

Open Enrollment Guide For Plan Year 2009

Local 77 – I. B. E. W.

October 1 to November 10, 2008



2009 plan enhancements start on page 4!
(Subject to new Collective Bargaining Agreement acceptance)

Letter from Mark M. McDermott, Personnel Director

Fall 2008

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

Open Enrollment is your opportunity to familiarize yourself with changes occurring to your benefit plans and to make changes to your benefits for the coming year. Please read through this Guide to familiarize yourself with benefits changes before you make choices for 2009. The City's Open Enrollment period this year for Local 77 is **October 1 – November 10, 2008**. All changes you make during this time will be effective January 1, 2009.

Please note the **eligibility age for dependent children will increase to age 25** (through age 24) on all plans regardless of whether they are in school. **If your child was not eligible in 2008 and will meet the new eligibility requirement, be sure to enroll him/her on your plans.** Read the Plan Changes section of the Guide (pp 4-7) for more information about this and other benefits changes, such as the new way to access your Health Care Flexible Spending Account (FSA) by using a dedicated debit card.

Subject to ratification of the new Collective Bargaining Agreement, several other changes will go into effect for 2009. The Traditional Plan offered through Healthcare Management Administrators (HMA) will be offered through Aetna. It will offer the same benefits as the HMA plan but will use the Aetna provider network and claims will be administered by Aetna. With this change, you will also be able to access a voluntary personal health assessment questionnaire, a personal health record, and 24-hour nurse consultation by telephone for both the Traditional and Preventive plans. In addition, the LifeMasters Diabetes Management program (which is being discontinued by Aetna) will be replaced with a disease management program that addresses diabetes and over 30 other conditions.

Please take the next few weeks to review your family's medical and other insurance needs so that you can update your coverage appropriately during open enrollment. City Benefits staff and plan providers will be available to answer questions at the benefits fairs held during the month of October. If you do not make any changes, your current coverage will continue in 2009, except with regard to the FSA. If you want to continue having a Flexible Spending Account, you must re-enroll in accordance with federal law.

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. Then 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 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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Checklist of Changes You Can Make During Open Enrollment

Higher Age Limit on Health Care Plans for Dependent Children

Please note eligibility age limit is being **increased** to age 25 (through age 24) for unmarried, dependent children regardless of whether they are in school, but you must **enroll them during open enrollment** to take advantage of this extension.

- Add your under age 25 dependent(s)

Medical coverage

- Change to a different plan
- Add a family member
- Drop a family member

Dental coverage

- Change to a different plan
- Add a family member
- Drop a family member

Vision coverage

- Add a family member
- Drop a family member

Supplemental Long Term Disability coverage

- Enroll in Supplemental LTD
- Drop Supplemental LTD

Life insurance (Medical History Statement required if adding or increasing coverage)

- Change beneficiary designation
- Add Basic Life or Limited Basic Life coverage
- Change your Basic Life to Limited Basic Life (or vice versa)
- Drop your Basic Life or Limited Basic Life coverage
- Add or increase your Supplemental coverage if you also 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

Long Term Care insurance

(You can apply at any time, although you are only guaranteed coverage if you apply during the first 60 days you are eligible)

- Enroll in Long Term Care

Accidental Death & Dismemberment insurance

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

Flexible Spending Accounts (By law, continuing participants must re-enroll every year)

- Enroll in Dependent Care Flexible Spending Account
- Enroll in Health Care Flexible Spending Account

Deferred Compensation Savings Plan (Changes can be made at any time)

- 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 12/31/09.)

Are Your Beneficiary Designations Up to Date? To avoid problems should the unexpected happen, it is important to periodically review your beneficiary designations for insurance, retirement, deferred compensation and sick leave cash-out. Now is a good time for this review. Beneficiary updates made online during open enrollment become effective immediately.

Open Enrollment is Here!

Between **October 1 and November 10**, you can make changes to your benefits coverages and add or drop dependents (see checklist on preceding page). You must make your online changes through **Employee Self-Service (ESS) by 5 PM on October 30**. **Paper enrollment forms** will be accepted by your Benefits representative **until 5 PM on November 10**.

Also remember that you must re-enroll if you wish to have a health care and/or dependent care Flexible Spending Account in 2009. Please **re-enroll** through Employee Self-Service. Even if you do not wish to make any changes, we encourage you to go on line and review/update your beneficiary information.

