Temporary Benefits-Eligible Employees

Benefits Guide

2020

Seattle
Human Resources

Updated April 30, 2020

Benefits Eligibility for Temporary City Employees

Benefits Program	TMP	TMP	TMP	TMP	TBE	TBE
	Interim/Short-term temporary assignment up to 1 year (assignment does **not** exceed 1,040 hours)*,******	Less than half-time temporary (seasonal, on-call) that does **not** exceed 1,040 hrs*,******	One or more Interim/Short term temp assignments. Within 1 year individual **has worked** 1,040 hrs*, **, ******	Variable Hour Temporary Employee (worked 30 hours or more per week on average during previous 12 months)*****, ******	Short-term/Interim temporary assignment of up to 1 year (after assignment in effect for 1,040 hrs.)***	Term-limited temporary assignment (1-3 years)***
Medical	Not eligible	Not eligible	EE may purchase	Yes	Yes	Yes
Dental	Not eligible	Not eligible	EE may purchase	Not eligible	Yes	Yes
Vision (Basic)	Not eligible	Not eligible	EE may purchase	Not eligible	Yes	Yes
Vision (Buy-Up)	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible
AD&D	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible
Deferred Compensation	Yes	Yes	Yes	Yes	Yes	Yes
Employee Assistance Program	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible
Flexible Spending Accounts (Health Care and Day Care	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible
Group Term Life (Basic)	Not eligible	Not eligible	Not eligible	Not eligible	Yes	Yes
Group Term Life (Supplemental)	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible
Long-Term Disability (Basic)	Not eligible	Not eligible	Not Eligible	Not eligible	Yes	Yes
Long-Term Disability (Supplemental)	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible
SCERS membership	Not eligible	Not eligible	****	Not eligible	****	****
Tobacco Cessation	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible

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Benefits Program	TMP	TMP	TMP	Variable Hour	TBE	TBE
	Interim/Short-term temporary assignment up to 1 year (assignment does **not** exceed 1,040 hours)*, ******	Less than half-time temporary (seasonal, on-call) that does **not** exceed 1,040 hrs*, ******	One or more Interim/Short term temp assignments. Within 1 year individual **has worked** 1,040 hrs*, **, ******	Variable Hour Temporary Employee (worked 30 hours or more average during previous 12 months)*****, ******	Short-term/Interim temporary assignment of up to 1 year (after assignment in effect for 1,040 hrs.)***	Term-limited temporary assignment (1-3 years)***
WW Savings	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible	Not eligible
Sick Leave	Yes	Yes	Yes	Yes	Yes	Yes
Vacation	Not eligible	Not eligible	Not eligible	Not eligible	Yes	Yes
Holiday Pay	Not eligible	Not eligible	Not eligible	Not eligible	Yes	Yes
Funeral Leave	Not eligible	Not eligible	Not eligible	Not eligible	Yes	Yes
Jury Duty Compensation	Not eligible	Not eligible	Not eligible	Not eligible	Yes	Yes

*Receives premium pay. If conversion for a regular position is requested, position becomes eligible for benefits.

**See Personnel Rule 11.21 A for more information on health care coverage for temporary workers who receive Premium Pay.

***Receives benefits in lieu of premium pay

****A temporary worker may elect to join the Seattle City Employees' Retirement System:

1. Within 6 calendar months of completing 1,044 hours of compensated straight-time service; or
2. Upon appointment to an eligible position if such appointment occurs after the work has completed 1,044 hours of City service but before they have completed 10,440 hours of City service; or
3. Within 6 calendar months of completing 10,440 hours of continuous compensated straight-time service.

*****To follow Health Care Reform requirements

******Temporary employees who receive premium pay in lieu of fringe benefits will accrue one hour of paid leave for every thirty hours worked.

Exclusions:

- Work study, interns and independent contractors are not eligible for benefits regardless of hours worked for the City.
- Benefits **do not include** health care or day care flexible spending account programs, AD&D insurance, supplemental Group Term Life, supplemental Long-Term Disability, Long-Term Care insurance, Vision Buy-Up plan, Employee Assistance Program, tobacco cessation program, and Weight Watchers City pricing.

For assistance understanding the information in this document

- **Need to speak with someone in a language other than English?** Call the Benefits Unit at 206-615-1340 and we will help you access Language Line Services. You will have access to an interpreter and a Benefits Unit staff member to answer your questions.
- **Hearing impaired?** If you use a TDD, the City provides interpretation 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 want to call. They will call the person for you, then interpret information from your TDD to the person you are calling.
- **Visually impaired?** This Employee Benefits Guide document 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 other week. Orientations are held every other week – enroll on Employee Self-Service, Training section.

If additional help is needed or you would prefer to speak to someone confidentially, please call the Benefits Unit at 206-615-1340.

Please note: We have made every attempt to ensure the accuracy of this information. If there is any discrepancy between this booklet and the insurance contracts, other legal documents or the terms of an authorized collective bargaining agreement, the contracts, legal documents, and applicable collective bargaining agreements will always govern.

The City of Seattle intends to continue these plans indefinitely but reserves the right to amend or terminate them at any time in whole or part, for any reason, according to the amendment and termination procedures described in the legal documents. This booklet does not create a contract of employment with the City of Seattle.

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Employee Responsibilities

Temporary Benefits Eligible employees are responsible for making benefits elections or changes by their due dates including Open Enrollment. They must notify their department's benefits representative of any family or employment status changes that impact benefits such as marriage, legal separation, divorce, new or terminated domestic partnership, a birth or adoption, a leave of absence, or a death in the family. If you add a dependent to City benefits, you will receive a letter from Alight Solutions, the City's business partner, with information on how to verify eligibility.

New Temporary Benefits Eligible employee? You are responsible for making your benefits elections within 30 days of your date of hire. It is important to note that if you **waive** City coverage when you are eligible as a temporary employee and later become a regular employee, you will have to wait until Open Enrollment to enroll.

Adding a new family member to your health care coverage? Contact your department's benefits representative within 30 days of marriage or new domestic partnership. You have 60 days to notify your representative of a birth or adoption for medical, dental or vision coverage.

Dropping a family member from your health care coverage? Contact your department's benefits representative within 30 days of divorce or legal separation, domestic partnership termination.

Planning a leave of absence? Contact your benefits representative about how it could affect your City benefits.

Designating or changing your beneficiary?

- Life insurance - Employee Self-Service
- Retirement - contact the Retirement Office
- Sick leave or Deferred Compensation - see your benefits representative.

Moving? Update your address in Employee Self-Service.

Access your benefits information from home at http://www.seattle.gov/human-resources/benefits.

Eligibility and Coverage Information

The City of Seattle provides employees and their families a range of benefit options to support individual financial planning.

Medical

The City offers regular employees and their family members* a choice among four medical plans:

- Aetna Preventive
- Aetna Traditional
- Kaiser Permanente Standard
- Kaiser Permanente Deductible

Dental

The City offers dental coverage through Delta Dental of Washington and Dental Health Services.

Vision

The City offers vision coverage through VSP.

Life Insurance & Long-Term Disability (LTD)

The City offers Basic Long-Term Disability insurance and shares the cost of basic Group Term Life insurance.

Deferred Compensation Plan

The City offers a "457 (b)"** tax advantaged savings plan which allows employees to invest current, pre- and after-tax earnings to generate additional retirement income.

*If you enroll a dependent, Alight Solutions, the City's business partner, will send a letter to your home within 2-3 weeks requesting documents that confirm the eligibility of your dependent. Thank you for participating! For additional information about the verification process, go here.

**A type of retirement savings plan available to state & local government employers.

Eligibility and Coverage Information

Eligibility for Temporary Benefits-Eligible Employees

If you are a temporary benefits-eligible employee working full- or part-time (scheduled to work at least 80 hours per month), you are eligible to participate in selected benefits programs when you meet the eligibility requirements of your position:

- Term Limited Assignment – on your date of hire of your 1-3 year assignment
- One or More Interim/Short Term Assignments: after your short-term assignment of up to 1 year is in effect for 1,040 hours.

This is your "eligibility date". **See page 4** for when your coverage begins.

The benefits you are eligible for are: the medical, dental, basic, basic life, basic LTD, and deferred compensation plans (see pages 1-2).

Eligible Family Members

The following family members are also eligible to participate in the medical, dental, and vision programs:

Spouse or domestic partner – an Affidavit of Marriage/Domestic Partnership or Certificate of State Registered Domestic partnership must be filed with your department's Human Resources Unit to cover your spouse or domestic partner.

Child Eligibility

Children – your children, and your spouse's or domestic partner's children. Please check child eligibility requirements below*,**.

Plan	Age	Other
Medical, Dental, Vision	Up to age 26 (through age 25)	Do not have to be: -single -living with you -dependent on you for support May have access to other coverage.

*If you enroll a dependent, Alight Solutions will send a letter to your home within 2-3 weeks requesting documents that confirm the eligibility of your dependents. Additional information here.

**Coverage may continue for a handicapped/incapacitated child if the child becomes disabled prior to the limiting age, provided that proof of his or her fully handicapped/incapacitated status has been documented by a physician.

Eligibility and Coverage Information

When do I enroll?

You must submit your benefits enrollment forms within 30 days of your benefits eligibility date (see prior page).

When does coverage begin?

Actual coverage in the plans in which you are enrolled will begin on either your eligibility date, or the first day of the month following your eligibility date:

- Your coverage begins on your eligibility date if that date is:
  - the first calendar day of the month designated as a City business day, or
  - the first calendar day of the month designated or recognized as the first working day for the shift to which you are assigned, whichever is later.
- Your coverage begins on the first day of the following month if your eligibility date begins *after* the date described immediately above.

Remember, to be covered, you must submit a completed benefits enrollment form to your department's Benefits Representative within 30 days of becoming benefits eligible. If you miss the deadline, you will be defaulted into certain benefits and ineligible for others. You must wait for the next Open Enrollment period to make changes.

You may decline coverage, but will not be eligible for premium pay in lieu of benefits as a result of declining coverage.

What if I miss the enrollment deadline?
If you fail to enroll within 30 days of becoming benefits eligible, you will automatically be enrolled for dental and basic vision coverage. Your dental coverage will default to the Delta Dental of Washington plan.

Starting after January 2, 2018, if you are newly eligible for health coverage and don't actively elect or waive medical coverage, you will automatically be enrolled in the Aetna Traditional employee only plan. This plan requires no premium contribution from you.

You also will need to meet additional requirements to enroll in Life Insurance coverage at a later date. You will be required to submit a Medical History Statement and have it approved by the insurance company to be eligible for Life Insurance coverage.

Waiving Coverage

If you waive coverage and later become a regular employee, your next opportunity to enroll will be during Open Enrollment.

Eligibility and Coverage Information

How do I enroll?

To enroll in medical, dental and vision coverage, you must complete and submit a health care benefit election form to your department's Human Resources Representative. Group Term Life has a separate enrollment form. Make sure all forms are signed and dated before they are submitted. Forms are available at the end of this booklet, from your department's Human Resources Representative or on the Benefits website www.seattle.gov/human-resources/benefits.

Continuing Eligibility

To remain eligible for City paid benefits, you must have at least 80 hours of paid time during the calendar month. If the number of hours worked per month is less than 80 hours, benefits will be terminated, you will be responsible for any charges incurred.

Can I enroll my family members?

The following family members are eligible for coverage:

- Your spouse or domestic partner;
- Your birth or adopted children, or children placed for adoption;
- Children of your domestic partner who live with you;
- Stepchildren; or
- Any child for whom you are legal guardian or for whom coverage is required by a Qualified Medical Child Support Order.

