covered subject to $5 copay	Paid at 80% Paid at 60%	Inpatient: Paid at 100% Paid at 70% Outpatient: Paid at 100% after $5 copay.
Tooth Injury (due to accident)		
Not covered	Paid at 80%. Maximum $600 per occurrence	Inpatient: Paid at 100% Paid at 70% Outpatient: Paid at 100% after $5 copay. Maximum $600 per occurence Maximum $600 per occurence
Vision Hardware		
Covered under Vision Service Plan	Covered under Vision Service Plan	Covered under Vision Service Plan
X-ray and Lab Tests		
Paid at 100%	Paid at 80% Paid at 60%	Paid at 100% Paid at 70%

* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

Plan details are in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp. **This document is not a contract.**

2010 Summary of Dental Benefits

Dental Plan Comparison		
Plan Features	**Washington Dental Service (WDS)**	**Dental Health Services (DHS)**
Annual Deductible	$0	$0
Annual Maximum	$2,000 per person per year	No Annual Maximum.
Outpatient Copay	None	$5 copay per visit for the first three years of employment
Diagnostic and Preventive (routine and emergency exams, x-rays, cleaning, fluoride treatment, sealants)	Incentive payments levels 1st Year – 70% 2nd Year – 80% 3rd Year – 90% 4th Year – 100%	Paid at 100% Composite fillings for all teeth covered at no extra charge. Two additional cleanings for pregnant women, up to four cleanings.
Crowns, Inlays, Onlays	Paid at incentive levels shown above	Paid at 100% (plus copays per unit of $70 for noble, $100 for high noble, $125 for upgraded, specialized porcelain if applicable.)
Prosthodonic Services	Paid at 50%	Paid at 100%
(Dentures, Bridges)		
Orthodontia	Paid at 50% Benefits are provided only for dependent children underage 25 (through age 24) regardless of attending school. or through completion of treatment, whichever occurs first. Lifetime maximum amount payable is $1,500 per eligible child.	$400 copay, and $150 pre-orthodontic service copay, which includes: Initial orthodontic exam $25 Study models/x-rays $125 No office visit copays for monthly visits. Benefits provided for eligible employees, spouse/partner, and dependent children underage 25 (through age 24) regardless of attending school or through completion of treatment, whichever occurs first.
Lifetime Maximum	$1,500	N/A
Choice of Providers	In-Network: Any contracted provider. Out-of-Network: Any licensed, qualified provider of your choice.**	In-Network: Any contracted provider in the DHS network. Out-of-Network: No out-of-network coverage.
Periodontics (surgical and nonsurgical procedures for treatment of the tissues supporting the teeth)	Paid at incentive levels above	Paid at 100%
Oral Surgery (routine and surgical extractions)	Paid at incentive levels above	Paid at 100%
Temporomandibular Joint (TMJ) Disorders	Not covered	$1,000 annual max $5,000 lifetime max
Dental Implants	Paid at 50%	Call the Dental Health Services office for details
Other	N/A	Occlusal (night guard) with $350 copay

** Expenses paid based on actual charges or average fee charged by 51% of providers in the area, whichever is less.

2010 Monthly Dental Premiums for I.B.E.W. Local 77 Represented City Employees

Dental Plan	Total Monthly Premium Amount	Employee's Monthly Premium Contribution
Washington Dental Service	$138.47	$0.00
Dental Health Services	$154.87	$0.00

2010 Summary of Vision Coverage

Plan Features	VSP Provider	Non-VSP Provider
Eye exam: Covered each calendar year.	$10 copay. Exam covered in full.	Covered up to $35.
Lenses and/or Frames Lenses covered every 12 months. Frames covered every 24 months.	$25 copay. Single vision, lined bifocal, lined trifocal lenses are covered in full. Frames covered in full up to $150.	$25 co-pay. Lenses covered at $30 to $45 depending on type of lens. Frames covered up to $30
Contact Lenses Covered every 12 months. (You may choose between glasses or contacts. You are not eligible for both during the same service period.)	Full payment of eye exam, contact lens evaluation exam, and fitting. Contact lenses covered in full up to $120 every 24 months.	Covered up to $90. Includes eye exam, lens evaluation exam, fitting & materials.

2010 Monthly Vision Premiums for I.B.E.W. Local 77 Represented City Employees

Vision Plan	Total Monthly Premium Amount	Employee's Monthly Premium Contribution
Vision Service Plan	$9.83	$0.00

Flexible Spending Accounts

The City offers two kinds of flexible spending accounts (FSA) – health care and dependent care.