Increase in Age Limit for Dependent Children: A dependent child currently considered “over-age” may be eligible for health care coverage in 2009. Effective January 1, 2009, dependent children up to age 25 (through age 24) will be eligible for the City’s medical, dental, and vision plans regardless of whether they are in school. You **must re-enroll** your dependent child if he/she was not eligible at the end of 2008 under current rules and if he/she will be younger than 25 for at least part of 2009.

If you submit a paper enrollment form and then decide to make changes on line as well, 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 changes you make on line. Therefore, if you submit a paper form with changes and wish to make further changes, use another paper form with a later completion date.

Plan Changes

Plan Changes Effective January 1, 2009 (**NOT** subject to new Collective Bargaining Agreement acceptance)

- **NEW ELIGIBILITY AGE LIMIT FOR MEDICAL, DENTAL AND VISION PLANS** – Increase eligibility of dependent children to age 25 (through age 24) regardless of whether they are in school. Applies to Preventive and Traditional Plans (currently administered by HMA), Group Health Standard Plan, Dental Health Services Plan (DHS), Washington Dental Services Plan (WDS) and Vision Service Plan (VSP).

Medical Plan Changes Effective January 1, 2009 (subject to new Collective Bargaining Agreement acceptance)

NEW ADMINISTRATOR – Administration of the Preventive and Traditional Plans (currently administered by HMA), will be taken over by Aetna.

Preventive and Traditional

- **NEW BENEFIT — Add Simple Steps to a Healthier Life**

Simple Steps to a Healthier Life is a new, voluntary and confidential wellness program to help you and your dependents age 18 or over determine your health risks now and plan for a healthier future. You may access the wellness program conveniently from work or home; there is no special software to buy or install. The registration process is quick, easy, and secure.

The program provides a health assessment questionnaire to gauge your health risks, readiness to change certain health behaviors, and the impact of health on productivity. The health assessment questionnaire generates:

- Tailored health reports to help you focus on the areas of your health that matter most. You also will receive a printable one-page health summary to keep, record, and compare your results over time and to share with your doctor, dentist, or other health-care provider.
- An action plan that is personalized to help you achieve and maintain good health through healthy living programs that are recommended based on your health needs. These may address weight loss, healthy aging, getting in shape, stress relief, a healthier diet, a healthy heart, cancer fighting, diabetes fighting, going smoke-free, and/or alcohol awareness. The programs are easy to follow and provide step-by-step guidance for making health changes and building skills for long-term success. The programs also provide tools for tracking progress.

You will be able to log into your account at www.aetnavigators.com to access Simple Steps.

- **NEW BENEFIT — Add Personal Health Record**

Your personal health record will provide you online access to personal information including individualized messages and alerts, detailed health history, and integrated information to help you make informed decisions about your health care. Your medical information is automatically entered into your record based on claims data submitted to Aetna. You may voluntarily enter additional health

information such as family history, non-prescription medications, or procedures you had prior to Aetna membership.

You will be able to log into your account at www.aetn navigator.com to access your personal health record.

- **NEW BENEFIT — Add Informed Health Line Nurse Consultation**

You will have 24-hour, toll-free access to a team of registered nurses experienced in providing information on a variety of health topics. Learn about health conditions and medical procedures, or improve the way you communicate with your doctor.

You will be able to call the Informed Health Line at 1-800-556-1555.

- **NEW BENEFIT** – Add hearing aid benefit, which will pay up to \$1,000 per ear every 36 months.
- **NEW BENEFIT:** Add orthotics coverage, paying up to \$500 during an individual's lifetime subject to annual deductible.
- **NEW BENEFIT** – Jaw surgery exclusion removed. Orthognathic surgery covered for correction of skeletal deformities of the jaw with required documentation.
- **ENHANCED BENEFIT** -- Eliminate the annual benefit limit (maximum) for durable medical equipment.
- **REPLACEMENT BENEFIT** – **Aetna Health ConnectionsSM disease management program.**

Because Aetna is discontinuing LifeMasters Diabetes Management program, it will be replaced by Aetna Health Connections, a broader-based disease management program. The program addresses 37 common chronic diseases and conditions such as hypertension, diabetes, low back pain, migraines, and asthma. Additionally, Aetna Health Connections clinical staff can provide support if an individual suffers from more than one condition.