Children may be covered on the following plans; see page 3 for detailed eligibility requirements for children.

- Kaiser Permanente plans
- Aetna Preventive Plan
- Aetna Traditional Plan
- Delta Dental of Washington
- Dental Health Services
- VSP

Coverage may continue after age 25 for a handicapped/incapacitated child if the child becomes disabled prior to the limiting age, provided that proof of fully handicapped/incapacitated status has been documented by a physician.

Visit www.seattle.gov/human-resoures/benefits for more information. Call your department's human resources or benefits representative or the City's Benefits Unit 206-615-1340 if you have questions.

Eligibility and Coverage Information

How do I disenroll my family members?

If you need to remove a family member from coverage outside of Open Enrollment, submit a completed Benefit Election Form to your department's benefits representative.

If you and your spouse or domestic partner's coverage due to legal separation, divorce or termination of the domestic partnership, submit a completed Statement of Termination of Marriage/ Domestic Partnership form or a Notice of Termination of State Registered Domestic Partnership within 30 days of the legal separation, divorce or domestic partnership termination.

Changing Your Benefits

There are two opportunities to change your benefit choices:

- Open Enrollment
- Within 30 days of a qualifying change in family or job status.

Open Enrollment

Open Enrollment is held once each year in the fall. During this time, you can change your benefits plans, add and drop family members, and add or drop coverages. If you make changes during Open Enrollment, your new coverage is effective on January 1 of the new (next) plan year. Increases in your Life insurance coverage are subject to the approval of your *Medical History Statement* by the life insurance carrier.

Life Events/Family Status Changes that May Affect Your Benefits

You must enroll a new spouse or domestic partner within 30 days of your marriage or establishment of a domestic partnership. You have 60 days to add a child acquired through birth, adoption, or placement for adoption. *If you miss the deadline,* you can only add family members during the annual fall Open Enrollment period.

If you have a change in family status, you may be able to make a related change to your benefits. Here are several examples. Contact your department's benefits representative if any of the following occur:

- You adopt a child - you may add coverage for that child (you may add coverage for your other dependents at that time).
- Your child loses coverage under your spouse's coverage - you may add this child to your plan.
- You get married or form a domestic partnership - you may enroll your new spouse or domestic partner and his/her eligible children.
- Your spouse or domestic partner loses coverage due to termination of employment, change in employment status, or beginning an unpaid leave of absence – you may add your spouse or partner to the plan.

Eligibility and Coverage Information

	• Your spouse or domestic partner gains coverage due to start of employment, change in employment status, or ending an unpaid leave of absence–you may drop your spouse or partner from the plan. • You get divorced, separate, or dissolve a domestic partnership – you must drop the spouse or domestic partner from the plan. • Your child no longer meets the age requirements for medical/dental/vision – your child will be dropped from coverage.
When Coverage Ends	Your medical/dental/vision, Basic Long-Term Disability, and Group Term Life coverages end on the last day of the calendar month in which you: • Are no longer eligible • Resign, retire or are terminated • Stop making any required payment. Your medical, dental and vision coverages will also end on the day the plan terminates, or if you die (your family members' coverage will end on the last day of the calendar month in which you die).
Continuing Coverage Under COBRA	To help you maintain health coverage, Congress passed the Consolidated Omnibus Reconciliation Act (COBRA) in 1986. Under COBRA, you are eligible to purchase continuing medical only, dental/vision only, or medical/dental/vision coverage under certain circumstances when your group health plan coverage with the City ends. If you are a City employee and have City medical, dental and vision coverage, you and your covered family members have the right to elect COBRA continuation coverage for up to 18 months if your coverage is lost because of one of these qualifying events: • Your employment ends for a reason other than gross misconduct • Your work hours are reduced to the point where you no longer are eligible for benefits. The 18-month COBRA continuation period may be extended to 29 months if you or a family member (who is a qualified beneficiary) is disabled according to Social Security at the time of one of the above qualifying events. This 11-month extension is available to all qualified beneficiaries who lose coverage due to termination of employment or a reduction of hours. Covered family members have the right to choose COBRA continuation coverage for up to 36 months if coverage is lost for any of these qualifying events:

Eligibility and Coverage Information

	• Death of the employee • Divorce or legal separation of the employee and spouse or dissolution of the domestic partnership. • A child loses coverage (turns 26) The Life and disability plans have conversion options.
Coverage through Health Insurance Exchange	As an alternative to COBRA, you may choose an individual medical plan through the health insurance exchange. Depending on your income and the number of dependents you cover, you may find a plan on the exchange that fits your coverage needs. More information at www.wahealthplanfinder.org.
Coverage through a City Retiree Plan	When you are eligible to retire, you will receive a packet of information about the City's retiree medical plans at your Retirement Office appointment. If you want to participate in a retiree medical plan instead of COBRA or a Health Insurance Exchange plan, be aware that you must choose a plan **at least 30 days** *before you retire*. In some cases, you can delay your enrollment in a City retiree medical plan if you are covered under another employer's plan. Contact the Benefits Unit at Benefits.Unit@seattle.gov for more information about the plans.

Paying for Benefits

Your Payroll Deductions

See page 23 for medical premiums

Medical, Dental and Vision
If you elect medical coverage, the City of Seattle pays most of the premium for you and your eligible, enrolled family members. The amount you pay depends on which plan you select and whether you cover a spouse or domestic partner.

Medical premiums are deducted each month on a pre-tax basis. Pre-tax deductions are exempt from Social Security taxes. This may slightly reduce your future Social Security benefits, but most people find that ongoing tax savings outweigh a future reduction in Social Security benefits, if any. If this is a concern for you, discuss it with your financial advisor. (Premium amounts paid for a domestic partner cannot be taken on a pre-tax basis if your partner is not a dependent on your IRS tax form.)

Dental and the Basic Vision plans are fully paid by the City for most employees. Your share of the cost for your medical premium is taken in equal amounts from the first and second paychecks of the month during the month of coverage on a pre-tax basis. For example, premium deductions taken from your March paychecks provide for March coverage.

Life Insurance
Your basic life insurance after-tax premium deductions are taken from your second paycheck of the month for the next month's coverage.

Benefits and Financial Planning

Because everyone's medical and financial situations are different, the City offers a variety of plans to help protect employees and their families from the financial hardship that unusual medical expenses can bring. The plans are designed to cover much of the cost of medically necessary health care services. However, employees still bear a portion of their medical service costs in the form of premiums, deductibles, copayments and coinsurance.

Since health care costs may be unanticipated, it makes sense to plan in advance and save for your out-of-pocket costs. Here are ways to cut costs and save money.

- Quit smoking and encourage your family to quit.
- Be more active and eat nutrient dense food. Many diseases and conditions are preventable, and healthy behavior reduces your future health care costs and enhances your life now.
- Go to check ups and screenings. Have regularly scheduled physical examinations by your doctor, dentist, eye doctor and so on. Take advantage of free medical screenings, flu shots and go to the City's wellness and benefits fairs.
- Choose the best health plan for you and your family. There is more to selecting a good health plan *than just the payroll deduction*. If you are shopping for a health plan, compare the premiums along with what is and is not covered by the various plans.
- Stay within the network. Look for doctors and health care providers that are within the plan's network. If you participate in an Aetna plan and require a specialist, make sure you use an Aexcel specialist, which will save you 10%.
- Review medical bills carefully. Billing errors can cost you hundreds or even thousands of dollars. Contact the billing office if there is an error or you do not understand your bill. You may be able to negotiate fees and bills that you feel are too high.

Medical Plan Options

Medical Plans	The City offers four different medical plans: • Aetna Preventive Plan • Aetna Traditional Plan • Kaiser Permanente Standard Plan • Kaiser Permanente Deductible Plan
How to Choose a Medical Plan	Plan features, coverages and costs vary. The City's plans with Aetna offer unlimited choice of doctors; coverage is higher if you use doctors in the Aetna network. The Kaiser Permanente plan requires that you use their network of doctors, clinics, hospitals, and pharmacies, but offer a higher level of coverage. Plans offering higher coverage (Aetna Preventive and Kaiser Permanente Standard) have lower copays but higher monthly premiums. The Aetna Traditional Plan has a larger annual deductible and lower or no monthly premiums. When making your decisions, you should consider cost, choice, and coverage. Here are some questions to ask yourself: • Do you want a plan that allows you to choose any doctor, hospital, or clinic (Aetna plans) or are you willing to stay within a network (Kaiser Permanente plans) and receive a higher level of coverage? • Would you rather pay higher monthly premiums to have a small annual deductible (Aetna Preventive Plan) or no annual deductible (Kaiser Permanente Standard Plan) and smaller copays? • Would you rather pay lower or no monthly premiums and have higher coinsurance and deductibles (Kaiser Permanente Deductible and Aetna Traditional plans)? The following very brief plan descriptions may help you make these choices. **New Temporary Benefits Eligible Employees:** Remember - You have 30 days from your hire date to enroll in the medical, dental, vision and Group Term Life plans. If you decline coverage when eligible as a temporary employee and later become a regular employee, you will have to wait until Open Enrollment to enroll.

Medical Plan Options

Aetna	The City has two plans with Aetna — the Preventive Plan and the Traditional Plan. The plans use the Aetna provider network, and Aetna administers the claims.
Preventive Plan	This plan has a $100 annual deductible per person ($300 per family) and a $15 copay for all office visits except preventive care (which is covered at 100%). The deductible applies to most services except where a copay applies. Most other services are covered at 90% after a copay if you use an Aetna network provider.
Traditional Plan	This plan has a $400 annual deductible per person ($1,200 per family). Most services are covered at 80% if you use an Aetna network provider. Most preventive care is not covered.
What If I Don't Use the Aetna Network?	If you choose a provider who is not in the network, you will pay a higher percentage of the visit cost. Prices charged by a non-network provider also are often higher than those charged by a network provider. If you use a non-network provider, you will pay 40% of the network service cost, and your doctor may charge you an additional amount above the network price.
Aetna's Aexcel Network	Aetna has a special sub-network, called the Aexcel network, which consists of doctors who specialize in the following areas: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/ gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, vascular surgery and urology. Doctors were selected for this special network because they meet screening criteria in the areas of experience, performance, effectiveness and efficiency. If you need care in one of these areas and you **do not** choose a doctor from the Aexcel network to provide that care, you will pay 10% higher coinsurance. You do not need a referral to see a specialist.
Accolade	Contact Accolade at 866-540-5418 or https://login.myaccolade.com/login for customer service, support with treatment decisions, benefit coverage questions, help finding a doctor or specialist, claim denials or complaints, prescription plan and formulary questions.
Aetna.com	Locate detailed claim information at Aetna.com.
Teladoc	Talk to a doctor anytime by phone or video. Be treated for health issues, including cold and flu symptoms, allergies and skin problems. You can also see a behavioral health provider and establish an ongoing relationship for issues such as depression and anxiety. Register at member.teladoc.com/registrations.
Urgent Care	Contact an Accolade Health Assistant at 866-540-5418 to find an urgent care facility near you. Or, log in to your account at Aetna.com

Medical Plan Options

Kaiser Permanente	Kaiser Permanente is a health maintenance organization which provides an integrated system of health care services. All services are delivered within Kaiser Permanente facilities or its contracted network providers. You must use Kaiser Permanente contracted providers and facilities unless a doctor refers you elsewhere. You do not need a physician's referral to see most Kaiser Permanente specialists.
Kaiser Permanente Standard Plan	The City offers two plans through Kaiser Permanente. This is a managed care plan with no deductible and an office copay of $15. Most services are covered at 100% after payment of a copay. Preventive care is covered.
Kaiser Permanente Deductible Plan	This is a managed care plan with a $200 annual deductible per person ($600 per family) and a $15 office copay. The deductible does not apply to ambulance service, prescription drugs, durable medical equipment and preventive visits (preventive visits do have a copay). After the deductible is satisfied, most services are covered at 100% after the copayment.
	The health care website is at KP.org/wa. Members can request appointments and exchange emails with their provider, view their online medical record, refill prescriptions online, and view lab and test reports. The provider and facility directory, and drug formulary are all accessible online. In addition, a mobile application is available.
Accolade	Accolade is a third-party resource that offers healthcare advocacy services at no cost. Kaiser members may use Accolade as a supplement to the Kaiser care team, member service and advice line. Contact Accolade at 866-540-5418 for health and benefits questions.
Health Profile	The plan has a health risk assessment called *Health Profile*. Members complete the profile online and receive a report and personalized action plan. Free healthy lifestyle coaching is available.
CareClinic	CareClinic is a walk-in health clinic in 15 Bartell Drugs locations. These clinics are for minor illnesses and injuries, like colds or coughs, eye or ear infections, vaccines for children, and sprains. Visit careclinic.org for locations.
Care Chat & Online Visits	Care Chat is a free online messaging feature that lets you get real-time care from a provider. Access through your account at kp.org/wa.
Consulting Nurse Service	Not sure what kind of care you need? Call Kaiser's Consulting Nurse Service 24/7 at 1-800-297-6877 (TTY 711).

