2003 – 2004 Employee Benefits Booklet

Seattle Public Schools

The John Stanford Center for Educational Excellence
2445 Third Avenue South
Seattle, WA 98134

206-252-0000
www.seattleschools.org

SPRAGUE ISRAEL GILES INC.
Insurance Consultants

1501 Fourth Avenue, Suite 2000
Seattle, Washington 98101-1637
ssdbenefits@sig-ins.com 1-800-526-0635 206-623-7035

The Seattle School District's Joint Insurance Committee is pleased to present this 2003-2004 Employee Benefits booklet. The information contained in this booklet provides information about your employee benefits, and describes the coverages provided by the Dental and Vision plans, the Flexible Benefits (Section 125) plan, the Life Insurance and Long Term Disability plans, the Employee Assistance Program, and finally, the Workers' Compensation coverage.

The medical plans are fully described in separate plan booklets provided by the insurance companies, but for your convenience a comparison of the six medical plans is also included in this booklet. The protection offered by these plans provides a comprehensive health maintenance program for you and your family. It is extremely important that you review the contents of these booklets in order for you to become informed about the provisions and limitations of each plan and to select the medical plan that most closely meets your particular health care needs.

Should you have any questions or need assistance concerning your group benefit program, please refer to the telephone numbers on page iv.

POLICY

The Seattle School District provides Equal Educational Opportunity without regard to race, creed, color, national origin, sex, handicap/disability or sexual orientation. The Seattle School District is an Equal Employment Opportunity, Affirmative Action employer and employs individuals without regard to race, creed, color, national origin, age, sex, marital status, handicap/disability or sexual orientation.

The District complies with all applicable State and Federal laws, including but not limited to, Title VI, Title VII, Title IX of the Civil Rights Act, the Americans with Disabilities Act (ADA), RCW 49.60, Law Against Discrimination, Section 504 of the Rehabilitation Act, and RCW 28A.640, "Sex Equality," and covers, but is not limited to, all District programs, courses, activities (including) extracurricular activities, services, access to facilities, etc.

The Title IX Officer and 504 Coordinator with the overall responsibility for monitoring, auditing, and ensuring compliance with this policy is: Rick Takeuchi, Manager, Office of Equity and Compliance, JSCEE, 2445 Third Avenue South, Seattle,WA 98134. Phone (206) 252-0371.

Individuals who believe they have been discriminated against in any of the District's educational or employment activities can file an internal discrimination complaint with the District's Office of Equity and Compliance.

IMPORTANT DISCLAIMER

This booklet outlines some of the important features of the group benefits program for District employees. The master policies contain many other provisions not described in this booklet, such as additional exclusions and limitations, requirements for filing claims, additional benefit provisions, etc.

The descriptions of the master policy provisions contained in this booklet are necessarily written in non-technical language and may not be fully descriptive and truly accurate when compared with the master policies. The controlling provisions are in the master policies and the information provided in this booklet is not intended in any way to modify the meaning of those provisions. You may inspect a copy of each master policy during normal business hours upon written request to Employee Benefits.

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IMPORTANT TELEPHONE NUMBERS

For Assistance or Answers to Your Specific Questions or Problems, Please Contact:

The District's Employee Benefits Staff:		
Medical, Vision & Dental Plans; Life & Disability Plans		206-252-0282
COBRA, Section 125		206-252-0292
Employee Assistance Program		206-252-4800
TRS & PERS Retirement; Tax Sheltered Annuities 403(b)		206-252-0286
Injury on Duty; Job-related Illness Risk Management Department Berkley Administrators		206-252-0710 206-575-2303
Medical Plans And Other Service Providers:		
Group Health Cooperative	www.ghc.org	206-901-4636 1-888-901-4636
PacifiCare	www.phs.com	1-800-932-3004
KPS Health Plans	www.kpshealthplans.com	360-478-6796 1-800-552-7114
Aetna Health, Inc.	www.aetna.com	1-800-756-7039
WEA/Premera Blue Cross Subscribers only Select Health Plan Customer Service	www.premera.com	1-800-722-1471
Washington Dental Service	www.deltadentalwa.com	206-522-2300 1-800-554-1907
Northwest Benefit Network Vision Plan	www.nwadmin.com	206-726-3278 or 1-800-732-1123
Flex Plan Services	www.flex-plan.com	425-452-3500 1-800-699-FLEX
For Assistance With Claims Problems or Benefit Questions Call:		
Sprague Israel Giles Inc. Insurance Consultant for the District	ssdbenefits@sig-ins.com	206-623-7035 1-800-526-0635

COMMONLY ASKED QUESTIONS

1. ***Where can I obtain Insurance Forms, provider lists, or other material regarding my benefits?***

   First, contact the administration office at your work place; they should be able to provide most of the forms you may need. If they cannot, contact Employee Benefits at 206-252-0282 or 206-252-0292.