Health Care Flexible Spending Account (FSA)

You can set aside from $300 to $5,000 of pre-tax earnings each year to pay for out-of-pocket expenses such as dental/orthodontia care; medical, dental and vision copays, deductibles, coinsurance; eye wear, massages, or any IRS-eligible health care expense. Amounts set aside in the health care FSA reduce your taxable income and taxes.

How the Health Care FSA Plan works:

- You select the amount per month you wish to set aside as a payroll deduction, from $25 per month or $300 per year to $416 per month or $5,000 per year.
- The amount you select is deducted from your paycheck BEFORE federal income and Social Security taxes are taken out.
- As you incur eligible expenses, you:
    - Submit your itemized receipts and reimbursement form to the City's FSA plan administrator (Benefit Administration Company) for reimbursement by check or direct deposit; and/or
    - Use your health care FSA debit card to purchase health care items, while retaining all your receipts.
- You must sign up for the health care FSA to participate in the program and **re-enroll each year** during open enrollment. Even if you are participating this year, you must re-enroll to participate in 2010.
- If you currently have an FSA debit card and will enroll in the 2010 health care FSA, retain your card. The expiration date is printed on the front of the card.
- In order to request a new FSA debit card, call Benefits Administration Company at 206-625-1800, extension 307 or email flexcs@baclink.com. The card will arrive in 8 – 10 business days by U.S. mail.
- Your dependents' health care expenses are also eligible for reimbursement. (Domestic partners/same-sex spouses and their children must meet the IRS dependent eligibility criteria to qualify under the FSA.)

Dependent Care (Day Care) Flexible Spending Account (FSA)

The City offers the Dependent Care FSA to help make day care expenses more manageable. By using the dependent care FSA to pay for care for 1) children under age 13 or for 2) any other tax dependent person who is physically or mentally incapable of self-care, you can reduce your taxes. (Please refer to IRS Publication 503 for eligible dependent care expenses.) Here's how it works:

- Set aside earnings each month on a pre-tax basis through payroll deduction for planned dependent care expenses. Contribute as little as $25 a month or as much as $416 a month ($5,000 maximum per family).
- The amount you select is deducted from your paycheck BEFORE federal income and Social Security taxes are taken out.
- When you have an eligible dependent care expense, you submit a paid receipt or invoice to Benefit Administration Company and are reimbursed for the expense, up to the amount currently in your account.
- You must **re-enroll** each year during open enrollment to participate the following year.

For more information go to http://personnelweb.ci.seattle.wa.us/benefits/optional/flexible.aspx . Go to Employee Self-Service to (re) enroll. Only use the form at the back of this booklet if you do not have access to ESS.

Optional Insurance Plans

Long Term Disability (LTD)

As part of your City benefits package you receive Basic Long Term Disability coverage to provide you with 60% of the first $667 of pre-disability earnings per month if you are sick or injured and cannot work. If you are disabled according to the plan definition, the benefit will combine with other income sources, if any, to pay you up to $400 per month after a 90-day waiting period while you are unable to work.

Supplemental LTD

You may add to your Basic LTD coverage during open enrollment by purchasing Supplemental LTD coverage. The Supplemental LTD benefit will combine with other income sources, if any, to provide 60% of your monthly base pay over $667 (up to a maximum of $8,333 monthly base pay) for a total benefit of up to $5,000 per month.

If you are currently eligible to receive a retirement benefit, you may not want to purchase this coverage because the maximum LTD benefit you would receive would be $100 per month if you elect to receive a retirement pension.

How Much Will Supplemental LTD Coverage Cost?
The cost for this additional level of earnings protection is figured according to the following formula:
1. Subtract $667 from your base monthly pay.
2. Multiply the remaining amount by .0075.
For example, if your base pay is $2,000 per month, your monthly premium would be $9.99/month ($2,000 - $667 = $1,333 x .0075 =$9.99/month). Your monthly cost and potential benefit increases each time your pay increases.

Group Term Life (GTL) Insurance

Benefit choices include three levels of optional term life insurance: Basic GTL, Limited Basic GTL, and Supplemental GTL. The City and you share in the cost of Basic GTL or Limited Basic GTL, while you pay the full cost for any Supplemental Life Insurance. The Group Term Life Insurance Election Form is on the Personnel Department http://personnelweb/benefits/library/forms.aspx, or available from your Human Resources Representative.

Basic Term Life Insurance

This optional coverage provides you with a term life benefit amount equal to 1.5 times your annual salary. The City contributes 40% of the cost and you pay the other 60%.