Aetna Health Connections also provides added health protection. State-of-the-art technology is used to assess whether individuals are getting the right care and to let the participant and doctor know if there's a chance for better or safer care. The ActiveHealth[®] Management CareEngine[®] system continuously scans medical, laboratory and pharmacy claims and other clinical data, comparing participants' health data with current guidelines of care on over 1,000 conditions, identifying gaps, errors, omissions and duplications, and notifies the treating doctor about opportunities to improve care. It can identify potentially dangerous drug-drug interactions, drug-disease interactions and the need for preventive screenings or other care.

Individuals may be identified for Health Connections participation through their physician or self-referral. Requests may be submitted through the Aetna Navigator website, Aetna patient management staff, or by submitting medical or pharmacy claims data. Supported diseases and conditions in the Health Connections program are listed below:

Vascular	Pulmonary	Orthopedic	Oncology	Gastrointestinal	Neurological	Other
Congestive Heart Failure	Asthma (adult & children)	Osteoporosis	Breast cancer	GERD (gastro esophageal/ reflux disease)	Geriatrics	Obesity
Diabetes (adult & children)	Chronic obstructive pulmonary disease	Rheumatoid arthritis	Lung cancer	Peptic ulcer disease	Migraines	Chronic kidney disease
Coronary artery disease		Osteoarthritis	Lymphoma /leukemia	IBS Crohn's disease & ulcerative colitis	Seizure disorders	Sickle cell disease
Peripheral artery disease		Chronic low back pain	Prostrate cancer	Chronic hepatitis	Parkinsonism	Cystic fibrosis
Hypertension			Colorectal cancer			End-stage renal disease
Cerebrovascular disease/stroke			General cancer			Low back pain
Hyperlipidemia						HIV
						Hypercoagulable state

Vision Plan Changes for 2009

Vision Service Plan

- **ENHANCED BENEFIT** -- Increase in-network retail frame allowance to \$150 every 24-month period.
- **ENHANCED BENEFIT** -- Increase in-network contact lens benefit to provide full payment for the exam and a \$120 lens allowance every 24-month period.

Dental Plan Changes for 2009

Dental Health Services

- **NEW BENEFIT** — Add occlusal guard (nightguard) coverage with \$350 copayment.
- **NEW BENEFIT** — Add two additional cleanings for pregnant women, up to four cleanings.
- Increase copayment on upgrade for noble and high noble crowns and bridges by \$20 due to the increase in the cost of gold. Copay for noble upgrade will be \$70 and will be \$100 for high noble upgrade.

Flexible Spending Account Program Change for 2009

- **NEW BENEFIT** — Add use of debit card for health care flexible spending account (FSA) program. Use “reimbursement” at point of purchase.

You may use the health care FSA to pay your non-reimbursed out-of-pocket expenses for medical, dental, prescription drug, vision and hearing services and supplies. Your before-tax contributions to your account through payroll deduction reduce your taxes and can be accessed currently to reimburse you after you incur eligible health care expenses.

Effective January 2009, you will have a second way to access your health care FSA money. Both options will allow you to access the unspent portion of your full annual contribution amount at any time for eligible expenses.

- 1) Submit your itemized receipts and reimbursement form, as you do now, to Benefit Administration Company for reimbursement by check or direct deposit; and/or
- 2) Request and use your new health care FSA debit card to purchase eligible health care items, thereby eliminating the need to request and wait for reimbursement. (Remember to retain all of your receipts.) You may obtain your debit card by contacting Benefits Administration Company starting the last week of December 2008 at 206-625-1800, extension 307 or emailing flexcs@baclink.com. Please allow 8 – 10 business days to receive your cards in the mail.

Eligible health care expenses fall into two categories. Here are some examples:

- The portion of covered expenses not paid by a health care plan, such as annual deductibles, co-pays, coinsurance, and covered charges that exceed the plan’s annual maximum.
- Services and supplies that may not be covered by the health care plan but are still considered an eligible expense by the IRS, such as hearing aid batteries, acupuncture, home improvements for medical reasons (e.g., wheelchair ramps, lowering of kitchen countertops), contact lens solution and laser vision correction.