2. ***How do I change medical plans?***

   You can only change plans during the open enrollment period, which occurs from mid-August to mid-September every year. Contact the administration office at your work place or Employee Benefits at 206-252-0282 or 206-252-0292 to obtain the necessary forms. (Also, s*ee page 1, ENROLLMENT PROCEDURES.*)

3. ***Who can help me with claim problems?***

   Sprague Israel Giles Inc., the insurance broker for the District, can assist you with any claims problems you may have. Call 206-623-7035. This booklet and the medical plan booklets from the carriers are also excellent sources for answers to many claims and benefits questions. The carriers may also be contacted directly. (S*ee page iv.*)

4. ***How do I find out about my benefits?***

   Eligible employees automatically have dental, vision, life insurance and long term disability benefits, and may choose from one of six medical plans. (The non-medical benefits are described in this booklet, and the medical carriers have their own booklets describing their medical plans.) In addition, new employees, or those newly eligible for benefits, attend a personnel orientation that includes information about the District's group benefits program.

5. ***What will be my share of the total premium costs?***

   A worksheet can be found on page 43 of this booklet, which you can use to determine your share of premium costs. The monthly rates for all benefits can be found on pages 41 and 42.

6. ***How does the District decide on what benefits I get?***

   The Seattle School District Joint Insurance Committee is made up of representatives from all bargaining units as well as the administration. This group meets regularly to discuss insurance issues relevant to the District and to discuss and agree on possible changes in benefit plans. If you would like to bring a relevant issue to the committee's attention, please contact your bargaining unit representative.

7. ***How do I add or delete eligible dependents?***

   In general, you may add eligible dependents during the open enrollment period and delete dependents from coverage at any time. A newly acquired dependent becomes eligible for insurance either on date of birth or placement of adoption, or on the first of the month following the date of marriage or receipt of an affidavit of domestic partnership. (*Please see page 3: COVERAGE FOR DEPENDENTS - ELIGIBILITY AND EFFECTIVE DATES; DEPENDENTS DEFINED; NEW DEPENDENTS.*) To add or delete coverage, a new application and Group Medical Plan Enrollment/Change Form must be submitted to Employee Benefits. (Call 206-252-0282 or 206-252-0292 for specific instructions concerning procedures for canceling coverage.)

8. ***Should I insure my dependents on my medical plan if they have coverage elsewhere?***

   While each person's situation is different, it is usually not in your best interest to pay for dependent coverage here at the District if your dependents have coverage elsewhere. This is because the monthly premiums you would pay for District coverage could cost you more than you would ever get back from the coverage provided by the second

insurance plan. Because the primary coverage is usually comprehensive, secondary plans frequently end up paying very little in extra medical benefits.

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9. ***Should I participate in the Flexible Benefits Plan, if I pay part of my medical premiums through payroll deduction?***

If the monthly cost of your benefits exceeds the contribution that the District makes toward your premium costs, you will have a monthly out-of-pocket expense and participation in the Flexible Benefits Plan would offer you favorable tax benefits. (*See page 9, FLEXIBLE BENEFITS PLAN, for a detailed explanation.*) Please note, however, that if you cover a domestic partner you are not eligible to participate in the premium conversion portion of the Flexible Benefits Plan.

10. ***What happens to my insurance if I leave the District?***

You may be eligible for COBRA coverage and able to continue your medical, dental and vision coverages for certain periods of time, usually 18 months, by paying the premium to the District. (*See page 5 for more information*.)

GENERAL INFORMATION

SEATTLE SCHOOL DISTRICT NO. 1
EMPLOYEE GROUP BENEFITS PROGRAM

As an employee of Seattle School District No. 1, you are automatically covered by a group dental plan, vision plan, life and long term disability plans and may participate in a choice of medical plans. You should become familiar with these plans in order to select those that most nearly fit your needs and to take full advantage of the benefits offered. You are also protected by the District's Workers' Compensation plan.