Your coverage amount is equal to your annual salary, rounded up to the next $1,000 increment, multiplied by 1.5. Your monthly premium equals $0.066 times each $1,000 of coverage. For example, if your salary is $25,500, round it up to $26,000. Your coverage amount is $39,000 (Calculation: $26,000 x 1.5 = $39,000). Your premium is $2.57 per month (Calculation: $0.066 x 39).

Remember, if you are not a new employee, but you want to apply for Basic Group Term Life Insurance during Open Enrollment, you must complete a Medical History Statement and return it with your Group Term Life Insurance Election Form. Medical History Statements are available from your Department's Human Resources Representative or the Benefits Unit.

The following table shows the monthly cost of Basic GTL insurance and the amount you are eligible to buy based on annual earnings.

Annual Earnings	Monthly Cost	Amount of Insurance
$49,000.01 – 50,000	$4.95	$75,000
$50,000.01 – 51,000	$5.05	$76,500
$51,000.01 – 52,000	$5.15	$78,000
$52,000.01 – 53,000	$5.25	$79,500
$53,000.01 – 54,000	$5.35	$81,000
$54,000.01 – 55,000	$5.45	$82,500
$55,000.01 – 56,000	$5.54	$84,000
$56,000.01 – 57,000	$5.64	$85,500
$57,000.01 – 58,000	$5.74	$87,000
$58,000.01 – 59,000	$5.84	$88,500
$59,000.01 – 60,000	$5.94	$90,000
$60,000.01 – 61,000	$6.04	$91,500
$61,000.01 – 62,000	$6.14	$93,000
$62,000.01 – 63,000	$6.24	$94,500
$63,000.01 – 64,000	$6.34	$96,000
$64,000.01 – 65,000	$6.44	$97,500
$65,000.01 – 66,000	$6.53	$99,000
$66,000.01 – 67,000	$6.63	$100,500
$67,000.01 – 68,000	$6.73	$102,000
$68,000.01 – 69,000	$6.83	$103,500
$69,000.01 – 70,000	$6.93	$105,000
$70,000.01 – 71,000	$7.03	$106,500
$71,000.01 – 72,000	$7.13	$108,000

Limited Basic GTL (benefit limited to $50,000):

The value of any life insurance coverage depends on your age (and associated risk of death) and the amount of the coverage. IRS rules state that the value of any Basic Life Insurance over $50,000, which is paid for by the City, is taxable. Because the City pays 40% of the cost for your Basic GTL, you may owe taxes on your Basic Life Insurance coverage. If you do, the amount (value) on which you pay taxes will be shown on your second paycheck stub each month under the section titled "Other Benefits and Information." To avoid the additional taxes, you may limit your Basic GTL coverage to $50,000 by signing a notarized Waiver form available from your department Human Resources Representative and completing and submitting the Group Term Life Insurance Election Form. The form is available at the Personnel Department InWeb site or from your department's Human Resources Representative.

Supplemental Group Term Life Insurance (GTL)

The City offers Supplemental GTL as an additional option. As long as you are enrolled for Basic GTL, you may purchase this extra term life insurance for yourself and for eligible family members; however, in order to cover your family members, you must enroll yourself, subject to various election rules. You pay the entire cost for Supplemental GTL coverage.

- You may purchase Supplemental GTL for yourself up to 4 times your base salary. The Supplemental coverage amount is rounded down to the nearest $5,000. For example, if your salary is $34,000, you should already have $51,000 in Basic coverage ($34,000 times 1.5). Then if you purchase two times your base salary in Supplemental coverage, your Supplemental coverage will provide an additional $65,000 in coverage ($68,000 rounded down), for a total of $116,000 in Life insurance coverage on yourself through the City. If the amount of Supplemental GTL when added to the amount of your Basic GTL would exceed $500,000 you will need to complete and submit a Medical History Statement.

- To elect life insurance for your family members, you must be enrolled or have applied for Supplemental GTL for yourself.
- You may purchase Supplemental GTL for your spouse/domestic partner in multiples of $5,000 up to a maximum of 50% of the amount of Supplemental GTL coverage you purchase for yourself. For example, if you purchase $120,000 of Supplemental GTL for yourself, you may purchase up to $60,000 of Supplemental GTL for your spouse/domestic partner. (There is no Basic Life insurance coverage for your spouse or partner.)
- You may purchase Supplemental GTL for your children equal to $2,000, $5,000 or $10,000 for each child. Children may be covered until their 25th birthday.

Costs for Supplemental GTL for you and your spouse/domestic partner are based on your age (and associated risk of death) and the amount of coverage. Costs for covering eligible children are fixed and the monthly premium is the same regardless of how many children you cover.