Expenses not eligible for reimbursement include health insurance premiums (already deducted on a pre-tax basis from your paycheck), vitamins, health club dues, and cosmetic surgery or treatments.

By law, if you participated in the dependent care and/or health care Flexible Spending Account program in 2008, you must re-enroll during Open Enrollment to participate in the 2009 program.

Enrollment Options

The plan and dependent coverage elections you make now are for the 2009 plan year. According to IRS Section 125 regulations, you cannot change your dependent election outside of the open enrollment period unless you have a qualifying change in family status. Your enrollment options for 2009 and the consequences of your decision are described below.

ACCEPT medical coverage for yourself and eligible family members by completing and submitting a Health Care Benefit Election Form or making changes on line. If you do not fill out a new form or make changes on line, 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 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 as defined in the Change in Family Status/Dependent Eligibility section. Enrollment must take place within 30 days.
- If you have medical coverage elsewhere (you may not decline dental or vision coverage) and lose your other coverage, you may enroll in a City medical plan 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 or dis-enroll your eligible dependents 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, 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 premium contributions for 2009. Premium contributions will be divided into two equal payments and taken from the first two pay checks 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.

Medical Plan	Employee's Premium Contribution	City-paid Premium Amount	Total Monthly Premium Amount
City of Seattle Preventive	\$54.14	\$1028.70	\$1082.84
City of Seattle Traditional	\$54.86	\$1042.31	\$1097.17
Group Health Standard	\$46.76	\$888.45	\$935.21
Vision Service Plan	\$0	\$9.83	\$9.83
Washington Dental Service	\$0	\$124.41	\$124.41
Dental Health Services	\$0	\$149.85	\$149.85

Domestic Partner/Same-Sex Taxable Values

Taxable Benefit Amount (Coverage Value)

If your domestic partner/same-sex spouse and/or his/her children do not qualify as your IRS tax dependents, you will be taxed on the **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.

2009 Monthly Taxable Values of City Benefits for Domestic Partners/Same-Sex Spouses		
Type of Coverage	Domestic Partner/ Same-sex Spouse Taxable Value	Taxable Value Per Child
Medical	\$461.28	\$206.10
Dental	\$62.01	\$32.97
Vision	\$4.26	\$1.90
Total Taxable Value	\$527.55	\$240.98

Changing Your Plan Choices Outside of Open Enrollment

You may only make changes to your benefits elections outside the open enrollment period, if certain family status changes occur in your family. The changes you can make depend on the change. Call your department 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, children of your spouse or domestic partner, or any child for whom you are the legal guardian. The child must be unmarried and under age 25 regardless of whether he/she is in school and primarily dependent upon you financially.

Eligibility Age Limit Increase: Your now over-age dependent child may be eligible again for health care coverage through you in 2009. Effective January 1, 2009, the eligibility age limit for the medical, dental, and vision plans will increase up to age 25 (through age 24), regardless of whether a dependent child is in school. You **must re-enroll** your dependent child if ineligible in 2008 and if he/she will be younger than 25 at least for part of 2009.

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://inweb/personnel/benefits/pubs/dp_affmarriage.doc. For dependent children, you may need to provide birth certificates, final adoption documents, proof of legal guardianship, etc.

If the premiums for a domestic partner or same-sex spouse are taken after taxes, you may drop a domestic partner or same-sex spouse at 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 Summaries

The following plan summaries will help you compare plan features and decide which plan best fits your needs. The summaries 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.

2009 Summary of Medical Benefits—Local 77 (Subject to new Collective Bargaining Agreement acceptance)

This summary is intended to assist you in decision making. Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.

	City of Seattle Traditional		City of Seattle Preventive	
	Preferred Provider	Participating Provider	In-Network	Out-of-Network
Deductible (per calendar year)				
Does not apply	\$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 (OOP) Maximum (excluding deductible if applicable)				
\$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	\$1,000,000
Inpatient 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.	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.	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.	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.
	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.			