A District contribution is provided for eligible employees to help defray the cost of the plans selected. Check your payroll warrant each month to see how the District contribution is applied and to ensure that you are receiving the coverage you desire.

This booklet is updated and distributed each year for your information and guidance.

ELIGIBILITY

Your eligibility to participate in the group benefits program is determined by Personnel and is based upon the eligibility criteria contained in the appropriate collective bargaining agreement of represented employees. In the case of non-represented employees, the determination is based upon the eligibility criteria contained in the Salary & Benefits Package for Non-represented Employees as approved by the Board of Directors of the District each year. A District benefit contribution allowance to help pay for part of the benefits program is provided to eligible employees. (*See page 2, COST.*) You must meet the following criteria in order to become eligible for the Dental, Vision, Medical and Life/Long Term Disability group benefits plans offered by the Seattle School District:

1. Be working in a regular, budgeted position requiring the equivalent of half-time or more;

2. Have sufficient salary each month from which the employee's share of costs, if applicable, may be deducted and be paid to the carrier on a twelve-month basis; and

3. Not be covered under another District benefits program with District contributions through a union contract.

If your position is reduced in hours to below half time you, will be given notice by Employee Benefits that your eligibility for District contributions will cease. Coverage may be continued on a self-pay basis as outlined under "COBRA" on page 5.

SPECIAL PROVISIONS FOR SUBSTITUTES

Certificated Substitutes, who are offered an individual contract during the school year or who work 60 continuous days or more in the same assignment, are eligible to participate in the benefits program upon notification by the Personnel Department. (*See page 2, WHEN COVERAGE BEGINS.*)

Senior Substitute Teachers are eligible to participate on a self-pay basis in any of the medical plans offered to regular employees. Senior substitute status is determined by the Personnel Department. After notification of senior substitute status, the senior substitute shall have thirty-one (31) days to enroll. Eligible senior substitute teachers should contact Employee Benefits (206-252-0282).

ENROLLMENT PROCEDURES

All enrollment procedures are handled through Employee Benefits (206-252-0282 or 206-252-0292).

Employees new to the District, or newly eligible for group benefits, attend a personnel orientation and are provided information about the District's group benefits program. It shall be the responsibility of the employee to ensure that the required application forms are completed and submitted to Employee Benefits within the specified timeline. For assistance concerning enrollment, contact Employee Benefits at 206-252-0282 or 206-252-0292.

Special Provisions for Domestic Partner Coverage Premium contributions for domestic partners are a taxable event. In addition, if you cover a domestic partner, you will not be eligible to participate in the premium conversion portion of the Section 125 plan.

Special enrollment forms are needed, including an Affidavit of Marriage/Domestic Partnership. These forms may be obtained at the payroll office or at your work location.

Dental and Vision - Coverage is automatically provided for you and eligible dependents if you meet the eligibility criteria described in the Eligibility section. Formal enrollment in these plans is not necessary, and no application forms are required. New employees may transfer WDS levels they attained on a previous group WDS incentive plan.

Life/Long Term Disability (Life/LTD) - You are automatically covered on the date you become eligible, provided you are actively at work. For life insurance, you must have a completed beneficiary form on file in the payroll office. If you do not designate a beneficiary, or if you are not survived by a beneficiary, all death benefits will be paid in equal amounts to the first surviving class of the following classes: a. your spouse, b. your children, c. your parents. If none of them survive you, the benefits will be

payable to your estate. Survivors benefits from LTD coverage are payable to Domestic Partners only if a valid Affidavit of Domestic Partnership is on file the Payroll Office.

Medical - New employees who are eligible to participate in the District's benefits program may enroll in one of the five group medical plans offered by the District: Group Health Cooperative of Puget Sound, Premera Blue Cross, Aetna US Healthcare Health Plan, PacifiCare and First Choice.

Employees who become eligible for the District's group benefits program must enroll in a medical plan option within 31 calendar days of their employment date. Employees who wait beyond the first 31 calendar days of employment to enroll in a group medical plan will forfeit coverage until the next established annual open enrollment period.