Rules for Electing Life Insurance

1. Unless you are a new employee, if you sign up for Basic and/or Supplemental GTL during this open enrollment period, you will need to complete and submit a Medical History Statement. To elect life insurance for your family members, you must be enrolled or have applied for Supplemental GTL.
2. If you want to purchase Supplemental GTL for your spouse/domestic partner, he/she will also need to complete and submit a Medical History Statement. If you are a new employee, a Medical History Statement is required for your spouse or domestic partner only for coverage in excess of $50,000.
3. If you want to purchase Supplemental GTL for your child(ren), no Medical History Statement is needed.

Supplemental Group Term Life Insurance 2010 Monthly Employee Cost			
Employee and Spouse/Domestic Partner		**Supplemental GTL for Children (cost includes all children)**	
Your Age	**Monthly cost/$1,000**	**Amount of coverage**	**Monthly cost**
18-29	$.032	$2,000	$ .40
30-34	$.048	$5,000	$1.00
35-39	$.064	$10,000	$2.00
40-44	$.090		
45-49	$.152		
50-54	$.232		
55-59	$.360		
60-64	$.552		
65 & over	$.960		

Accidental Death and Dismemberment (AD&D) Insurance

To supplement your Basic and Supplemental Life Insurance, you may purchase AD&D Insurance for yourself, your spouse/domestic partner, and/or children. AD&D Insurance pays a death benefit (full insurance amount or "principal sum") if the insured person dies due to an accident or a percentage of the principal amount if the covered person loses a limb(s) due to an accident. For example, a person who is covered by AD&D Insurance would receive 50% of the full insurance amount if he/she lost a limb from an injury relating to an accident. This coverage may be purchased in addition to or instead of Basic and Supplemental Life Insurance.

You can add or change your AD&D coverage by completing and submitting an AD&D Insurance Election Form or making the changes on line. The form is available on the Personnel Department InWeb page (at http://personnelweb/benefits/optional/add.aspx or at http://personnelweb/benefits/library/forms.aspx), or from your department's Human Resources Representative.

Employee Only Coverage
You can cover yourself for amounts from $25,000 to $500,000 (in $25,000 increments).

Family AD&D Coverage
If you elect Family AD&D coverage, the amount of coverage for your covered dependents/domestic partner is a percentage of your coverage amount as shown below:

Coverage when Covered Dependents include:	Spouse/ Partner coverage amount relative to covered employee's coverage amount	Each Child's coverage amount relative to covered employee's coverage amount
Spouse/DP Only	60%	Not applicable (0%)
Spouse/DP & Children	50%	15%
Children Only	Not applicable (0%)	20%

AD&D Coverage Costs

This chart shows the monthly costs for AD&D coverage for employee and family coverage.

Accidental Death & Dismemberment Insurance 2010 Monthly Cost to Employees					
	Your Monthly Cost			**Your Monthly Cost**	
Principal Sum:	**Employee Only:**	**Employee and Family**	**Principal Sum:**	**Employee Only:**	**Employee and Family**
$ 25,000	.38	.63	275,000	4.13	6.88
50,000	.75	1.25	300,000	4.50	7.50
75,000	1.13	1.88	325,000	4.88	8.13
100,000	1.50	2.50	350,000	5.25	8.75
125,000	1.88	3.13	375,000	5.63	9.38
150,000	2.25	3.75	400,000	6.00	10.00
175,000	2.63	4.38	425,000	6.38	10.63
200,000	3.00	5.00	450,000	6.75	11.25
225,000	3.38	5.63	475,000	7.13	11.88
250,000	3.75	6.25	500,000	7.50	12.50

Where to Find More Information about Your Benefits

- You can check your current benefits elections on line if you have access to Employee Self Service on the City's InWeb. Go to http://selfservice . Benefit elections are under the Benefits Menu. If you do not have access to the InWeb, contact your department's Human Resources Representative.
- The Personnel Benefits website provides coverage summaries and informational booklets, as well as websites and contact information for each plan. Go to http://inweb/personnel/benefits
- You can access Aetna's custom DocFind website for the City of Seattle self-insured medical plans at http://www.aetna.com/docfind/custom/cityofseattle
- Aetna Navigator (www.aetnavigator.com) is a personalized website packed with health and provider information. Once you have registered, you can check the status of your claim, view Explanation of Benefits (EOB) statements, find a doctor or pharmacy, compare hospitals, price a prescription drug, sign up for the mail order drug (MOD) program, and refill MOD prescriptions. You can access the site 24 hours a day, 7 days a week.
- You can access Group Health's website at www.ghc.org and register for MyGroupHealth. Once you've registered, you can send a secure e-mail to your health care team, refill prescriptions and get drug information, make appointments, view lab test results, access a huge database of health information, use health risk assessment and improvement tools, and find facility and service information.