2020 Medical Benefits Highlights - Most City of Seattle Employees

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 https://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/temporary-benefits-eligible-employees.

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Deductible (per calendar year)					
No Deductible	$200 per person $600 per family Deductible applies as noted except for prescriptions, preventive visits, ambulance, and durable medical equipment.	$400 per person $1,200 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$1,000 per person $3,000 per family	$100 per person $300 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$450 per person $1,350 per family
Annual Out of Pocket Maximum (OOP Max) includes medical coinsurance. Excludes the deductible and prescription drug copays/coinsurance.					
Includes medical copays		Excludes copays		Excludes copays	
$2,000 per person $4,000 per family	$2,000 per person $6,000 per family	$1,000 per person $3,000 per family	$2,000 per person** $6,000 per family*	$2,000 per person $4,000 per family	$3,000 per person* $6,000 per family*
Total Out of Pocket Maximum includes medical coinsurance and the deductible. Excludes prescription drug copays/coinsurance.					
Includes medical copays		Excludes copays		Excludes copays	
$2,000 per person $4,000 per family	$2,000 per person $6,000 per family	$1,400 per person $4,200 per family	$3,000 per person $9,000 per family	$2,100 per person $4,300 per family	$3,450 per person $7,350 per family
Hospital Copay					
$200 per admission	Deductible applies	$200 copay per admission	$200 copay per admission	$200 copay per admission	$200 copay per admission
Hospital Pre-admission Authorization					
Except for maternity or emergency admissions, must be authorized by Kaiser Permanente		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission. Member responsible for obtaining precertification of out-of-network care.		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission Member responsible for obtaining precertification of out-of-network care.	

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Choice of Providers					
All care and services provided at Kaiser Permanente Facilities or network providers Members may self-refer to most Kaiser Permanente specialists.		Aetna contracted providers. No primary care physician selection or referrals required. Aexcel*** specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.	Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.
COVERED EXPENSES					
Acupuncture					
$15 copay for up to 8 visits per medical diagnosis per calendar year. Additional visits when approved.	$15 copay for up to 8 visits per medical diagnosis per calendar year. Additional visits when approved. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
		Up to 12 visits per calendar year in- and out-of-network combined		Up to 20 visits per calendar year in- and out-of-network combined	
Alcohol/Drug Abuse Treatment (inpatient)					
Paid at 100% after $200 copay per admission	Paid at 100% after deductible	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
		Review and coordination of care in complex situations including residential treatment centers and partial hospitalization		Review and coordination of care in complex situations including residential treatment centers and partial hospitalization	
Alcohol/Drug Abuse Treatment (outpatient)					
Paid at 100% after $15 copay	Paid at 100% after $15 co-pay Deductible applies	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
		Additional focus on review and coordination of care in complex situations including psychological testing, neurological testing and intensive outpatient.		Additional focus on review and coordination of care in complex situations including psychological testing, neurological testing and intensive outpatient.	

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Contraceptives					
For contraceptive drugs and devices, see Prescription Drug benefit		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit.		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit.	
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80% Breast pump covered at 100% through DME provider	Paid at 60%	Paid at 90% Breast pump covered at 100% through DME provider	Paid at 60%
Emergency Medical Care					
➢ **Urgent Care Clinic**					
Paid at 100% after $15 copay	$15 copay Deductible applies	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay (no fee for preventive care)	Paid at 60%
➢ **Emergency Room (copays waived if admitted)**					
Kaiser Permanente facility: $100 copay Non-Kaiser Permanente facility: $150 copay	Kaiser Permanente facility: $100 copay Non-Kaiser Permanente facility: $150 copay Deductible applies	Paid at 80% after $150 copay	Paid at 80% after $150 copay. If non-emergency, paid at 60% after copay.	Paid at 90% after $150 copay	Paid at 90% after $150 copay If non-emergency, paid at 60% after copay
➢ **Ambulance**					
Paid at 80%.	Paid at 80%.	Paid at 80% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Gender Reassignment Services					
Covered as any other service; copays/coinsurance depending on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.
Hearing Aids (per ear, every 36 months)					
Up to $1,000	Up to $1,000	Up to $1,000	Up to $1,000	Up to $1,000	Up to $1,000
		In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.		In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	
Home Health Care					
Paid at 100% when authorized. No visit limit	Paid at 100% when authorized.	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%
	No visit limit	Maximum benefit of 130 visits per calendar year for in- and out-of-network combined		Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Hospital Inpatient					
Paid at 100% after $200 copay per admission	Paid at 100% after deductible	Paid at 80% after $200 copay. Physician services paid at 70% if Aexcel** specialist not used in specialty areas.	Paid at 60% after $200 copay	Paid at 90% after $200 copay. Physician services paid at 80% if Aexcel** specialist not used in specialty areas.	Paid at 60% after $200 copay
Hospital Outpatient					
Paid at 100% after $15 copay	$15 copay Deductible applies	Paid at 80% after deductible. Physician services paid at 70% if Aexcel** specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible	Paid at 90% after deductible. Physician services paid at 80% if Aexcel** specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80%	Paid at 60%	Paid at 90%	Not covered
Infertility Services					
Procedures covered are artificial insemination and ovulation induction. Copays/coinsurance depend on type and location of service provided. $10,000 lifetime maximum benefit.	Procedures covered are artificial insemination and ovulation induction. Copays/coinsurance depend on type and location of service provided. $10,000 lifetime maximum benefit.	Procedures covered are artificial insemination and ovulation induction. Copays/coinsurance depend on type and location of service provided. $10,000 lifetime maximum benefit.	Procedures covered are artificial insemination and ovulation induction. Copays/coinsurance depend on type and location of service provided. $10,000 lifetime maximum benefit.	Procedures covered are artificial insemination and ovulation induction. Copays/coinsurance depend on type and location of service provided. $10,000 lifetime maximum benefit.	Procedures covered are artificial insemination and ovulation induction. Copays/coinsurance depend on type and location of service provided. $10,000 lifetime maximum benefit.
Maternity Care (delivery & related hospital)					
Paid at 100% after $200 copay per admission	Deductible applies.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Maternity Care (prenatal and postpartum)					
Paid at 100% after $15 copay Routine care not subject to outpatient services copay.	$15 copay Deductible applies. Routine care not subject to outpatient services copay.	Paid at 80%	Paid at 60%	Paid 100% after one $15 copay	Paid at 60%
Mental Health Care (inpatient)					
Paid at 100% after $200 copay	Paid at 100% after deductible	Paid at 80% after $200 copay Review and coordination of care in complex situations including residential treatment centers and partial hospitalization.	Paid at 60% after $200 copay	Paid at 90% after $200 copay Review and coordination of care in complex situations including residential treatment centers and partial hospitalization.	Paid at 60% after $200 copay
Mental Health Care (outpatient)					
Paid at 100% after $15 copay per session.	$15 copay per session. Deductible applies.	Paid at 80% Ongoing consultation with a behavioral health provider by web, phone or mobile device through Teledoc. Additional focus on review and coordination of care in complex situations including psychological testing, neurological testing and intensive outpatient.	Paid at 80%	Paid at 100% after $15 copay Ongoing consultation with a behavioral health provider by web, phone or mobile device through Teledoc. Additional focus on review and coordination of care in complex situations including psychological testing, neurological testing and intensive outpatient.	Paid at 60% after deductible

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Physician Office Visit					
Paid at 100% after $15 copay.	Paid at 100% after $15 copay. Deductible applies	Paid at 80% Additional access to medical consultation with a physician by web, phone or mobile device for selected short-term services through Teladoc.	Paid at 60%	Paid at 100% after $15 copay per visit (waived for preventive care) Additional access to medical consultation with a physician by web, phone or mobile device for selected short-term services through Teladoc.	Paid at 60%
Prescription Drugs (retail)					
For a 30-day supply: **Generic**: $15 copay. Generic contraceptive drugs paid at 100%. **Brand:** $30 copay Brand contraceptive drugs and devices subject to copay	For a 30-day supply: **Generic**: $15 copay. Generic contraceptive drugs paid at 100%. **Brand:** $30 copay Brand contraceptive drugs and devices subject to copay	For a 31-day supply: **Generic**: 30% coinsurance. Generic contraceptive drugs paid at 100%. **Brand**: 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug.	Not covered	For a 31-day supply: **Generic**: 30% coinsurance Generic contraceptive drugs paid at 100%. **Brand:** 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug.	Not covered
Smoking cessation prescription drugs not subject to pharmacy copay.	Smoking cessation prescription drugs not subject to pharmacy copay.	Coinsurance applies to the prescription $1,200 out-of-pocket annual maximum per person, $3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment). City pays $20 per month, and plan participant pays remaining; some over the counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Many contraceptive products are covered. IUDs and Depo Provera covered under the medical plan benefit. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand pharmacy.			
Prescription Drugs (mail order)					
For a 90-day supply: **Generic**: $45 copay. Generic contraceptive drugs paid at 100%. **Brand:** $90 copay	For a 90-day supply: **Generic**: $30 copay. Generic contraceptive drugs paid at 100%. **Brand:** $60 copay	For a 90-day supply: **Generic**: 30% coinsurance. Generic contraceptive drugs paid at 100%.	Not Covered	For a 90-day supply: **Generic**: 30% coinsurance. Generic contraceptive drugs paid at 100%.	Not Covered