Open Enrollment Period - Each year an open enrollment period is held between mid-August and mid-September during which time you may change medical coverage with no restrictions on prior health conditions. Changes in the medical plans and/or dependent medical coverage may only be requested during the annual open enrollment period, or as a result of a loss of medical coverage under a separate group medical plan, or to add a newly eligible dependent. (*See page 3, COVERAGE FOR DEPENDENTS; NEW DEPENDENTS.*) **All changes made at open enrollment are effective October 1st of the same year.**

COST

Employees who are working in regular, budgeted positions requiring the equivalent of half-time or more are eligible for a monthly benefit contribution allowance from the District. This contribution allowance will help defray the cost of the plans selected. The cost of each plan is provided on pages 41 and 42, and a cost worksheet is provided on page 43. Use the worksheet to determine what portion of the total monthly cost of your benefits program, if any, exceeds the District contribution allowance. If the amount of your total benefits cost is not covered by the District benefit contribution, the excess amount will be your responsibility and will be deducted from your pay warrant each month. Employees whose total monthly cost exceeds the District contribution allowance may participate in the District's Flexible Benefit Plan (*See page 9*), which could provide tax savings. (Note: Employees covering domestic partners may not participate in the premium conversion portion of the Flexible Benefit Plan.)

CANCELLATION OF MEDICAL COVERAGE

Employee - You may cancel your medical coverage at any time upon written notice to Employee Benefits. You cannot cancel the dental, vision or life/LTD plans.

Dependents - To delete medical coverage, a new application indicating the change must be submitted to Employee Benefits.

Contact Employee Benefits for specific instructions concerning procedures for canceling coverage. All changes must be received by Employee Benefits by the 20th of the month in order for the cancellation to be effective the first of the following month.

To continue benefits on COBRA, an employee, or a family member, has the responsibility to inform Employee Benefits of a death, divorce, termination of a domestic partnership, legal separation, or a child losing dependent status, within 60 days of the event.

WHEN COVERAGE BEGINS

If you begin work or return from an unpaid leave on or before the 15th of the month and if your valid application for Medical coverage is received by Employee Benefits on or before the 20th day of that month, your coverage will begin on the first of the following month. If your application is received after the 20th day of the month, *but not later than 31 calendar days from your employment date*, your coverage will begin on the first of the month following your first regular pay warrant.

If you begin work or return from an unpaid leave on or after the 16th of the month and you submit valid applications for coverage by the 20th of the next month, *but not later than 31 calendar days from your employment date*, your coverage will begin the first day of the second month following your employment. If a benefit premium is shown on your monthly warrant, your coverage is active and you are eligible for services provided under the group plans you have selected.

The effective date for group coverage for Certificated Substitutes who are offered an individual contract during the school year will be the first of the month following the month in which notification of eligibility is received from Personnel, provided the valid applications for insurance are received by Employee Benefits on or before the 20th day of the month in which the contract assignment is made. If the application is received after the 20th day of the month, then the effective date of coverage will be the first of the second month following the contract assignment date. All applications must be made within 31 calendar days of the date the contract assignment was made.

WHEN COVERAGE ENDS

If you terminate or go on an unpaid leave on or before the 15th of the month, your coverage will cease at the end of the month. If you terminate or go on an unpaid leave on or after the 16th of the month, your coverage will cease at the

end of the next month following your termination. If you are a school year employee and you terminate at the completion of your scheduled work year, your coverage will continue through the summer months to September 30th. You may continue coverage as outlined under "COBRA" on page 5.

COVERAGE FOR DEPENDENTS - ELIGIBILITY AND EFFECTIVE DATES

Your dependents may be enrolled only if you are enrolled as an employee. When enrolled, coverage for eligible dependents becomes effective on the same date as yours. If you, or your dependent, are confined in a hospital, or similar institution, because of injury or illness on the date your District group coverage would otherwise have become effective, actual coverage will be postponed until the end of the confinement, with the exception of a subscriber's newborn child.

Eligible dependents (spouse, domestic partners and children) are automatically covered under the group dental and vision plans. Life and LTD benefits are extended to Domestic Partners (and their children) only if an Affidavit of Domestic Partnership is on file in the Payroll Office.

Medical coverage for dependents is provided if they meet the eligibility requirements and are properly enrolled in your medical plan within 31 calendar days of your employment date, or during the annual open enrollment period. Dependents not previously covered under your medical plan may be added under special enrollment conditions.

SPECIAL ENROLLMENT RULES

1. Employees and/or dependents not previously covered under a medical plan may be added outside of the annual open enrollment period under the following conditions. If the employee and/or dependents are not presently covered under a District medical plan of the spouse, the employee and/or dependents may join a District medical plan if the coverage through the spouse is involuntarily lost. This loss must be due to loss of eligibility because of legal separation, divorce, death, end of employment, retirement or a reduction in the number of hours of employment. The employee must submit valid application with a letter from the spouse's employer to Employee Benefits within 60 calendar days of the date the spouse's coverage terminates.