Who to Contact if You Have Questions

If you have questions, contact the following organizations by phone or obtain information through their web sites. The Personnel Department's Central Benefits Unit can be reached at 206-615-1340.

Aetna	877-292-2480	www.aetnanavigator.com
Group Health Cooperative	888 901-4636	www.ghc.org
Vision Service Plan	800-877-7195	www.vsp.com click on "Members and Consumers"
Washington Dental Service (WDS)	206-522-2300 or 800-554-1907	www.deltadentalwa.com
Dental Health Services	206-788-3444 877-495-4455	www.dentalhealthservices.com/cityofseattle
Prudential Retirement Bill Miller	800-833-5761 206-447-1924	www.prudential.com/online/retirement
Employee Assistance Program	206-654-4144 or 800-553-7798	http://www.eapfs.com Click on "I am an Employee" Username: "City of Seattle"
Long-Term Care John Hancock Insurance	800-439-3030	www.cityofseattle.jhancock.com User name: cityofseattle Password: mybenefit
Life, AD&D, LTD		Your Department/HR Representative
Health/Dependent Care Flexible Spending Accounts	206-625-1800 800-967-3709 FAX: 206-682-8016	Benefits Administration Company www.benefitadministrationcompany.com

City of Seattle

2010 OPEN ENROLLMENT

Local 77 HEALTH CARE BENEFIT ELECTION FORM

Last Name (Please Print)	First Name	Employee Number	Department

Home Address – Street	City	State	Zip

Hire Date	Work Phone	Birth Date (M/D/Y)	Social Security Number - -

MEDICAL, DENTAL and VISION INSURANCE

Effective date of coverage/change is **January 1, 2010** for:

☐Adding dependent(s) ☐Dropping dependent(s) ☐ Plan Change

Medical Plan Selection	**Employee Premium Share**
☐ City of Seattle Preventive Plan	$58.18
☐ City of Seattle Traditional Plan	$58.94
☐ Group Health Standard Plan	$50.16
☐ Decline Medical Coverage	

Dental Plan Selection

☐ Dental Health Services **OR** ☐ Washington Dental Service $ 0

Vision Plan ☐ Vision Service Plan $ 0

Add Dependent Coverage Information: List all eligible dependents to be included. Attach list for any additional dependents.

Spouse/Domestic Partner						**Birth Date**	**Enroll In**	
							☐**Yes** ☐ **No**	☐**Yes** ☐ **No**
Last Name	First Name	MI		Social Security Number		(M/D/Y)	Medical	Dental/Vision

Relationship

☐ **Spouse** ☐ Male ☐ Female	**OR**	☐ **Domestic Partner** ☐ Male ☐ Female		Partner claimed as IRS tax dependent ☐Yes ☐ No

1. Dependent Child						**Birth Date**	**Enroll In**	
							☐**Yes** ☐ **No**	☐**Yes** ☐ **No**
Last Name	First Name	MI		Social Security Number		(M/D/Y)	Medical	Dental/Vision

Relationship

Employee's Dependent ☐ Son ☐ Daughter	**OR**	**Partner's Dependent** Is child employee's IRS tax dependent? ☐ Son ☐ Daughter ☐Yes ☐ No	**OR**	**Other** (Step-child or Legal Guardian) ☐Male ☐ Female

THIS ENROLLMENT FORM IS NOT VALID UNLESS IT IS SIGNED AND DATED ON THE REVERSE SIDE

2. Dependent Child **Birth Date** **Enroll In**

							☐Yes ☐ No	☐Yes ☐ No
Last Name	First Name	MI		Social Security Number		(M/D/Y)	Medical	Dental/Vision

Relationship

Employee's Dependent	**OR**	**Partner's Dependent** Is child employee's IRS tax dependent?	**OR**	**Other** (Step-child or Legal Guardian)
☐ Son ☐ Daughter		☐ Son ☐ Daughter ☐Yes ☐ No		☐Male ☐ Female

3. Dependent Child **Birth Date** **Enroll In**

							☐Yes ☐ No	☐Yes ☐ No
Last Name	First Name	MI		Social Security Number		(M/D/Y)	Medical	Dental/Vision