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Contraceptive drugs and devices are covered subject to the pharmacy copay.		**Brand**: 40% coinsurance Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug.		**Brand:** 40% coinsurance Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug.	
Preventive Care					
Paid at 100% after $15 copay	Paid at 100% after $15 copay	Mammograms paid at 80%.	Mammograms paid at 60%	Paid at 100% (copay waived) Covers adult physical and well child exams, immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening.	Paid at 60% for well woman care and mammograms
		No other preventive services are covered			No other preventive services covered
Rehabilitation Services (inpatient)					
Paid at 100% after $200 copay per admission	Paid at 100% after deductible.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Maximum of 60 days per calendar year (combined with other therapy benefits)				Maximum of 120 days per calendar year for skilled nursing and rehab services in- and out-of-network combined	
Rehabilitation Services (outpatient)					
Paid at 100% after $15 copay	$15 copay Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
Maximum of 60 visits per calendar year (combined with other therapy benefits)		Twenty-five visits per calendar year for physical, massage and occupational therapy. Additional visits may be covered if deemed medically necessary. Coinsurance does not apply to OOP Max.		Twenty-five visits per calendar year for physical, massage and occupational therapy. Additional visits may be covered if deemed medically necessary.	
Skilled Nursing Facility					
Paid at 100%. 60-day maximum per calendar year.	Paid at 100% after deductible. 60-day maximum per calendar year.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
		Maximum of 90 days per calendar year for in- and out-of-network combined		Maximum of 120 days per calendar year for rehab services and skilled nursing in- and out-of-network combined	

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Smoking Cessation					
Paid at 100% for individual or group sessions	Paid at 100% for individual or group sessions	Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic, 20% brand. See Prescription Drugs.	Not covered	Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	Not covered
Nicotine replacement therapy included in Prescription Drug benefit					
Spinal Manipulations					
Paid at 100% after $15 copay	$15 copay. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
Self-referral to Kaiser Permanente designated providers. Must meet Kaiser Permanente protocol. Maximum of 10 visits per calendar year.		Maximum of 10 visits per calendar year for in-network and out-of-network combined.		Maximum of 20 visits per calendar year for in-network and out-of-network combined.	
Sterilization Procedures					
Inpatient: Paid at 100% after $200 copay	Inpatient: Paid at 100%	Inpatient: Paid at 80% after $200 copay	Inpatient: Paid at 60% after $200 copay	Inpatient: Paid at 90% after $200 copay	Inpatient: Paid at 60% after $200 copay
Outpatient: Paid at 100% after $15 copay	Outpatient: $15 copay Deductible applies	Outpatient: Paid at 80%	Outpatient: Paid at 60%	Outpatient: Paid at 90%	Outpatient: Paid at 60%
Temporomandibular Joint Services					
Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.
		$5,000 lifetime maximum for non-surgical services in- and out-of-network combined		$5,000 lifetime maximum for non-surgical services in- and out-of-network combined	

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Tooth Injury (due to accident)					
Not covered	Not covered	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100%after $15 copay for office visit. Other charges paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Vision Exam/Hardware					
Exam: Paid at 100% after $15 copay. One exam every 12 months. Hardware: Not covered.	Exam: Paid at 100% after $15 copay. One exam every 12 months. Hardware: Not covered.	Covered under VSP.		Covered under VSP.	
X-ray and Lab Tests					
Paid at 100%	Paid at 100% Deductible applies	Paid at 80% Provider responsible for obtaining precertification of high tech radiology	Paid at 60%	Paid at 90% Provider responsible for obtaining precertification of high tech radiology	Paid at 60%

* a. Coverage for any service is subject to the carrier's determination of medical necessity and adherence to their clinical policy guidelines.
b. Accolade advocacy services will be available to assist you and your covered family members find providers; deal with billing, claim and appeals problems; understand diagnoses and treatment options and manage chronic diseases.

** 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 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). Call Accolade for more information about the Aexcel network.

Plan details are in your medical plan booklet at http://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/temporary-benefits-eligible-employees. **This document is not a contract.**

Health Care Premiums

2020 Premium Sharing

Effective January 1, 2020, you will pay the monthly premium amount listed below. The table also shows the total premium amount each month for each employee's coverage and the City's contribution.

	Total Monthly Premium	Employee, with or without children		Employee with Spouse/Domestic Partner, with or without children	
		City Pays	Employee Pays*	City Pays	Employee Pays*
Medical Plan					
City of Seattle Preventive	$1,555.93	$1,507.81	$48.12	$1,457.43	$98.50
City of Seattle Traditional	$1,409.38	$1,409.38	$ 0.00	$1,377.04	$32.34
Kaiser Permanente Standard	$1,234.80	$1,186.40	$48.40	$1,134.90	$99.90
Kaiser Permanente Deductible	$1,137.99	$1,112.99	$25.00	$1,081.07	$56.92

Your premium will be divided into two equal payments and taken from the first two paychecks of the month for the current month's coverage. (For example, deductions taken in January will pay for January coverage.) No premiums are deducted from the third paycheck. Premiums are deducted on a pre-tax basis, reducing your taxable income.

*Provided they are IRS tax dependents.

Health Care Premiums

Enrolling Spouse/DP

To cover a spouse or domestic partner (and tax dependents of your domestic partner), you must complete a Benefit Election form and an Affidavit of Marriage/ Domestic Partnership.

Spouse/DP/ Dependents Who are IRS Tax Dependents

If they are IRS tax dependents, the rate information on the previous page applies. If you enroll your domestic partner and your domestic partner's children, you will be taxed on the value of their medical coverage if they are not your tax dependents. (The value of the benefits will be imputed to your gross income.)

DP/Dependents Who are Not IRS Tax Dependents

After Tax Premium Contributions
If you choose to cover a domestic partner **who is not your IRS tax dependent**, the portion of the premium deducted from your paycheck (your contribution) that pays for his/her coverage must be taken "after tax" to comply with IRS regulations. The column headed "**Monthly Premium Contributions Taken After Taxes**" shows the portion of your monthly premium contribution that will be deducted from your paycheck after taxes are calculated.

Medical Plans	Monthly Premium Contribution Taken After Taxes for Domestic Partner
City of Seattle Preventive	$50.38
City of Seattle Traditional	$32.34
Kaiser Permanente Standard	$51.50
Kaiser Permanente Deductible	$31.92

Imputed Income for Value of Health Coverage
In addition, if your domestic partner 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 each month 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.

Health Care Premiums

DP/Dependents Who are Not IRS Tax Dependents (cont'd.)

Taxable Benefit Amount – (with DDWA)

2020 Monthly Taxable Values of City Coverage Provided to: Your Non-IRS Tax Dependent Domestic Partner Your Domestic Partner's Non-IRS Tax Dependent's Child		
Type of Coverage	**Domestic Partner Taxable Amount**	**Taxable Amount Per Child**
Preventive Plan	$702.72	$602.48
Traditional Plan	$649.82	$545.73
Kaiser Permanente Standard	$546.16	$478.13
Kaiser Permanente Deductible	$518.89	$440.65
DDWA Coverage	$51.85	$36.29
Vision Coverage	$4.33	$3.03
Buy-Up Vision Plan	$9.07	$6.35
Total Taxable Value with DDWA & VSP Basic Plan		
Preventive Plan	$758.90	$641.80
Traditional Plan	$706.00	$585.05
Kaiser Permanente Standard Plan	$602.34	$517.45
Kaiser Permanente Deductible Plan	$575.07	$479.97
Total Taxable Value with DDWA and VSP Buy-Up Plan		
Preventive Plan	$763.64	$645.12
Traditional Plan	$710.74	$588.37
Kaiser Permanente Standard Plan	$607.08	$520.77
Kaiser Permanente Deductible Plan	$579.81	$483.29

Health Care Premiums

DP/Dependents Who are Not IRS Tax Dependents (cont'd.)

Taxable Benefit Amount – (with DHS)

Medical/Dental/Vision Coverage Values with Dental Health Services Coverage

2020 Monthly Taxable Values of City Coverage Provided to: Your Non-IRS Tax Dependent Domestic Partner Your Domestic Partner's Non-IRS Tax Dependent's Child		
Type of Coverage	**Domestic Partner Taxable Amount**	**Taxable Amount Per Child**
Preventive Plan	$702.72	$602.48
Traditional Plan	$649.82	$545.73
Kaiser Permanente Standard Plan	$546.16	$478.13
Kaiser Permanente Deductible Plan	$518.89	$440.65
DHS Coverage	$68.76	$48.13
Basic Vision Plan	$4.33	$3.03
Buy-Up Vision Plan	$9.07	$6.35
Total Taxable Value with DHS & VSP Basic Plan		
Preventive Plan	$775.81	$653.64
Traditional Plan	$722.91	$596.89
Kaiser Permanente Standard Plan	$619.25	$529.29
Kaiser Permanente Deductible Plan	$591.98	$491.81
Total Taxable Value With DHS & VSP Buy-Up Plan		
Preventive Plan	$780.55	$656.96
Traditional Plan	$727.65	$600.21
Kaiser Permanente Standard Plan	$623.99	$532.61
Kaiser Permanente Deductible Plan	$596.72	$495.13

Prescription Drug Coverage

	Prescription Drug Retail Program Aetna classifies medications into three tiers: • Generic • Preferred brand-name • Non-preferred brand-name Kaiser Permanente uses two classifications: • Generic • Preferred brand-name (no coverage for non-preferred brands)
Preventive and Traditional Plans (Aetna)	With the Aetna plans, you pay 30% of the actual cost for generic drugs, and 40% for preferred and non-preferred brand-name drugs, up to a maximum of $100 per drug per month. There is a $1,200 annual out-of-pocket maximum per member for retail and mail order drugs. Present your medical plan ID card at any Aetna network retail pharmacy. Prescriptions filled at a non-network pharmacy will not be covered. You may contact the toll-free Member Services number on the back of your ID card to find a participating pharmacy, or check the website AetnaNavigator.com
Kaiser Permanente Plans	You are responsible for a $15 copay for generic drugs and a $30 copay for brand name drugs. All prescriptions must be filled at a Kaiser Permanente pharmacy. Prescriptions filled at any non-Kaiser Permanente pharmacy will not be covered. See next page for more detailed information about prescription drug coverage.

Prescription Drug Coverage Comparison				
Plan Features	**Kaiser Permanente Standard**	**Kaiser Permanente Deductible**	**Aetna Preventive**	**Aetna Traditional**
Annual out-of-pocket Maximum	Rx copays do not apply to out-of-pocket maximum.	Rx copays do not apply to out-of-pocket maximum.	$1,200	$1,200
Retail				
• **Days' Supply**	30-day	30-day	31-day	31-day
• **Coinsurance**	You pay $15 copay for generic drugs; $30 copay for brand name drugs.	You pay $15 copay for generic drugs; $30 copay for brand name drugs.	You pay 30% of actual cost of generic drug; 40% of cost for brand drugs*	You pay 30% of actual cost of generic; 40% of cost for brand drugs*
• **Minimum Coinsurance**	Not applicable	Not applicable	$10 or actual cost of drug if less.	$10 or actual cost of drug if less
• **Monthly out-of-pocket Maximum**	Not applicable.	Not applicable.	$100 per prescription	$100 per prescription
• **Out-of-Network**	Not covered	Not covered	Not covered	Not covered
Mail Order				
• **Coinsurance**	Generic:$45 copay Brand: $90 copay	Generic:$30 copay Brand: $60 copay	You pay 30% of actual cost of generic drug; 40% of cost for brand drugs	You pay 30% of actual cost of generic; 40% of cost for brand drugs
• **Minimum Coinsurance**	Not applicable	Not applicable	$30 or actual cost of drug if less.	$30 or actual cost of drug if less.
• **Monthly out-of-pocket Maximum**	Not applicable	Not applicable	$200 per prescription	$200 per prescription
• **Days' Supply**	90-day supply	90-day supply	90-day supply	90-day supply

*Coinsurance exceptions:

- City pays $20 towards cost of proton pump inhibitors and non-sedating antihistamines and you pay the remaining amount, whether medication is purchased over-the-counter or is a brand name drug.