2. Court ordered coverage of dependents will be made effective the 1st of the month after submission of the enrollment form and a copy of the court documents.

3. District employees may not cover spouses who are in work stoppage situations except during the annual open enrollment period.

4. An employee of the District may not be enrolled in a District-sponsored plan as both an employee and a dependent.

5. Only one employee may cover dependent children in the event that the District employs both parents.

DEPENDENTS DEFINED

Dependents are defined as a legally married spouse, a domestic partner and his/her children, natural, adopted or step children and children legally placed for adoption, who are unmarried and under the age of 23. Legal documentation of adoption and stepchildren is required. *(See page 26 for special conditions for life insurance eligibility under the Standard Insurance Life/LTD plan.)*

NEW DEPENDENTS

Newborns are covered from birth. Adopted children are covered on date of placement. You must submit a valid application to Employee Benefits within 60 days of birth or placement for adoption of a child; otherwise you must wait for the next annual open enrollment period to obtain coverage for the new dependent. Costs resulting from the addition of newborns or adopted children will be effective the first of the month following the date of eligibility.

New spouses or domestic partners and their children are eligible for insurance on the first of the month following date of marriage or the first of the month following receipt of a valid affidavit signed by an employee declaring a domestic partner relationship. You must submit a valid application to Employee Benefits within 31 calendar days of marriage or the establishment of domestic partnership; otherwise you must wait for the next annual open enrollment period to obtain coverage for the new dependent. Costs resulting from the addition of a spouse, domestic partner and their children will be effective the first of the month following the date of eligibility.

Note: Be sure to send your application directly to Employee Benefits, not to the insurance carrier or health care service contractor.

COVERAGE DURING LEAVE WITH PAY

During a leave with pay the full District contribution for your group insurance coverage will be continued.

Medical Coverage

You may discontinue medical coverage while on a paid leave. However, if coverage is desired upon return to work, you must contact Employee Benefits and enroll within 31 calendar days of your return to work, to reinstate your coverage.

Dental, Vision and Life/LTD

Your coverages will continue to be provided for you and your dependents during your paid leave.

COVERAGE DURING LEAVE WITHOUT PAY

A self-pay program is available to employees on approved leave without pay. There is no District contribution while on an unpaid leave. Self-pay privileges are granted for a period of 12 months. If leave is extended beyond one year, all coverages will end, except that eligible employees will be offered COBRA continuation for Medical, Dental and Vision coverage. *(See page 5.)* Contact Employee Benefits 206-252-0292 to make arrangements for self-paying the full costs directly to the District.

Contact the Leave Desk in Employment Services, 206-252-0368, for application and information regarding leave eligibility.

Medical Coverage

1. You may continue your medical coverage if you are on an approved unpaid leave of absence by arranging to self-pay the appropriate cost.

2. When you return to work from an unpaid leave, you must complete new application forms in order to reinstate your coverage through payroll deduction. This is required whether or not you choose to self-pay during your leave.

3. If you choose to discontinue medical coverage during your leave of absence, you must complete new application forms to reinstate coverage upon your return from leave. (*See page 2, WHEN COVERAGE BEGINS.*)

4. New dependents acquired during leave of absence must be added to your coverage within 31 calendar days of marriage or domestic partnership and within 60 calendar days of birth or placement for adoption.

Life/LTD Coverage

1. You may continue your coverage if you are on an approved unpaid leave of absence by arranging to self-pay the appropriate cost.
2. Whether or not you choose to continue coverage during your unpaid leave, your coverage will automatically resume after your return to work in an eligible position. (*See page 2, WHEN COVERAGE BEGINS.*)
3. If you become totally disabled during an unpaid leave of absence, your 45-day elimination period will not begin to accrue until the date you are scheduled to return to work.

Dental and Vision Coverage

1. You may continue your dental and vision coverage if you are on a leave of absence approved by the District by arranging to self-pay the appropriate cost. Contact Employee Benefits for assistance.