Relationship

Employee's Dependent	**OR**	**Partner's Dependent** Is child employee's IRS tax dependent?	**OR**	**Other** (Step-child or Legal Guardian)
☐ Son ☐ Daughter		☐ Son ☐ Daughter ☐Yes ☐ No		☐Male ☐ Female

Dependent Eligibility Information: If you have listed a dependent child under the age of 25 years, please answer the questions below about your dependent:

1. Married? ☐ Yes ☐No
2. Income tax dependent? ☐Yes ☐ No
3. Incapacitated or Disabled? ☐ Yes ☐ No

Coverage Options

☐ I ACCEPT COVERAGE

Previously submitted enrollment information for a specific insurance plan is superseded by changes indicated on this form. I certify that my family members and I are eligible for the coverage requested. I authorize the City to deduct from my earnings any premium I am required to pay for the coverage I selected above.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under the City of Seattle's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines.

_____ _____

Employee's signature Date

☐ I DECLINE COVERAGE

If you have medical coverage elsewhere and lose your other coverage, you may enroll within 30 days of the loss of the other coverage upon providing proof of continuous medical coverage. If you have a qualifying change in family status, you may enroll within 31 days (or 60 days for a new child) of that change. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law through the City. However, if you retire you will be eligible to enroll in a City retiree medical plan.

If you decline coverage and have no medical insurance elsewhere, you will NOT be eligible to enroll in a medical plan until the next annual Open Enrollment unless you have a qualifying change in family status. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law or enroll in a City retiree medical plan.

I understand that by declining City of Seattle medical insurance, my medical coverage through the City will end, but my vision and dental insurance will continue.

I decline medical coverage for myself and family members.

_____ _____

Employee's signature Date

Department Representative's signature_____ Date Entered into HRIS _____

CITY OF SEATTLE

Accidental Death and Dismemberment (AD&D) and Supplemental Long-Term Disability (LTDS) Insurance Election Form

Last Name (Please Print) | First Name | Employee Number | Department

Home Address – Street | City, State | Zip

Hire Date | Work Phone | Birth Date | Social Security Number

ACCIDENTAL DEATH & DISMEMBERMENT

Effective date of coverage/change _____ for: ☐ Adding coverage ☐ Canceling coverage
☐ Changing principal sum ☐ Changing type of coverage (individual or family) ☐ Changing beneficiary

☐ **YES,** I am applying for accidental death and dismemberment insurance according to the terms of the group policy issued to the City of Seattle. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

☐ **Individual** ☐ **Family** **Principal Sum $ _____**

BENEFICIARY: Specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent. Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, please use a separate list, sign, date, and attach to form.

Last Name (Please Print) | First Name | Address | % of Benefit | ☐ Check if Contingent

Last Name | First Name | Address | % of Benefit | ☐ Check if Contingent

Last Name | First Name | Address | % of Benefit | ☐ Check if Contingent

☐ **NO,** I do not wish to purchase accidental death and dismemberment coverage at this time. I understand that if I later want coverage, I may only enroll during an open enrollment period.

SUPPLEMENTAL LONG TERM DISABILITY

Effective date of coverage/change _____ for:
☐ New employee ☐ Adding supplemental coverage ☐ Canceling supplemental coverage

☐ **YES,** I am applying for Supplemental Long Term Disability insurance according to the terms of the group policy issued to the City of Seattle. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. I understand that my coverage will be subject to any applicable pre-existing condition exclusions. This coverage is in addition to the Basic LTD coverage provided by the City. **Enrollment in this insurance is mandatory for LEOFF II Police and Fire employees.**

☐ **NO**, I do not care to participate in the City of Seattle's Supplemental Long Term Disability insurance plan. I understand that if I enroll later during an open enrollment period, my insurance will be subject to a longer pre-existing condition exclusion. I also understand that Basic LTD will still be provided by the City even if I do not elect Supplemental LTD coverage.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carriers to obtain, examine or release information needed to process claims for myself or my family.

Employee's signature_____ Date_____

Department Representative's signature_____ Date Entered into HRIS_____

City of Seattle

GROUP TERM LIFE INSURANCE ELECTION FORM

Last Name (Please Print) | First Name | Employee No. | Department

Home Address - Street | City, State | Zip

Hire Date | Work Phone | Birth Date | Social Security Number

BASIC GROUP TERM LIFE INSURANCE

Effective date of coverage/change ____ for: ☐ New Employee ☐ Adding coverage ☐ Canceling coverage

☐ **YES**, I am applying for group term life insurance according to the terms of the group policy issued to the City of Seattle, with coverage equaling 1½ times my annual salary. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

☐ **NO,** I do not care to participate in the City of Seattle's group term life insurance plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