Group Health Cooperative (GHC)	City of Seattle Traditional		City of Seattle Preventive	
	Preferred Provider	Participating Provider	In-Network	Out-of-Network
COVERED EXPENSES				
Acupuncture				
Paid at 100% after \$5 copay with physician's referral for certain conditions.	Paid at 80%	Paid at 60%	Paid at 100% after \$5 copay	Paid at 70%
Maximum of eight visits per condition per calendar year.	Maximum of 12 visits per calendar year.	Maximum does not include acupuncture treatment for chemical dependency.		
Ambulance Service				
Paid at 80%.	Paid at 80% when medically necessary			
GHC-initiated non-emergency transfers are paid at 100%				
Chemical Dependency Treatment (alcohol/drug addiction)				
Inpatient: Paid at 100%	Paid at 80%		Inpatient: Paid at 100%	Inpatient: Paid at 70%
Outpatient: Paid at 100% after \$5 copay			Outpatient: Paid at 100% after \$5 copay	Outpatient: Paid at 70%
Combined benefit maximum of \$14,500 per 24 month period for inpatient and outpatient services	Combined benefit maximum of \$14,500 per 2-year period for inpatient and outpatient services, and preferred and participating services.		Combined benefit maximum of \$14,500 per 24 month period for in-network and out-of-network services	
Contraceptives				
Contraceptive drugs and devices: see Prescription Drug benefit.	Oral contraceptive drugs: see Contraceptive Drug 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%			
	Maximum benefit unlimited for in-network and out-of-network combined.			
Emergency Room Services				
GHC facility: Paid at 100% after \$50 copay (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.)	Paid the same as in-network except if it's non-emergency, then it's 70% after \$50 copay. (waived if admitted). Urgent care paid at 70%.
Non-GHC facility: Paid at 100% after \$100 deductible (waived if admitted)			Urgent Care paid at 100% after \$35 copay.	Urgent Care is paid at 100% after \$35 copay.

Group Health Cooperative (GHC)	City of Seattle Traditional		City of Seattle Preventive	
	Preferred Provider	Participating Provider	In-Network	Out-of-Network
Hospice				
Paid at 100% when authorized	Paid at 90%. Lifetime maximum of 6 months. 14 day inpatient limit. 120 hour limitation for skilled nursing care.	Paid at 100%	Paid at 100%	Not covered
Maternity Care (Inpatient)				
Delivery and related hospital..	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maternity Care (Outpatient)				
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 50%. Coinsurance does not apply to the annual out-of-pocket maximum.		Paid at 100% after \$5 copay	Paid at 70%
Neurodevelopmental Therapy (for children under age 7)				
Covered under Rehabilitation benefit.	Paid at 80%		Inpatient: Paid at 100% Outpatient: Paid at 100% after \$5 copay.	Paid at 70%. Coinsurance applies to the annual out-of-pocket maximum.
Physician and Hospital Services (Inpatient)				
Inpatient: Paid at 100%	Maximum of \$2,000 per calendar year for preferred and participating services combined. Coinsurance does not apply to the out-of-pocket maximum.	Paid at 80%	Maximum of \$3,000 per calendar year for in-network and out-of-network combined.	Paid at 70%
Physician and Hospital Services (Outpatient)				
Paid at 100% after \$5 copay for most visits	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%

Group Health Cooperative (GHC)	City of Seattle Traditional		City of Seattle Preventive	
	Preferred Provider	Participating Provider	In-Network	Out-of-Network
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 name: \$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 name: \$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.
	Mammograms limited to one per year for preferred and participating services combined and not applied to \$300 maximum.			
Rehabilitation Services (Inpatient)				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maximum of 60 days per condition per calendar year for all types of rehabilitation.	Maximum of \$50,000 per condition per calendar year for preferred and participating services combined.		Maximum of 120 days per calendar year for in-network and out-of-network combined.	
Rehabilitation Services (Outpatient)				
Paid at 100% after \$5 copay	Paid at 80%		Paid at 100% after \$5 copay	Paid at 70%
Maximum of 60 days per condition per calendar year for all types of rehabilitation.	Coinsurance does not apply to out-of-pocket maximum. Maximum calendar year benefit of \$2,000.		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.	