2. Whether or not you choose to continue your dental and vision coverage during your unpaid leave, your coverage will automatically resume after your return to work in an eligible position. (*See page 2, WHEN COVERAGE BEGINS.*)

3. Vision services received during a self-pay period are credited toward the maximum services that you are allowed in a 12 or 24 month period. Refer to the NBN Vision Plan section, page 17. Your incentive level under the dental plan will decrease by 10% each benefit year in which you do not see your dentist. *(See page 11, HOW YOUR DENTAL INCENTIVE DELTAPREFERRED OPTION PROGRAM WORKS.)*

4. If you choose not to continue your dental coverage while on a Leave of Absence, the incentive level you had when you went on Leave will be reduced by 10% upon your return to active status.

FAMILY MEDICAL LEAVE ACT

Employees who are eligible to take leave under Family Medical Leave Act of 1993 are entitled to receive health benefits while they are on unpaid leave for up to 12 weeks under the same conditions as when they were on the job.

Unpaid leave must be granted for any of the following reasons:

1. To care for the employee's child after birth or placement for adoption or foster care;

2. To care for the employee's spouse, son or daughter or parent who has a serious health condition; or

3. For a serious health condition that makes the employee unable to perform the employee's job. A serious health condition includes Childbearing Leave.

The District requires that an employee use any available accumulated paid leave or shared leave in order to be eligible for FMLA benefits.

The employee ordinarily must provide 30 (thirty) days advance notice, when the leave is foreseeable. The District may require medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the District's expense) and a fitness for duty report to return to work.

For the duration of the FMLA leave, the District must maintain the employee's health coverage under the group health plan and, upon return from leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the state of an employee's leave.

FMLA makes it unlawful for any employer to interfere with, restrain or deny the exercise of any right provided under FMLA or to discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

The U.S. Department of Labor is authorized to investigate and resolve complaints of violations. An eligible employee may bring a civil action against an employer for violations.

COBRA and HIPAA

Continuation of Health Benefits After Termination of Employment

EMPLOYEE: Your coverage as an active employee ceases on the last day of the month in which you terminate employment. If your employment terminates for reasons other than gross misconduct or if you lose your coverage because you have a reduction in your hours of employment below the plan eligibility requirements, you may continue your medical, dental, or vision coverage separately or on a combined basis, by self paying the required premiums as calculated by the District (102% of the employer and employee premium costs for an active employee and any covered family members).

FAMILY MEMBERS: a covered spouse/domestic partner or covered dependent child may elect to continue coverage for the permitted COBRA coverage period because of any of the following "qualifying events":

1. Death of the covered employee;
2. Termination of the covered employee's employment (for reasons other than gross misconduct) or termination of the employee's coverage due to a reduction in the employee's hours of employment;
3. A covered spouse/domestic partner's divorce or legal separation;
5. The covered employee becoming entitled to Medicare benefits.

Further, a covered dependent child may continue coverage for the permitted COBRA coverage period if the covered dependent ceases to be a "dependent child" under the plan's rules of eligibility.

The employee or family member has the responsibility to notify the District of a divorce, legal separation or a child losing dependent status under the plan. Notice must be given no later than 60 days after the date coverage would be lost because of the applicable event. If you fail to give this notice during the 60-day period, you will not be offered the option to elect continuation coverage.

ELECTING COVERAGE: You must elect continuation coverages within 60 days after coverage ends, or within 60 days after the District provides you with notice of your right to elect continuation coverage, whichever is later. If you do not elect continuation coverage within this 60-day period, you will lose your right to elect continuation coverage. A covered employee or the covered spouse/domestic partner of the covered employee may elect continuation coverage for all covered family members. The covered employee, and his or her covered spouse/domestic partner and covered dependent children, however, have an independent right to elect continuation coverage. Thus, a covered spouse/domestic partner or covered dependent child may elect continuation coverage even if the covered employee does not elect it. If a child is born to or placed for adoption with a covered former employee during the COBRA coverage period, the covered person may elect COBRA coverage for that child.

PREMIUM PAYMENTS: You must pay the premium payments for your "initial premium months" by the 45th day after you elect continuation coverage. Your initial premium months are the months that end on or before the 45th day after you elect continuation coverage. All other premiums are due on the 20th of the prior month for which the premium is paid, subject to a 30-day grace period.