BASIC GROUP TERM LIFE INSURANCE -- LIMITED COVERAGE

Effective date of coverage/change ____ for: ☐ New Employee ☐ Adding coverage ☐ Canceling coverage

☐ My gross salary is greater than $33,000, and I am applying for Basic GTL coverage limited to $50,000 (instead of the above Basic GTL coverage equal to 1½ times my salary) according to the terms of the group policy issued to the City of Seattle. I authorize premiums to be deducted from my salary. Previously submitted enrollment information for Basic GTL insurance, excluding current beneficiary information, is superseded by this election. I understand if I later want to increase my GTL coverage amount, I will be required to provide a Medical History Statement. My signed and notarized *Waiver Agreement* accompanies this application.

SUPPLEMENTAL GROUP TERM LIFE INSURANCE -- INDIVIDUAL COVERAGE

Effective date of coverage/change ____ for: ☐ New employee ☐ Adding coverage
☐ Canceling coverage ☐ Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for myself in the following amount according to the terms of the group policy issued to the City of Seattle. The coverage amount selected below does not exceed four times my annual salary rounded to the next lower multiple of $5,000 if not already a multiple of $5,000. ***I understand this coverage can only be purchased if I have also elected Basic GTL or Basic GTL - Limited Coverage***. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

Coverage Amount: $ ____ Current Annual Salary: $ ____

☐ **NO**, I do not care to participate in the City of Seattle's Supplemental GTL plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

SPOUSE OR DOMESTIC PARTNER COVERAGE

Effective date of coverage/change ____ for: ☐ New employee ☐ Adding coverage
☐ Canceling coverage ☐ Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for my spouse/domestic partner in the amount of **$** ____ according to the terms of the group policy issued to the City of Seattle. **This coverage amount is at least $5,000 or a multiple of $5,000, and is *not greater* than 50% of my Individual Supplemental GTL coverage amount.** I understand this coverage can only be purchased if I have also elected Individual Supplemental GTL coverage, and benefits for any loss are payable to me. I authorize deductions from my salary for contributions I am required to make toward the cost of this insurance.

☐ **NO**, I do not care to select the City of Seattle's Supplemental GTL insurance plan for a spouse or partner. I understand that if I currently have a spouse or partner, s/he will be required to submit a Medical History Statement if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

DEPENDENT CHILD COVERAGE

Effective date of coverage/change _____ for: ☐ New employee ☐ Adding coverage
☐ Canceling coverage ☐ Changing coverage amount

☐ **YES**, I am applying for Supplemental GTL Insurance for my child(ren) or my spouse's/domestic partner's child(ren) in the amount selected below according to the terms of the group policy issued to the City of Seattle. I understand this coverage can only be purchased if I have also elected Individual Supplemental GTL coverage, covered child(ren) must meet the eligibility criteria, and benefits for any loss are payable to me. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. (One amount covers all children)

☐ **$2,000** ☐ **$5,000** ☐ **$10,000**

☐ **NO**, I do not care to select the City of Seattle's Supplemental GTL insurance plan for dependent children. I understand that if I currently have a dependent child(ren), I may apply for coverage later only during an annual open enrollment period.

BENEFICIARY INFORMATION

Effective date of beneficiary change

List the beneficiary(ies) for *your* Basic and Supplemental Group Term Life Insurance. (You are the designated beneficiary for any spouse or partner, or dependent child loss.) Please specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. *Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, use a separate list, sign, date and attach to this form.

Beneficiaries for Basic Group Term Life

Last Name (Please Print)	First Name	Address	% of Benefit / ☐ Check if Contingent
Last Name	First Name	Address	% of Benefit / ☐ Check if Contingent

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Beneficiaries for Supplemental Group Term Life

Last Name (Please Print)	First Name	Address	% of Benefit / ☐ Check if Contingent
Last Name	First Name	Address	% of Benefit / ☐ Check if Contingent

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By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge, that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carrier to obtain, examine or release information needed to process claims for myself or my family.

Employee's signature _____ Date_____

I have completed and mailed the required Medical History Statement to the insurance company because:

☐ I am not a new employee and I am applying during open enrollment.
☐ I am not a new employee and I am applying for Spouse or Domestic Partner coverage during open enrollment.
☐ I am a new employee and the combined total of my Basic and Supplemental coverage exceeds $500,000.
☐ I am a new employee and the Supplemental coverage for my spouse/domestic partner exceeds $50,000.