Group Health Cooperative (GHC)	City of Seattle Traditional		City of Seattle Preventive	
	Preferred Provider	Participating Provider	In-Network	Out-of-Network
Skilled Nursing Facility				
Paid at 100%; 60 day maximum per calendar year (in addition to coverage in lieu of hospitalization).	Paid at 80%		Paid at 100%	Paid at 70%
	Maximum of 90 days per calendar year.		Maximum of 120 days per calendar year for in-network and out-of-network combined.	
Smoking Cessation				
Paid at 100% for individual/group sessions. 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.	Paid at 80%		Paid at 100% after \$5 copay.	Paid at 70%
Maximum of 10 visits per calendar year.	Maximum of 10 visits per calendar year.		Maximum of 20 visits per calendar year for in-network and out-of-network combined.	
Sterilization Procedures				
Vasectomy and tubal ligation covered subject to applicable copayment	Paid at 80%	Paid at 60%	Inpatient: Paid at 100% Outpatient: Paid at 100% after \$5 copay.	Paid at 70%
Temporomandibular Joint (TMJ) Services				
Inpatient: Paid at 100%. Outpatient: Paid at 100% after \$5 copay. Maximum benefit of \$1,000 per calendar year/\$5,000 lifetime for inpatient and outpatient combined.	Not covered			Not covered
Tooth Injury due to accident				
Not covered	Paid at 80%		Inpatient: Paid at 100% Outpatient: Paid at 100% after \$5 copay.	Paid at 70%
	Services of dentist or dentist covered based on R&C charges up to 12 months from injury date to a maximum of \$600. Physician and hospital benefits provided if inpatient care needed.			Services of dentist or dentist covered based on R&C charges up to 12 months from injury date. Physician and hospital benefits provided if inpatient care needed.

Group Health Cooperative (GHC)	City of Seattle Traditional		City of Seattle Preventive	
	Preferred Provider	Participating Provider	In-Network	Out-of-Network
Travel Outside of Country				
Emergency: Paid at 100% after \$100 deductible. Waived if admitted.	Emergency paid at 80%. Non-emergency paid at 60%		Not applicable	Paid at 100% after applicable office, or emergency room copay.
Non-emergency: Not covered.				Paid at 70% after applicable copay for non-emergency
Vision Hardware				
Covered under Vision Service Plan	Covered under Vision Service Plan.		Covered under Vision Service Plan	
Wellness Tools				
On line health profile to determine health risks. Health report and recommendations based on profile. Unlimited lifestyle coaching. Group Health Medical Records: All claims are included in the member's permanent record. Health profile data is integrated into the electronic medical record.	On line health profile to determine health risks. Health report and recommendations based on profile. No lifestyle coaching. Personal Health Record: Medical information is automatically populated based on claims data submitted. Targeted messages, alerts, and reminders via each individual's record.	N/A	On line health profile to determine health risks. Health report and recommendations based on profile. No lifestyle coaching. Personal Health Record: Medical information is automatically populated based on claims data submitted. Targeted messages, alerts, and reminders via each individual's record.	N/A
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.

^ Applies to Aetna – Aexcel network, a specialty network of doctors in the 13 specialty areas. The coinsurance level will drop 10% for non-Aexcel doctors in the 13 specialty areas (coinsurance applies to in-network, out-of-pocket maximum).

This summary is intended to assist you in decision making. Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.

2009 Summary of Dental Benefits (Subject to new Collective Bargaining Agreement acceptance)

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 1 st Year – 70% 2 nd Year – 80% 3 rd Year – 90% 4 th 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.)
Prosthetic Services (Dentures, Bridges)	Paid at 50%	Paid at 100%
Orthodontia	Paid at 50% Benefits are provided only for dependent children under age 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 under age 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.

2009 Summary of Vision Coverage

(Subject to new Collective Bargaining Agreement acceptance)

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.

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 may set aside from \$300 to \$5,000 of pre-tax earnings annually to pay for out-of-pocket expenses such as dental/orthodontia care not covered by the dental plan; 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 taxes.

Here is how the Health Care FSA Plan works:

- You select the amount per month you wish to set aside as a payroll deduction, which may not exceed \$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, as you do now, to the City's FSA plan administrator (Benefits Administration Company) for reimbursement by check or direct deposit; and/or
 - Use your new 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 2009.
- In order to receive an FSA debit card for 2009, call Benefits Administration Company at 206-625-1800, extension 307 or email flexcs@baclink.com starting the **last week of December 2008**. 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 eligibility criteria for dependents.)