Cobra Coverage Periods:

1. ***18 Months***. If the covered employee, covered spouse/domestic partner or covered dependent child loses group health coverage because of a termination of employment or reduction in hours of the employee's employment, the maximum COBRA continuation coverage period is 18 months from the date of termination of employment or reduction in hours. There are two exceptions:

    a. For a covered employee or covered family member who is disabled during the first 60 days of COBRA continuation coverage, the

continuation coverage period is 29 months from the date of termination or reduction in hours. The disability that extends the 18 month coverage period must be determined under Title II or Title XVI of the Social Security Act. For the 29 month continuation period to apply, notice of the determination of disability under the Social Security Act must be provided by the disabled individual to the District within the 18 month coverage period or within 60 days after the date of determination of disability by the Social Security Administration, whichever is earlier. After the 18-month coverage period is extended by disability, the disabled individual must self-pay 150% of the employer and employee premium costs for an active employee and any covered family members.

b. If a second qualifying event occurs (for example, the covered employee dies, becomes divorced, or becomes entitled to Medicare) within the 18 month or 29 month coverage period, the maximum coverage period becomes three years from the date of termination or reduction in hours.

2. ***36 Months***. If a covered spouse/domestic partner or covered dependent child loses coverage because of the covered employee's death, divorce, legal separation, or because of lost status as a dependent under the plan, the maximum coverage period is three years from the date of the qualifying event.

3. ***Special Rule When Covered Employee Becomes Entitled to Medicare Before Termination of Employment or Reduction in Hours***. If a covered employee becomes entitled to Medicare while employed by the District, and within eighteen (18) months after the covered employee becomes entitled to Medicare, he or she terminates employment with the District or loses group medical, dental or vision coverage due to a reduction in work hours, then his or her covered spouse/domestic partner or covered dependents may elect COBRA continuation for a period beginning with that loss of coverage and ending thirty-six (36) months after the date the covered employee becomes entitled to Medicare.

Termination Before The End of Maximum Cobra Coverage Period

Your COBRA continuation coverage automatically terminates (even before the end of the maximum coverage period) when any one of the following six events occurs:

1. The District no longer provides the coverage to any of its employees;

2. The premium for your continuation coverage is not paid in a timely manner;

3. After your termination you become covered under another group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any pre-existing condition;

4. After your termination you become covered under another group health plan (as an employee or otherwise) which contains a pre-existing condition limitation or exclusion, provided the pre-existing condition limitation or exclusion does not apply to the qualified beneficiary by reason of the 1996 Health Reform Act's rules restricting the application of pre-existing condition limitations and exclusions;

5. After your termination you become entitled to Medicare benefits;

6. If you become entitled to a 29-month maximum coverage period, but then there is a final determination under Title II or Title XVI of the Social Security Act that you are no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after that determination.

If your marital status changes, or if a dependent ceases to become eligible, or you or your spouse/domestic partner's address changes, you must immediately notify Employee Benefits.

Note: Upon termination of regular or COBRA medical and dental coverage, you and your family members will receive a Certificate of Creditable Coverage from the insurance company. This Certificate will provide proof of your continuous coverage under the plan for 18 months or from the date you enrolled in the plan until the date your coverage with the plan terminated, whichever is less. (HIPAA law)

CONVERSION PRIVILEGE

When you or your participating dependents cease to be eligible to participate in the life insurance or group health care program, coverage may be continued through a conversion policy. The application must be received by the insurance company within 31 calendar days from the date your group coverage ceases. Contact Sprague Israel Giles Inc., 206-623-7035, for more information.

COVERAGE FOR RETIRED EMPLOYEES

Retiree plans are available to qualified retirees through the Washington State Public Employee Benefits Board (PEBB) and are administered by the Health Care Authority. Call 1-800-200-1004 for information. In addition, you may want to consider purchasing individual medical coverage separately. Contact Sprague Israel Giles Inc. at 206-623-7035 for information. For Washington Dental Service retiree coverage, call 206-522-1300.

COORDINATION OF BENEFITS

In Case of Coverage by Two Group Policies

The State of Washington Insurance Commissioner's Office has adopted rules governing coordination of benefits when a person is covered by two group insurance policies. In coordinating benefits, one program is determined to have primary responsibility for payment of health care benefits. Other programs will then provide reduced benefits so that the total payments made under the combined coverages will not exceed 100 percent of the covered expenses.

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

It is your responsibility to advise your health care provider of dual coverage. In addition, it is important for you to promptly respond to any written request from your benefits carrier for information concerning dual coverage. The primary program for a person is that program which first satisfies any of the rules below in the order in which they appear.