Department Representative's signature_____ Date Entered into HRIS_____

CITY OF SEATTLE 2010 FLEXIBLE SPENDING ACCOUNT ENROLLMENT AND SALARY AGREEMENT FORM

If you wish to participate in a 2010 Flexible Spending Account (FSA), you must (re)enroll by **October 23,** 2009.

Enrollment is easy on Employee Self-Service (ESS) at http://selfservice.ci.seattle.wa.us/. Online enrollment improves accuracy; your submission serves as your electronic signature. **Go to page 2 for ESS online instructions.**

Use this form only if you cannot access Employee Self-Service.

Last Name (Please Print) First Name _____ Employee No _____ Department _____ Bargaining Unit _____

Home Address - Street _____ City, State, Zip _____ Work Telephone _____

☐ **Health Care FSA**
Medical, Dental and Vision expenses not covered by your insurance plans

☐ **Dependent Care FSA**
Day Care expenses for eligible dependents

Health Care Flexible Spending Account Contribution Amount	Dependent Care (Day Care) Flexible Spending Account Contribution Amount
The minimum amount you can contribute is $25 each month. (*$25 x 12 = $300 per year.)* The maximum is $416.66 each month *($416.66 x 12 = $5,000 per year.)* I authorize the City to deduct $ _____ from my salary **each month** before federal taxes are withheld. **(The monthly amount cannot exceed $416.66.)** I understand that this amount cannot be revoked or modified during the plan year except as explained in the materials provided.	The minimum amount you can contribute is $25 each month (*$25 x 12 = $300 per year.)* The maximum is $416.66 each month *($416.66 x 12 = $5,000 per year.)* I authorize the City to deduct $ _____ from my salary **each month** before federal taxes are withheld. **(The monthly amount cannot exceed $416.66.)** I understand that this amount cannot be revoked or modified during the plan year except as explained in the materials provided.
Deduction Schedule	**Deduction Schedule**
I understand that the City will deduct **half** of my contribution from the first paycheck and **half** from the second paycheck each month. **Note: NO deduction is taken from the third paycheck.**	I understand that the City will deduct **half** of my contribution from the first paycheck and **half** from the second paycheck each month. **Note: NO deduction is taken from the third paycheck.**
For 2010, this is a ☐ new enrollment ☐ re-enrollment	For 2010, this is a ☐ new enrollment ☐ re-enrollment

Note: This paper (hard copy) form is not valid unless signed on the reverse side.

Signature

My signature below indicates that I have read the enrollment form and descriptive materials, including the plan document, covering the Health Care and/or Dependent Care Flexible Spending Account programs provided by the City of Seattle. This enrollment form is binding on me and cannot be revoked or modified (other than as explained in the materials provided). I also understand that my salary will be reduced by the amount I have elected, that salary deductions occur twice a month (with no FSA deductions from the third paycheck), and that any amount left in my FSA account after all 2010 claims have been paid will be forfeited.

I also understand that this arrangement for paying eligible expenses with nontaxable dollars is intended to meet Internal Revenue Service requirements for such arrangements. If tax laws change or if this arrangement is deemed not to satisfy the requirements, I understand that the tax advantages described may not be available. I acknowledge that the City of Seattle makes no guarantee concerning the availability of any tax advantage.

Participant's Signature _____ Date _____

Please forward the completed form to Your Department's Benefits Representative.

Online Enrollment Instructions

Log onto the InWeb

1. **Go to**: http://selfservice.ci.seattle.wa.us/.
2. **Select** Employee Self-Service/.
3. **Enter your employee number and password** (if you do not know your employee number, contact your HR rep. For a password reset contact DoIT or the appropriate department contact.)
4. **Select Open Enrollment** on the menu, left side of the screen, under FAMILY.
5. **Select Flexible Spending Account.** If this is your first time opening the benefits enrollment, review the agreement and select agree.
6. **Select Flexible Spending Account** (again).
   Step 1 - Select re-enroll *or* enroll.
   Step 2 - Enter ***MONTHLY*** amount.
   Step 3 - Save your changes.
7. **Select** Summary of Election to confirm your 2010 benefit elections.

Remember: DO NOT submit a paper copy if you enroll on line.

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SEATTLE, WA
PERMIT # 1046

City of Seattle
Personnel Department
Benefits Unit
700 Fifth Avenue, Suite 5500
P.O. Box 34028
Seattle, WA 98124-4028

RETURN SERVICE REQUESTED

Open Enrollment for 2010
Ends on <u>October 23, 2009</u>

IMPORTANT: If you have access to Employee Self-Service, please make your changes on line. If you do not have access, paper forms are due to your Department's Human Resources representative by **<u>October 23.</u>**