- You pay 10% of cost for generic and 20% for brand drugs for anti-high cholesterol, asthma, and tobacco cessation drugs

- Diabetic drugs and supplies have special copays: $5 copay for generic, $15 copay for brand.

Dental Plan Options

There are two dental plans: Delta Dental of Washington (DDWA) and Dental Health Services (DHS).

Delta Dental of Washington

If you select DDWA, you can receive services from any dentist, but your out-of-pocket expenses may be lower if you choose a dentist who belongs to the DDWA network. To locate a DDWA network provider, search https://www.deltadental.com/us/en/find-a-dentist.html. For claim issues or appeals, please call (206) 522-2300 or 1-800-554-1907.

Selecting an in-network DDWA dentist means:

- The portion of the dental bill you pay is smaller than if you use a non-network dentist.
- You do not need to submit a claim - the dentist's office will submit the claim form.
- After you pay your portion of the bill, you will not be balance-billed more for a covered service. *(A non-DDWA dentist may bill you for the portion of the bill that DDWA does not cover).*

Orthodontia
(children only, up to age 26)

Pre-treatment estimates are recommended. The orthodontia benefit is paid at a 50% level to a lifetime maximum of $1,500 for each eligible child. **NOTE:** for children who are already in treatment when joining the City's DDWA plan, DDWA will prorate claim payment(s) based on the original banding date and remaining balance. The dental office needs to contact DDWA customer service for patient-specific details.

ID Cards

You will receive your DDWA ID card about 2 weeks following your dental plan selection. However, a card is not needed to access care – simply let your provider know you are covered under a City of Seattle plan, and they will ask you some information to identify you and confirm your benefits and eligibility. You can also set up your online account or Go Mobile at https://www.deltadentalwa.com/.

Dental Plan Options

	Dental Health Services
	If you select DHS, you can only receive services from an in-network dentist or dental practice – there is no out-of-network benefit available. In some instances, the DHS plan may provide a greater benefit for services received than DDWA but, the list of in-network dentists and clinics is much smaller than DDWA and you **must see** an in-network, DHS-participating dentist or clinic for services to be covered. Selecting a DHS dentist means: • There are no deductibles and no annual maximums • There are no incentive-level services
Accessing Care (Notify DHS once you've selected your care provider)	To begin, visit: http://www.dentalhealthservices.com/ and click "Plan Members" – from here, you will be able to: • Search for a DHS dentist/clinic and to set up your online account. • If you provided a personal email to the City during your on-boarding, that address is on file with DHS and should be used on the **Register Member** screen when setting up your account. • If your personal email wasn't provided or doesn't work on the **Register Member** screen, contact DHS directly at (206) 849-7100 to request your Member Number.
Payment of Basic Services	This plan has an office visit copay of $10 for all covered members and there are also copays for selected services. The plan comparison on the next page lists services and copay requirements.
Orthodontia	DHS offers both child and adult (age 25 and over) orthodontia. Coverage includes: a copayment of $1,800 per adult or $1,000 per child; a $150 charge for the initial exam, study models and x-rays; and a $10 copay for each visit during the course of ortho treatment. **NOTE:** for members who are already in treatment when joining the City's DHS plan, there is **no** transition of care; the orthodontia benefit is available for *new patients only*.
ID Cards	You will receive your DHS ID card about 2 weeks following your dental plan selection.
Plan Comparison	The table on the next page compares the coverages offered by the two dental plans.

Dental Plan Comparison		
Plan Features	**Delta Dental of Washington (DDWA)**	**Dental Health Services (DHS)**
Calendar Year Deductible	$50 per person, $150 per family (No deductible for preventive services)	$0
Annual Maximum Benefit	$2,000 per person per year	No Annual Maximum.
Diagnostic and Preventive (routine and emergency exams, x-rays, cleaning, fluoride treatment, sealants)	Class I: 100%	$10 office visit copay Two additional cleanings for pregnant women, up to four cleanings.
Fillings	Class II: Incentive payments levels***** 1st Year – 80% 2nd Year – 90% 3rd Year – 100%	$10 office visit copay Covers composite fillings in all teeth (posterior composite fillings additional $15)
Crowns	Class II: Constant 70%	$145 noble, $175 high noble or titanium, $200 upgraded, specialized porcelain if applicable per unit. (Non-specialized porcelain is $75.)
Prosthodontic Services (Dentures, Bridges)	Class III: Constant 50%	$125 plus $10 office visit copay (dentures) $75 plus $10 office visit copay (bridges)
Orthodontia	Child(ren) Only (up to age 26)	Available for Child & Adult
For DDWA: transition of care available for new members already in treatment (see DDWA Orthodontia – prior page) **For DHS:** new cases only – no transition of care for new members already in treatment who join the City's DHS	Plan pays 50% up to lifetime maximum of $1,500; deductible doesn't apply	Adult (age 25 and over) $1,800 plus $150 for initial exam, study models and x-rays covers full course of treatment plus $10 copay for each visit Orthodontia cases (less than age 25) $1,000 copay $150 for initial exam, study models and x-rays covers full course of treatment only; plus, $10 copay for each visit
Choice of Providers	In-Network: Any contracted provider. Out-of-Network: Expenses paid will be based on actual charges or DDWA's maximum allowable fees for non-participating dentists, whichever is less. You will be responsible for any balance due	In-Network: Any contracted provider in the DHS network. Out-of-Network: No out-of-network coverage available.

Dental Plan Comparison (continued)		
Plan Features	**Delta Dental of Washington (DDWA)**	**Dental Health Services (DHS)**
Periodontics (surgical and nonsurgical procedures for treatment of the tissues supporting the teeth)	Class II: Paid according to incentive payment levels shown above*	Paid at 100% after $25 copay for periodontal scaling and maintenance at general dentist. If referred to periodontist, member pays 20%. Up to 4 visits for specific situations.
Endodontics (procedures for pulpal and root canal treatment)	Class II: Paid according to incentive payment levels shown above, Root canal treatment of same tooth covered only once in a 2-year period.*	Paid at 100% after applicable copay ($50 for anterior, $75 for bicuspid, or $100 for molar root canal) If referred to endodontist, member pays 20%.
Oral Surgery (routine and surgical extractions)	Class II: Paid according to incentive payment levels shown above*	Paid at 100% after $10 office visit copay for general dentist. If referred to an oral surgeon, member pays 20%
Temporomandibular Joint (TMJ) Disorders	Not covered	$1,000 annual maximum $5,000 lifetime maximum
Dental Implants	Constant 50%	Call DHS Office at 206-788-3444 for details – copayments apply
Other	Class III: Occlusal (night guard) covered at 50% if patient has advanced gum disease.	Occlusal (night guard) with $350 copay

2020 Monthly Dental Premiums for Most City Employees

Dental Plan	Total Monthly Premium Amount	Employee's Monthly Premium Contribution	
		Coverage for Employee with or without children	**Coverage for Employee with Spouse/Domestic Partner with or without children**
Delta Dental of Washington	$113.46	$0	$0
Dental Health Services	$150.46	$0	$0

Plan booklets are located at http://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/temporary-benefits-eligible-employees

***Incentive levels from other DDWA plans are not carried over to the City's plan.

Vision Coverage

ID Cards	The City offers a vision plan through VSP, which is fully paid for by the City. Receive services from any vision provider, but your out-of-pocket expenses will be lower if you choose a doctor or vision facility that is preferred with the VSP network. Find network providers, create your online account, review Special Offers, and more at www.vsp.com VSP does not issue ID cards - your network doctor or facility will be able to access your eligibility and coverage. You can print an ID card, one once you set up your online account.

Vision Plan Benefit

Plan Benefit *Benefit Frequency is every plan year unless otherwise noted*	**PLAN TYPE** **VSP Basic** *(City pays premium)*
WellVision Exam	$10 copay
Prescription Glasses	$25 copay
Frames *Every other year*	$175 allowance for select frames $195 allowance for featured frame brands 20% savings on amounts over allowance
Lenses	Copay included in Prescription Glasses *Includes: single vision, lined bifocal, and lined trifocal* *Polycarbonate lenses for dependent children*
Lens Enhancements	Standard progressive* lenses: $55 Premium progressive* lenses: $95-$105 Custom progressive* lenses: $150-175
Contact Lenses *(instead of glasses)*	$175 allowance for contacts (no copay) $60 Copay: contact lens exam (fitting and evaluation)

** Progressive lenses are no-lined multi-focal with a clear, smooth transition between focals*
*** Photochromic lenses are clear indoors and darken automatically when exposed to sunlight*

Vision Coverage (continued)

Additional Vision Benefits

Extra Savings www.vsp.com/specialoffers to view updated discounts and member extras	**Glasses and Sunglasses** Extra $20 for featured frame brands 20% savings on additional glasses and sunglasses, including lens enhancements • *Must be within 12 months of your last WellVision exam from any VSP provider*
	Retinal Screening No more than a $39 copay on routine retinal screening as an enhancement to a WellVision exam
	Laser Vision Correction Average of 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities

Your Coverage with Out-of-Network Providers *(Visit www.vsp.com for additional details)*	
Exam	Up to $45
Frames	Up to $70
Single Vision Lenses	Up to $30
Lined Bifocal Lenses	Up to $50
Lined Trifocal Lenses	Up to $65
Progressive Lenses	Up to $50
Contact Lenses	Up to $105

Coordination of Benefits*: when there are 2 City of Seattle VSP plans in place, the secondary City VSP plan will typically pay at least the copayments remaining after the primary City VSP plan makes payment.

**While having 2 VSP plans may cover some of the out-of-pocket (either City plan or a City plan and another VSP plan), there is no guarantee that all out-of-pocket expenses will be paid in full by a secondary plan. Claim payment determination is made by VSP.*

2020 Monthly Vision Premium

Vision Plan	Total Monthly Premium Amount	Employee's Monthly Premium Contribution	
		Employee with/without dependents	
VSP Plan	$9.47	$0	$0

Basic Long-Term Disability

Basic Long-Term Disability (LTD)

The basic benefits package provided by the City includes a Long-Term Disability (LTD) policy that will pay you a portion of your monthly pay 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 perform with reasonable continuity the material duties of your own occupation (first 24 months) or any occupation (after 24 months).

You do not need to enroll in this plan, you are automatically enrolled as a temporary employee with benefits.

Benefit Amount

	Basic LTD
Percentage of monthly pre-disability earnings	60%
Maximum monthly benefit	$400
Minimum monthly benefit	$100

Basic Group Term Life

Group Term Life (GTL) Insurance

The City provides one level of optional Term Life Insurance to temporary employees who are eligible for benefits. The City and you pay for Basic Life Insurance. You can sign up for Group Term Life Insurance within 30 days of becoming benefits eligible, or during an Open Enrollment period. For more information, see the Certificate of Insurance.

Basic Life Insurance

This optional coverage provides you with two options of Term Life Insurance benefit amounts. The first option is equal to one-and-a-half times your annual salary and the second option is $50,000. The City contributes 40% of the cost and you pay the remaining 60% of the cost. Within the coverage amount guidelines shown below, you select the option of basic Life insurance for which you are interested in applying. Below is a table with information regarding the monthly cost of Basic Term Life Insurance follows.