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

The City offers the Dependent Care FSA to help make day care expenses more manageable. You can reduce your taxes by using the dependent care FSA to pay for care for children under age 13 or for any other person who qualifies as a dependent if he or she is physically or mentally incapable of self-care, (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 to pay 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 an invoice or a paid receipt to Benefits 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://inweb/personnel/benefits/flex.asp>. A form is included at the back of this booklet.

Optional Insurance Plans

Long Term Disability (LTD)

Basic LTD

As part of your basic City benefits package you receive a Basic Long Term Disability policy that will pay a portion — 60% of the first \$667 in base earnings or up to \$400/month—of your monthly pay if you are sick or injured and cannot work. If you are disabled according to the definition in the plan, the plan benefit will combine with other sources of income to pay you up to \$400 per month after a 90-day waiting period. Your basic benefit maximum will be up to \$400 per month 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 plan will combine with certain other income sources 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 from the City if you were to leave employment, 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 ($\$2,000 - \$667 = \$1,333 \times .0075 = \$9.99/\text{month}$). Your monthly cost 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 pay for Basic GTL or Limited GTL, while you pay the full cost for any Supplemental Life Insurance. The Group Term Life Insurance Election Form is on the Personnel Department InWeb page, 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 \$0.081 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: $\$26,000 \times 1.5 = \$39,000$). Your premium is \$3.16 per month (Calculation: $\$0.081 \times 39$)

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.

Limited Basic GTL:

IRS rules state that the value of any Basic Life Insurance over \$50,000, which is paid for by the City, is taxable. The value depends on your age (and associated risk of death) and the amount of the coverage. Because the City pays 40% of the cost for your Basic GTL, you may have some taxable value. If you do, the amount 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.

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	6.08	75,000
50,000.01 – 51,000	6.20	76,500
51,000.01 – 52,000	6.32	78,000
52,000.01 – 53,000	6.44	79,500
53,000.01 – 54,000	6.56	81,000
54,000.01 – 55,000	6.68	82,500
55,000.01 – 56,000	6.80	84,000
56,000.01 – 57,000	6.93	85,500
57,000.01 – 58,000	7.05	87,000
58,000.01 – 59,000	7.17	88,500
59,000.01 – 60,000	7.29	90,000
60,000.01 – 61,000	7.41	91,500
61,000.01 – 62,000	7.53	93,000
62,000.01 – 63,000	7.65	94,500
63,000.01 – 64,000	7.78	96,000
64,000.01 – 65,000	7.90	97,500
65,000.01 – 66,000	8.02	99,000
66,000.01 – 67,000	8.14	100,500
67,000.01 – 68,000	8.26	102,000
68,000.01 – 69,000	8.38	103,500
69,000.01 – 70,000	8.51	105,000
70,000.01 – 71,000	8.63	106,500
71,000.01 – 72,000	8.75	108,000

Supplemental Group Term Life Insurance (GTL)

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

- You may purchase Supplemental GTL for yourself for up to 4 times your base salary. The coverage amount is rounded down to the nearest \$5,000. For example, if your salary is \$34,000 and you purchase one times your base salary, your actual coverage amount is \$30,000. 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.

- 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.
- 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 2009 Monthly Cost to Employees			
Supplemental GTL for 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. 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 at the Personnel Department InWeb page, or from your Human Resources Representative.

Employee Only Coverage

You can cover yourself for amounts from \$25,000 to \$500,000 (in \$25,000 increments). AD&D Insurance pays a death benefit (full insurance amount or "principal sum") if the insured person dies due to an accident; it pays 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.

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 Dependents include:	Spouse/ Partner coverage amount	Each Child's coverage amount
Spouse/DP Only	60%	0%
Spouse/DP & Children	50%	15%
Children Only	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 2009 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.aetnavigators.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, 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 a Question

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.aetnavigators.com
Group Health Cooperative	888-901-4636	www.ghc.org
Vision Service Plan	800- 877-7195	www.vsp.com click on "Members and Consumers"
Dental Health Services (DHS)	206-788-3444 877-495-4455	https://www.dentalhealthservices.com/cityofseattle/
Washington Dental Service (WDS)	206 522-2300 800-554-1907	www.ddpwa.com
Prudential Retirement Bill Miller	800-833-5761 206-447-1924	www.prudential.com/online/retirement
Employee Assistance Program	206 654-4144 800-311-0216	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/Benefits Representative
Health and/or Dependent Care Flexible Spending Accounts	(206) 625-1800 ext 307 FAX 206-628-8016	Benefits Administration Company www.benefitadministrationcompany.com