	Minimum	**Maximum***
Option A	1.5 times your Annual Earnings, rounded to the next higher multiple of $1,000, if not already a multiple of $1,000	No maximum
Option B	1.5 times your Annual Earnings, rounded to the next higher multiple of $1,000, if not already a multiple of $1,000	$50,000

* IRS rules state that the value of Basic Life Insurance over $50,000, which is paid for by the City, is taxable. You may limit your Basic Term Life Insurance coverage amount to $50,000 to avoid the additional taxes. The amount on which you pay taxes will be shown on your second paycheck each month.

Coverage Amount Needed

Your family has a unique set of circumstances and financial demands. To help you figure out the amount of basic Life insurance you may need to protect your family, The Standard has created a Life Insurance Needs Calculator found at http://www.standard.com/lifeneeds.

Basic Group Term Life

How Much Will Coverage Cost?

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 $0.048 times each $1,000 of coverage.

To calculate your basic Life insurance, use the following table:

1. Annual Salary = Line 1	Line 1: _____
2. Round Up Line 1 to nearest $1,000 = Line 2	Line 2: _____
3. Multiply Line 2 by 1.5 = Line 3	**Coverage Amount** Line 3: _____
4. Divide Line 3 by $1,000 = Line 4	Line 4: _____
5. Multiply Line 4 by the plan rate of 0.048 = Line 5	**Monthly Premium** Line 5: _____

For example, if your salary is $78,600 per year, round it up to $79,000. To determine your coverage amount, multiply $79,000 by 1.5 = $118,500. $118,500 is your coverage amount. Divide your coverage amount by $1,000 ($118,500 / $1,000 = 118.50). Multiply 118.50 by the plan rate of 0.048 (118.50 x 0.048 = $5.68) Your premium is $5.68 per month.

Features and Benefits

Travel Assistance
This service provides you and your dependents with access to appropriate medical care and other emergency services when you travel 100 miles or more from home or internationally for up to 180 days. Travel Assistance also offers a range of professional, 24-hour medical, legal and trip assistance information and coordination services to help your travel go smoothly. For more information, go here.

Conversion
This policy includes a conversion privilege which allows you to continue some level of coverage if you leave City employment. Conversion is guaranteed, which means you can continue the policy regardless of any existing medical condition. It is more costly than your active employee coverage because of this provision, but could allow you to maintain coverage when you otherwise might not qualify for new life insurance coverage. To be eligible, you must apply within 30 days of leaving City service.

Basic Group Term Life

	Accelerated Benefit If you become terminally ill before age 60, you may be eligible to receive up to 75% percent of your basic Life Benefit to a maximum of $500,000. **Life Services Toolkit** This service helps beneficiaries cope with grief and loss, get answers to legal questions, plan a memorial or a funeral, address financial concern, and more. Additionally, all covered employees have access to online information and calculators including online will preparation and other estate planning documents and articles that help deal with identity theft and improve wellness. For more information visit Life Services Toolkit.
Resources	For additional information, see the below links. **Certificate of Insurance** Certificate of Insurance **Evidence of Insurability** Evidence of Insurability
File a Claim	To file a claim, please contact your department's Benefit Representative.

Basic Group Term Life

Basic Group Life Insurance Costs*

Costs for Basic Life Insurance (based on employee's annual earnings)	Employee's Annual Earnings	Amount of Insurance	Employee Monthly Premium	City Monthly Premium	Total Monthly Premium
	$30,000.01 – $31,000	$46,500	$2.23	$1.49	$3.72
	$31,000.01 – $32,000	$48,000	$2.30	$1.54	$3.84
	$32,000.01 – $33,000	$49,500	$2.38	$1.58	$3.96
	GTL Limited	$50,000	$2.40	$1.60	$4.00
	$33,000.01 – $34,000	$51,000	$2.45	$1.63	$4.08
	$34,000.01 – $35,000	$52,500	$2.52	$1.68	$4.20
	$35,000.01 – $36,000	$54,000	$2.59	$1.73	$4.32
	$36,000.01 – $37,000	$55,500	$2.66	$1.78	$4.44
	$37,000.01 – $38,000	$57,000	$2.74	$1.82	$4.56
	$38,000.01 – $39,000	$58,500	$2.81	$1.87	$4.68
	$39,000.01 – $40,000	$60,000	$2.88	$1.92	$4.80
	$40,000.01 – $41,000	$61,500	$2.95	$1.97	$4.92
	$41,000.01 – $42,000	$63,000	$3.02	$2.02	$5.04
	$42,000.01 – $43,000	$64,500	$3.10	$2.06	$5.16
	$43,000.01 - $44,000	$66,000	$3.17	$2.11	$5.28
	$44,000.01 - $45,000	$67,500	$3.24	$2.16	$5.40
	$45,000.01 - $46,000	$69,000	$3.31	$2.21	$5.52
	$46,000.01 - $47,000	$70,500	$3.38	$2.26	$5.64
	$47,000.01 - $48,000	$72,000	$3.46	$2.30	$5.76
	$48,000.01 - $49,000	$73,500	$3.53	$2.35	$5.88
	$49,000.01 – $50,000	$75,000	$3.60	$2.40	$6.00
	$50,000.01 – $51,000	$76,500	$3.67	$2.45	$6.12
	$51,000.01 – $52,000	$78,000	$3.74	$2.50	$6.24
	$52,000.01 – $53,000	$79,500	$3.82	$2.54	$6.36
	$53,000.01 – $54,000	$81,000	$3.89	$2.59	$6.48
	$54,000.01 – $55,000	$82,500	$3.96	$2.64	$6.60
	$55,000.01 – $56,000	$84,000	$4.03	$2.69	$6.72
	$56,000.01 – $57,000	$85,500	$4.10	$2.74	$6.84
	$57,000.01 – $58,000	$87,000	$4.18	$2.78	$6.96
	$58,000.01 – $59,000	$88,500	$4.25	$2.83	$7.08
	$59,000.01 – $60,000	$90,000	$4.32	$2.88	$7.20
	$60,000.01 – $61,000	$91,500	$4.39	$2.93	$7.32
	$61,000.01 – $62,000	$93,000	$4.46	$2.98	$7.44
	$62,000.01 – $63,000	$94,500	$4.54	$3.02	$7.56
	$63,000.01 – $64,000	$96,000	$4.61	$3.07	$7.68
	$64,000.01 – $65,000	$97,500	$4.68	$3.12	$7.80
	$65,000.01 – $66,000	$99,000	$4.75	$3.17	$7.92
	$66,000.01 – $67,000	$100,500	$4.82	$3.22	$8.04

*Cost is $0.08 per $1,000: Employee cost is 60% or $0.048/$1,000; City cost is 40% or $0.032/$1,000

Optional Insurance – Group Term Life

Basic Group Life Insurance Costs* - *Continued*				
Employee's Annual Earnings	**Amount of Insurance**	**Employee Monthly Premium**	**City Monthly Premium**	**Total Monthly Premium**
$67,000.01 – $68,000	$102,000	$4.90	$3.26	$8.16
$68,000.01 – $69,000	$103,500	$4.97	$3.31	$8.28
$69,000.01 – $70,000	$105,000	$5.04	$3.36	$8.40
$70,000.01 – $71,000	$106,500	$5.11	$3.41	$8.52
$71,000.01 – $72,000	$108,000	$5.18	$3.46	$8.64
$72,000.01 - $73,000	$109,500	$5.26	$3.50	$8.76
$73,000.01 - $74,000	$111,000	$5.33	$3.55	$8.88
$74,000.01 - $75,000	$112,500	$5.40	$3.60	$9.00
$75,000.01 - $76,000	$114,000	$5.47	$3.65	$9.12
$76,000.01 - $77,000	$115,500	$5.54	$3.70	$9.24
$77,000.01 - $78,000	$117,000	$5.62	$3.74	$9.36
$78,000.01 - $79,000	$118,500	$5.69	$3.79	$9.48
$79,000.01 - $80,000	$120,000	$5.76	$3.84	$9.60
$80,000.01 - $81,000	$121,500	$5.83	$3.89	$9.72
$81,000.01 - $82,000	$123,000	$5.90	$3.94	$9.84
$82,000.01 - $83,000	$124,500	$5.98	$3.98	$9.96
$83,000.01 - $84,000	$126,000	$6.05	$4.03	$10.08
$84,000.01 - $85,000	$127,500	$6.12	$4.08	$10.20
$85,000.01 - $86,000	$129,000	$6.19	$4.13	$10.32
$86,000.01 - $87,000	$130,500	$6.26	$4.18	$10.44
$87,000.01 - $88,000	$132,000	$6.34	$4.22	$10.56
$88,000.01 - $89,000	$133,500	$6.41	$4.27	$10.68
$89,000.01 - $90,000	$135,000	$6.48	$4.32	$10.80
$90,000.01 - $91,000	$136,500	$6.55	$4.37	$10.92
$91,000.01 - $92,000	$138,000	$6.62	$4.42	$11.04
$92,000.01 - $93,000	$139,500	$6.70	$4.46	$11.16
$93,000.01 - $94,000	$141,000	$6.77	$4.51	$11.28
$94,000.01 - $95,000	$142,500	$6.84	$4.56	$11.40
$95,000.01 - $96,000	$144,000	$6.91	$4.61	$11.52
$96,000.01 - $97,000	$145,500	$6.98	$4.66	$11.64
$97,000.01 - $98,000	$147,000	$7.06	$4.70	$11.76

*Cost is $0.08 per $1,000: Employee cost is 60% or $0.048/$1,000; City cost is 40% or $0.032/$1,000

Work Life Programs	
Thrive	Thrive is the City's online and app-based well-being program for employees and spouses/domestic partners. Thrive combines tools, educational content and engaging activities to support physical, emotional, and financial well-being goals. • Learn how to manage stress or achieve better work/life balance • Connect with health advocacy services for benefit and clinical questions • Get involved in your community • Make healthier choices and take action to improve your health • Create a budget, manage debt or plan for future retirement. To start using Thrive, go to cityofseattle.limeade.com and register. For access to Thrive on the go, download the Limeade app and enter the City of Seattle code: seattle.
MyTrips	The City of Seattle encourages employees to use alternatives to driving alone to work. Temporary Benefits Eligible Employees are eligible for the City employee transit benefit as part of your employee commute options program, MyTrips. City of Seattle employees are eligible to receive an ORCA Passport which pays full fare for all land based transit. Employees who use the ferry may instead choose to receive up to $99 per month towards a WA State ferry pass. City employees that use the transit system, carpool, and/or bike to work are also eligible for a guaranteed ride home and may also receive discounted membership in Zipcar. Visit your employee transit benefit website: mytrips.seattle.gov to find out more about your program.
Transit Pass Subsidy and Tax Savings Program	The Internal Revenue Code allows up to $265 per month (less City subsidy) for transit passes to be deducted from paychecks on a pre-tax basis. Employees who purchase a payroll-deducted transit pass are automatically enrolled in the pre-tax plan. For more information and to apply online, go to mytrips.seattle.gov, your employee commute options program website.

Leave Policies

Vacation

Represented Employees - see your collective bargaining agreements for provisions regarding leave policies.

If any of this information differs from the union bargaining agreement, the bargaining agreement prevails.

You earn vacation based on the number of hours (non-overtime) you are paid each pay period. Vacation hours are accumulated on a maximum of 80 hours per pay period. (See the vacation accrual chart below.) Approximately 2,088 hours of regular pay status equal one year of full-time employment. Your vacation accrual rate is 12 days per year for your first four years of service. The accrual rate gradually increases to 20 days per year after 20 years of service with an additional day per year of service thereafter to a maximum of 30 days.

You can accumulate two times your annual vacation without penalty. The amount of vacation you have earned and not used is shown on your biweekly paycheck. You may also view this information on Employee Self-Service.