City of Seattle
2009 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, 2009** for:

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

Medical Plan Selection

- City of Seattle Preventive Plan
- City of Seattle Traditional Plan
- Group Health Standard Plan
- Decline Medical Coverage

Employee Premium Share

\$54.14
 \$54.86
 \$46.76

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

Spouse/Domestic Partner				Birth Date		Enroll In	
Last Name	First Name	MI	Social Security Number	(M/D/Y)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					Medical	Dental/Vision	

Relationship

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

1. Dependent Child

1. Dependent Child				Birth Date		Enroll In	
Last Name	First Name	MI	Social Security Number	(M/D/Y)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					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

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

2. Dependent Child

				Birth Date	Enroll In	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last Name	First Name	MI	Social Security Number	(M/D/Y)	Medical	Dental/Vision

Relationship

Employee's Dependent <input type="checkbox"/> Son <input type="checkbox"/> Daughter	OR	Partner's Dependent Is child employee's IRS tax dependent? <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Yes <input type="checkbox"/> No	OR	Other (Step-child or Legal Guardian) <input type="checkbox"/> Male <input type="checkbox"/> Female
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3. Dependent Child

				Birth Date	Enroll In	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last Name	First Name	MI	Social Security Number	(M/D/Y)	Medical	Dental/Vision

Relationship

Employee's Dependent <input type="checkbox"/> Son <input type="checkbox"/> Daughter	OR	Partner's Dependent Is child employee's IRS tax dependent? <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Yes <input type="checkbox"/> No	OR	Other (Step-child or Legal Guardian) <input type="checkbox"/> Male <input type="checkbox"/> Female
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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.

[]	[]	[]	[] % of Benefit
Last Name (Please Print)	First Name	Address	<input type="checkbox"/> Check if Contingent
[]	[]	[]	[] % of Benefit
Last Name	First Name	Address	<input type="checkbox"/> Check if Contingent
[]	[]	[]	[] % of Benefit
Last Name	First Name	Address	<input type="checkbox"/> 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 <input type="text"/>	for:	<input type="checkbox"/> New employee	<input type="checkbox"/> Adding coverage
<input type="checkbox"/> Canceling coverage	<input type="checkbox"/> 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 <input type="text"/>

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> % of Benefit
Last Name (Please Print)	First Name	Address	<input type="checkbox"/> Check if Contingent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> % of Benefit
Last Name	First Name	Address	<input type="checkbox"/> Check if Contingent

Beneficiaries for Supplemental Group Term Life

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> % of Benefit
Last Name (Please Print)	First Name	Address	<input type="checkbox"/> Check if Contingent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> % of Benefit
Last Name	First Name	Address	<input type="checkbox"/> Check if Contingent

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 _____
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CITY OF SEATTLE 2009 FLEXIBLE SPENDING ACCOUNT ENROLLMENT AND SALARY AGREEMENT FORM

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

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

Health Care FSA **Dependent Care (Day Care) FSA**
Medical, Dental and Vision expenses not covered by your insurance plans **Day Care expenses for eligible dependents**

Health Care Flexible Spending Account Contribution Amount	Dependent Care Flexible Spending Account Contribution Amount
<p>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.)</p> <p>I authorize the City to deduct \$ _____ from my salary each month before federal taxes are withheld. (This 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.</p>	<p>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.)</p> <p>I authorize the City to deduct \$ _____ from my salary each month before federal taxes are withheld. (This 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.</p>

Deduction Schedule	Deduction Schedule
<p>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.</p> <p>For 2009, this is a <input type="checkbox"/> new enrollment <input type="checkbox"/> re-enrollment</p>	<p>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.</p> <p>For 2009, this is a <input type="checkbox"/> new enrollment <input type="checkbox"/> re-enrollment</p>

Note: This form is not valid unless signed on Page 2 – see 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 deductions on the third paycheck), and that any amount left in my FSA account after all 2008 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 this Form to the Benefits Representative in Your Department



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 Plan Year 2009
October 1 to November 10, 2008**

IMPORTANT: Change forms and Flexible Spending Account enrollment forms are due to your Department Human Resources representative by November 10. You also can enroll on line by October 30.

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