Follow your department's protocol for requesting and taking vacation.

Your unused vacation balance will be cashed out when you leave City employment, unless your collective bargaining agreement provides otherwise.

Hours of Regular Pay Status	Years of Service	Vacation Accrued per Hour	Days per Year	Hours per Year	Maximum Balance
Less than 08321	0 to 4	.0460	12	96	192
08321 to 18720	5 to 9	.0577	15	120	240
18721 to 29120	10 to 14	.0615	16	128	256
29121 to 39520	15 to 19	.0692	18	144	288
39521 to 41600	20	.0769	20	160	320
41601 to 43680	21	.0807	21	168	336
43681 to 45760	22	.0846	22	176	352
45761 to 47840	23	.0885	23	184	368
47841 to 49920	24	.0923	24	192	384
49921 to 52000	25	.0961	25	200	400
52001 to 54080	26	.1000	26	208	416
54081 to 56160	27	.1038	27	216	432
56161 to 58240	28	.1076	28	224	448
58241 to 60320	29	.1115	29	232	464
60321 and over	30	.1153	30	240	480

Leave Policies

Sick Leave

Sick leave is a short-term disability program that pays your wages if you must be absent from work because of your own medical appointments, personal illness, injury or disability which makes you temporarily unable to perform your job or when you are absent because of medical appointments, illness, injury or disability of your spouse or domestic partner, parent, grandparent, sibling, grandchild or dependent child. Sick leave may also be requested for the non-medical care of a newborn or child recently placed for adoption, foster care or legal guardianship, closure of your worksite or your child's school or place of care by a public health official and for reasons related to domestic violence, sexual assault or stalking. You are eligible to use available sick leave hours after 30 days of employment.

Full-time employees accumulate 12 days or 96 hours of sick leave per calendar year, at the rate of .046 hours per hour on regular pay status. If you are absent more than four consecutive work days, you must submit a medical certification stating why you needed sick leave and confirming your ability to return to work. You are eligible to use available sick leave hours after 30 days of employment. When you retire through the City of Seattle Retirement System you are eligible to receive a cash equivalent of 25 percent of unused sick leave hours, unless your union has elected to participate in VEBA or you are eligible to defer your sick leave into Deferred Compensation. Check with your HR representative.

Leave Policies

Holidays

Temporary Benefits Eligible employees are eligible for 10 official paid holidays and two personal paid holidays per year. To qualify for a paid holiday, you must be on regular pay status either the day before or the day after the observed holiday. However, if you returned the day after a holiday, but had been on unpaid leave for more than four days immediately preceding the holiday, you would not be eligible for holiday pay. For more information regarding holiday leave policies, consult Personnel Rule 7.6 at seattle.gov/human-resources/rules-and-resources/personnel-rules and any applicable union contract.

Below is the 2020 holiday schedule.

New Year's Day	Wednesday, 1/1/2020
Martin Luther King Jr. Day	Monday, 1/20/2020
President's Day	Monday, 2/17/2020
Memorial Day	Monday, 5/25/2020
Independence Day	Friday, 7/3/2020
Labor Day	Monday, 9/7/2020
Veterans' Day	Wednesday, 11/11/2020
Thanksgiving Day	Thursday, 11/26/2020
Day following Thanksgiving	Friday, 11/27/2020
Christmas Day	Friday, 12/25/2020

The 2021 New Year's Day holiday will be Friday, January 1.

Bereavement Leave

You are permitted time off without loss of pay or paid leave balances to mourn the loss of a close relative. With supervisory approval, you make take vacation or discretionary time off you to mourn the death of a friend, co-worker or other individual who is not a close relative.

Jury Duty

If you serve on jury duty during normal work hours, you will be paid your regular straight-time pay upon surrendering to the City any compensation you receive from the Court, less transportation allowance.

Leave Policies	
Family and Medical Leave	The City provides up to 90 calendar days of unpaid Family and Medical Leave per year. You may receive this in addition to any paid leave for a properly certified Family and Medical Leave qualifying condition; however, Paid Family Care Leave counts towards the family medical Leave entitlement. When you use Family and Medical Leave for the non-medical care of your newborn child or for a child who has been placed with you for foster care or adoption, you must provide 30 days' advance notification, when possible. You must also write and sign a memorandum attesting to the date of the child's birth or placement with you. When you use Family and Medical Leave for your own serious health condition or to care for the serious health condition of an eligible family member, you must provide as much notification as possible. You must also submit your health care provider's certification of a serious health condition. Additionally, you will need your health care provider's release to return to work. Employees are eligible to use the leave after six months of employment. For more information, see Personnel Rule 7.1
Paid Family Care Leave	The City provides up to four weeks per a rolling 12 month period for an employee to care for a FMLA qualifying family member with a serious health condition, and has available FMLA entitlement hours. Employees are not eligible to use the leave until after having completed a consecutive six months of employment in a benefitted position or temporary assignment. Hours are pro-rated for part-time employees. The leave expires after one year or when the qualifying condition ends (if the need for leave is less than a year).
Paid Parental Leave	The City of Seattle's Paid Parental Leave program provides eligible employees up to 12 weeks paid leave to bond with their new child, pro-rated for part time employees. Regular or temporary employees who are benefits-eligible per Seattle Municipal Code Subsection 4.20.055(C) who have worked at least 6 months in the benefit eligible position will receive twelve weeks of leave if they experience the following qualifying event on or after October 2, 2019: • Birth of a child; placement of a child for adoption; placement of a child for foster care; placement of a child for legal guardianship The employee must use the leave by the first anniversary of the child's birth or placement. If an employee has two qualifying events in a single 12-month period, they may only use up to 480 hours of their eligible Paid Parental Leave to bond with children in multiple qualifying events. The employee would not be eligible for additional leave until after the first 12-month period. For more information and the application form, go to the Paid Parental Leave page.

Washington State Paid Family and Medical Leave

Washington's Paid Family and Medical Leave is an insurance program funded through premiums paid by the City of Seattle and employees. It offers partially paid leave for qualifying medical, family and certain military connected events. The program covers between 12 and 18 weeks of paid leave for a qualifying event, depending on the circumstances. For more information, please visit the Washington State Employment Security Department's website at https://www.paidleave.wa.gov/

You can start applying for Washington State Paid Family and Medical Leave with the Washington State Employment Security Department (ESD) beginning January 1, 2020.
To apply for this State benefit with the Washington State Employment Security Department (ESD), you can contact ESD directly at 1 (833) 717-2273 or submit your online application at www.paidleave.wa.gov.

Retirement

City Retirement System	There are three opportunities when a temporary employee may elect membership in the Seattle City Employees' Retirement System 1. At the completion of 1,044 hours of City employment, the equivalent of 6 months' full-time work 2. After completing 10,440 hours of City employment, the equivalent of 5 years' full-time work 3. When appointed to a regular position of City employment, you may join the Retirement System and purchase prior credit, provided this occurs before completion of 10,440 hours of City employment. Contact the Retirement Office (206-386-1292) for more information.
Retirement System Death Benefit	Temporary employees who participate in the Retirement System are automatic members of the Death Benefit Program. The intended purpose of this policy is to be an adjunct to your burial insurance. The benefit is $2,000 and payable only to the beneficiary. The premium is $12.00 per year, deducted from the first paycheck of the year. The policy has no cash value for the retiree.
Deferred Compensation Savings Plan	You may participate in the City of Seattle Voluntary Deferred Compensation Plan administered by Nationwide. You may enroll any time throughout the year. The plan allows you to save a portion of your annual wages to supplement retirement funds. Contributions are made through pre-tax or after-tax (Roth) payroll deductions and you are immediately 100% vested in any contributions you make. You have the choice of several investment options to diversify your savings. For more information, reach out to an on-site Deferred Compensation education consultant in the Seattle Municipal Tower (floor 16, suite 1635) at 206-447-1924. Education consultants are available Monday through Friday during normal business hours. Or please contact Nationwide at 855-550-1757. Customer Service Representatives are available from 5:00 am to 8:00 pm Pacific Time, Monday through Friday and Saturday 6:00 am to 3:00 pm. You can also access your account 24/7 at Nationwide. • You may start, stop or change the amount of your deferrals (contributions) at any time at www.cityofseattledeferredcomp.com or by calling 855-550-1757.

Retirement

Deferred Compensation Savings Plan

- You may contribute as little as $10 per pay period and as much as 50% of your annual taxable income up to the annual limit published on http://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/retirement-plans.
- You do not pay federal income tax on your pre-tax money until it is withdrawn.
- You can apply for a loan, not to exceed the lesser of $50,000 or half your account balance, but are required to repay the loan.
- You are eligible to withdraw your money only when you leave City service, regardless of age.
- Hardship withdrawals are available, subject to IRS rules and approval by the Plan Trust Committee.
- You can deposit a portion of your sick leave balance (if eligible) and all your vacation payout to your account when you retire up to your unused annual deferral limit for the year in which you retire. For yearly maximum deferral amount, please refer to http://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/retirement-plans.
- You may consolidate prior retirement plans (457, 403(b), 401(k), 401(a) and IRA) into your Deferred Compensation Plan account too.

Year	Regular Contributions Limit	Additional Contribution Limit for employees over age 50
2020	$19,500	$6,500

Glossary

Balance billing	The amount over and above your co-insurance amount that you may be required to pay if you use a non-network provider. See the explanation for **Paying out-of-network claims** that bills more than Aetna's allowable amount on page 18.
Coinsurance	The arrangement by which both the Plan and the employee share a specified ratio of the covered expenses under the policy. For example, the Aetna Open Choice Traditional Plan pays 80% of most covered expenses while the employee pays the remaining 20% of covered expenses once the deductible has been met.
Copay	A fee paid at the time a medical or dental service is provided. A copay may be a percentage of charges, but is usually a flat fee. In general, copayments may not be applied toward the coinsurance or out-of-pocket deductibles.
Deductible	The amount of covered expenses that must be incurred before Plan benefits are paid. The deductible is set on an annual basis and there are individual and family deductibles.
Eligible Expenses	Expenses as defined in the health plan as being eligible for coverage. This could involve specified health services fees or "reasonable and customary charges."
Formulary	A list of preferred brand-name and generic drugs. Drugs are selected for inclusion based on evaluation criteria developed by each Plan. Formularies are different depending on the Plan, and may change to include new drugs or to drop brand-name drugs as generic equivalents become available.
Generic Drug	A drug which contains the same active ingredients in the same amounts as the brand-name product, although it may differ in color, shape, or size from the brand-name product. It is produced after the brand name drug's patent has expired. It is also called a "generic equivalent."
Network Provider	A medical provider, such as a physician, who has a signed contract to participate in a health plan. Also known as a preferred provider.
Non-network Provider	A provider who has not signed a contract with a health plan. Also known as a non-preferred provider.
Out-of-Pocket Cost	The amount not covered by the plan that the plan member pays. This includes such things as coinsurance, deductibles, etc.
Out-of-Pocket Limit (Out-of-Pocket Maximum)	The amount of copays and/or coinsurance an individual will be required to pay within a calendar year before most covered expenses are covered in full.

Pre-existing condition	A physical condition that existed prior to the effective date of a policy. In many health policies, these are not covered until after a stated period of time has elapsed. The City's medical plans cover all pre-existing conditions.
Preferred Provider	A medical provider, such as a physician, who has a signed contract to participate in a health plan. Also known as a network provider.
Preventive Care	Care that consists of routine physical examinations and immunizations. The emphasis is on preventing illnesses before they occur.
Recognized Charge	The charge determined by Aetna on a semiannual basis to be in the 70th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

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 Seattle Department of Human Resources' Benefits Unit can be reached at 206-615-1340.

Accolade	866-540-5418	https://login.myaccolade.com/login
Aetna	877-292- 2480	AetnaNavigator.com Custom Doc Find: aetna.com/docfind/custom/cityofseattle
Kaiser Permanente	888-901-4636	KP.org/wa
VSP	800- 877-7195	vsp.com Click on "Members and Consumers"
Delta Dental of Washington (DDWA)	206-522-2300 or 800-554-1907	DeltaDentalWa.com
Dental Health Services	206-788-3444 877-495-4455	DentalHealthServices.com/cityofseattle
Nationwide Retirement Local Representative	855-550-1757 206-447-1924	www.cityofseattledeferredcomp.com
Life, LTD		Your department's Benefits Representative
Alternative Dispute Resolution	206-615-0089 206-615-1692 TTY: 206-684-7888	sdhrweb/adr/default.asp
City's Benefits Unit	206-615-1340	http://www.seattle.gov/human-resources/benefits
Employee Self-Service		http://www.seattle.gov/ess/

Health Care Benefits Election Form

Temporary Benefits Eligible Employees – Most Plans

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

Home Address - Street | City | State | Zip

Hire Date | Work Phone | Birth Date (M/D/Y)

☐ New Hire ☐ Re-Enrolling ☐ Decline coverage (*skip to Page 2*) Effective Date of Coverage _____

Reason for re-enrolling: ☐ Loss of other coverage (Attach proof of other coverage) ☐ Birth/adoption of child
☐ Marriage/new domestic partnership (Attach affidavit of marriage/domestic partnership)
☐ Other _____

Medical Plan Selection	**Employee Premium Share**
(Please choose ONE Medical Plan below)	
City of Seattle Preventive Plan	
☐ Employee Only (with or without Children)	$48.12
☐ Employee & Spouse/Domestic Partner (with or without Children)	$98.50
City of Seattle Traditional Plan	
☐ Employee Only (with or without Children)	$ 0.00
☐ Employee & Spouse/Domestic Partner (with or without Children)	$32.34
Kaiser Permanente Standard Plan	
☐ Employee Only (with or without Children)	$48.40
☐ Employee & Spouse/Domestic Partner (with or without Children)	$99.90
Kaiser Permanente Deductible Plan	
☐ Employee Only (with or without Children)	$25.00
☐ Employee & Spouse/Domestic Partner (with or without Children)	$56.92
Vision Plan	
☐ Vision Service Plan	$ 0.00
Dental Plan Selection *(Please choose ONE Dental Plan)*	
☐ Dental Health Services **OR** ☐ Delta Dental of Washington	$ 0.00

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** Medical | ☐**Yes** ☐ **No** Dental/Vision

Last Name First Name MI | Social Security Number | (M/D/Y)

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** Medical | ☐**Yes** ☐ **No** Dental/Vision

Last Name First Name MI | Social Security Number | (M/D/Y)

Relationship

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** ☐ Son ☐ Daughter **OR** **Other** (Step-child or Legal [illegible] ☐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**

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

Relationship

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** ☐ Son ☐ Daughter **OR** **Other** (Step-child or Legal ☐ Male ☐ Female

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

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

Relationship

Employee's Dependent ☐ Son ☐ Daughter **OR** **Partner's Dependent** ☐ Son ☐ Daughter **OR** **Other** (Step-child or Legal ☐ Male ☐ Female

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Dependent Eligibility Information: If you have listed a dependent child over the age of 18 years, please answer the questions below about your dependent:

1. Incapacitated or Disabled? ☐ Yes ☐ No
2. Working full time and have access to health insurance? ☐ Yes ☐ No

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

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 30 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 in HRIS _____

CITY OF SEATTLE
Affidavit of Marriage/Domestic Partnership for Benefits and/or Leave Eligibility

SECTION I

I, _____ certify that:
(print name of employee)

Complete either A for marriage or B for domestic partnership

A.

I, and _____ were legally married on _____
(print name of spouse) (date of marriage)

- OR -

B.

I, and _____ formed a domestic partnership on _____
(print name of domestic partner) (date of domestic partnership)

and we:

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

"Basic living expenses" means the cost of basic food, shelter, and any other expenses of a Domestic partner, which are paid at least in part by a program or benefit for which the partner qualified because of the Domestic Partnership. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

SECTION II

___A. I understand that this affidavit shall be terminated upon the death of my
initial spouse/domestic partner or by a change of circumstance attested to in this affidavit.

I agree to notify my payroll/personnel representative if there is any change of circumstances attested to in this affidavit within thirty (30) days of change by filing a Statement of Termination of Marriage/Domestic Partnership.

___B. I understand that if I have indicated on my Medical Benefit Election Form or
initial Employee Self-Service panel that my domestic partner is my IRS tax dependent, he/she meets the IRS Section 152 definition of a dependent.

___ C. I understand that if my domestic partner is not an IRS tax dependent that any
initial employee health premiums attributed to my domestic partner will be paid with after tax dollars.

SECTION III

We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or if otherwise required by law.

We understand that this declaration of responsibility for our common welfare may have legal implications under Washington law.

We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, because of a false statement contained in this Affidavit of Marriage/Domestic Partnership.

We also certify under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

I, the undersigned City of Seattle Employee, understand that willful falsification of information on this affidavit may lead to disciplinary action, up to and including discharge from employment.

Signature of Employee	Signature of Spouse/Domestic Partner
Address	Address
City, State Zip	City, State Zip
Employing Department	Employing Department (if applicable)
Date	Date

Send completed form to your HR Department

City of Seattle
Basic Group Term Life Election Form

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

Home Address - Street | City, State | Zip

Hire Date | Work Phone | Birth Date

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.

BENEFICIARY INFORMATION

Effective date of beneficiary change

List the beneficiary(ies) for *your* Basic 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

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 a new employee and the combined total of my Basic coverage exceeds $500,000.

Department Representative's signature_____ Date Entered into HRIS_____

*Temporary benefits eligible employees (TBE) **are not eligible** for Supplemental, Spouse/DP, and Child GTL Coverage.

INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

**CONTINUATION COVERAGE RIGHTS UNDER COBRA **

Introduction
It is important that all covered individuals (employee, spouse/domestic partner, and eligible dependent children, if able) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent not living at your address, please provide written notification to your department's Benefits Representative so a notice can be sent to that dependent as well.

You are receiving this notice because you may have recently become covered under one or more of the following group health plans: City of Seattle Preventive Plan, City of Seattle Traditional Plan, Kaiser Permanente, Delta Dental of Washington, Dental Health Services, Vision Service Plan, United HealthCare, and the Health Flexible Spending Account (Health FSA). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under a plan under certain circumstances when coverage would otherwise end due to a qualifying event. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plans listed above (medical, dental, vision, and the Health FSA) and not to any other benefits offered by the City of Seattle (such as life insurance, long term disability, or accidental death and dismemberment insurance). **Should an actual qualifying event occur in the future, the City of Seattle will send you additional information and an election notice at that time.**

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under a plan. It can also become available to your spouse/domestic partner and dependent children, if they are covered under a plan, when they would otherwise lose their group health coverage under the plan. This notice does not fully describe COBRA coverage or other rights under a plan. For additional information about your rights and obligations under a plan and under federal law, you should review the plan booklet or contact the City of Seattle Personnel Department Benefits Unit, which is the COBRA Plan Administrator. A plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed in this notice. After a qualifying event occurs and any required notice of that event is properly provided to your department's Benefits Representative, COBRA coverage must be offered to each person losing plan coverage who is a "qualified beneficiary." You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under a plan is lost because of the qualifying event. Under a plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage.

Who is entitled to elect COBRA Continuation Coverage?
If you are an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason.

If you are the spouse/domestic partner, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because any of the following qualifying events happens:

- your spouse/domestic partner dies;
- your spouse's/domestic partner's hours of employment are reduced;
- your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse, or you terminate your domestic partnership. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation occurs within three months of the reduction or elimination of coverage, then the divorce or legal separation will be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under a plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child stops being eligible for coverage under a plan as a "dependent child."

When is COBRA Continuation Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, a COBRA election notice will be made available to qualified beneficiaries. You do not need to notify the Benefits Representative in your department of the occurrence of any of these three qualifying events. However, notice must be provided to your department's Benefits Representative for other qualifying events, as explained below in the section entitled "You Must Give Notice of Some Qualifying Events."

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, termination of domestic partnership, or a dependent child's loss of eligibility for coverage as a dependent child), a COBRA election notice will be available to you only if you complete and submit a *Health Care Benefits Change Form* to the Benefits Representative for your department within 60 days after the date on which the qualified beneficiary loses or would lose coverage under the terms of the plan as a result of the qualifying event. If this procedure is not followed during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE. (A *Health Care Benefits Change Form* is available from your department's Benefits Representative.)

Electing COBRA Coverage

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses/domestic partners (if the spouse/domestic partner is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce, legal separation or termination of domestic partnership; or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months BEFORE the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse/domestic partner and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component."

Extension of Maximum Coverage Period
If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

Disability extension of 18-month period of continuation coverage
If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above.)

The disability extension is available only if you complete and submit a *Notice of Disability* and a copy of the Social Security Administration's determination of disability to the COBRA Plan Administrator: (a) during the 18 months after the covered employee's termination of employment or reduction of hours, and (b) within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of a plan as a result of the covered employee's termination of employment or reduction of hours.

If these procedures are not followed or if the notice is not provided to the COBRA Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. You can obtain a copy of a *Notice of Disability* from the COBRA Plan Administrator.

Second qualifying event extension of COBRA coverage
If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse/domestic partner and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Plan Administrator. This extension may be available to the spouse/domestic partner and any dependent children receiving COBRA coverage if the employee or former employee dies; gets divorced or legally separated, or terminates a domestic partnership; or if the dependent child stops being eligible under a plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under a plan had the first qualifying event not occurred. (This extension is not available to the spouse/domestic partner and any dependent children under a plan when a covered employee becomes entitled to Medicare after electing COBRA coverage .)

This extension due to a second qualifying event is available only if you notify the COBRA Plan Administrator by completing and submitting a *Notice of Second Qualifying Event* within 60 days after the date of the second qualifying event. You can obtain a copy of a *Notice of Second Qualifying Event* from the COBRA Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the COBRA Plan Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Health Care FSA Component
COBRA coverage under the Health Care FSA will be offered to qualified beneficiaries. Health Care FSA COBRA coverage will consist of the Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. Health Care FSA COBRA coverage will consist of the Health FSA coverage in force at the time of the

qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and Health Care FSA COBRA coverage will terminate at the end of the plan year.

More Information About Individuals Who May Be Qualified Beneficiaries

- *Children born to or placed for adoption with the covered employee during COBRA coverage period*

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in a plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in a plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

- *Alternate recipients under QMCSOs*

A child of the covered employee who is receiving benefits under a plan pursuant to a qualified medical child support order (QMSCO) received by the COBRA Plan Administrator during the covered employee's period of employment with the City of Seattle is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your department's Benefits Representative informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your department's Benefits Representative or COBRA Plan Administrator.

If You Have Questions

Questions concerning your Plan or COBRA coverage should be addressed to the:

COBRA Plan Administrator
City of Seattle Human Resources
Benefits Unit
700 5th Ave., Suite 5500
PO Box 34028
Seattle, WA 98124-4028 **Phone**: 206-615-1340