1. The program that does not have a Coordination of Benefits (COB) provision.

2. The program covering the person as an active employee.

3. The program covering the person as a dependent except:

    (a) If the person is a dependent child, then the program covering the parent whose month and day of birth falls earlier in the year will be the primary program. However, if one of the parent's programs does not follow this "birthday rule", then the program covering the father is primary; or

    (b) If the person is a dependent child of parents who are separated or divorced, then the benefits are determined in the following order:

    (c)

        (1) The program of the parent with custody;

        (2) The program of the new spouse of the parent with custody;

        (3) The program of the parent without custody;

        (4) The program of the new spouse of the parent without custody.

    However, if the court decrees financial responsibility for the dependent child's health care, the program of the parent with the responsibility is the primary program.

4. If the above order does not establish the primary program, then the program that has covered the person for the longest period of time is the primary program. For a retired or laid-off employee, or dependent of such person, this program will pay after the program covering the person as an active employee or dependent thereof. If the other program does not have a provision regarding retired or laid-off employees resulting in conflicting orders of benefit determination, this program's provisions will not apply.

5. If none of the above establishes the primary program then the program that has covered the employee for the longest period of time is the primary program.

This provision does not apply to any individual insurance policy or contract that the person may have.

GROUP COVERAGE FOR INCAPACITATED OR DEVELOPMENTALLY DISABLED CHILDREN

Medical, dental and vision coverage can be continued for an unmarried dependent child over age 23 who is incapacitated. You must verify that the child is incapacitated or developmentally disabled and chiefly dependent on you for support within 31 calendar days after the dependent turns age 23 and periodically thereafter. Medical verification of this condition must be submitted to the benefits carrier within 31 calendar days after the child attains the age limit. Coverage can continue for the duration of the incapacity provided the condition existed before age 23 and the coverage does not terminate for any reason. Premera Blue Cross and Group Health plans do not

allow the initial enrollment of incapacitated or developmentally disabled children who have attained age 23.

LABOR DISPUTES

State law allows employees to self-pay their benefit premiums if compensation is halted because of a labor dispute. Under these circumstances, self-pay is permitted for up to six months through Employee Benefits. You may also be eligible for a longer extension of coverage through COBRA. (*See page 5.*)

REINSTATEMENT RESULTING FROM LEGAL PROCEEDINGS

Coverage will be granted retroactively upon payment of costs by the District when an employee is retroactively reinstated to a regular assignment as the result of a court action, binding arbitration or established District grievance procedure, the terms of which specify retroactive salary and fringe benefits. The carriers will refund to the employee any costs that may have been self-paid and adjust for any medical, dental, vision and/or disability or death benefits to the extent of contract liability for which the employee would otherwise have been eligible.

STATEMENT REGARDING PLAN DOCUMENTS

The District shall make plan documents describing the group benefits program available for inspection at no cost to any employee upon reasonable notice. All employees of the District whether or not eligible to participate, and any unions representing District employees, are entitled to inspect and copy the plan documents at a reasonable time, place and charge for copies.

To make arrangements to inspect or copy these documents, contact Employee Benefits at 206-252-0292.

FLEX-PLAN SERVICES, INC.
P.O. Box 70366
Bellevue, Washington 98005
Phone Number: 425-452-3500

Flexible Benefits Plan

The Seattle School District provides a Flexible Benefits Plan (Section 125 Plan) to any employee who receives a District contribution for group benefits. Under this plan, you can purchase certain benefits (identified below) with a part of your pay that is entirely free from federal income and Social Security taxes. This means that you will pay less tax and have more money to spend and save.

Under the plan you can choose to use a portion of your pay, with tax-free dollars, for one or more of the following plans:

Premium Conversion - You can use tax-free dollars to pay for your share of the medical premiums through payroll deduction. Note: If you are covering a domestic partner, you are not eligible to participate in the premium conversion portion of the Flexible Benefits Plan.

Health Care Flexible Spending Account - This account allows you to be reimbursed for out-of-pocket medical, dental or vision expenses incurred by you and your tax qualified dependents up to a maximum of $3,600 per year.

Dependent Day Care Flexible Spending Account - This allows you to use up to $5,000 per year of tax-free dollars to pay for tax qualified work related dependent care costs.

Premium Reimbursement Account - This allows you to use tax-free dollars to pay for certain tax qualified individual insurance plans that are not offered by the District. This could include expenses for individual medical plans, Medicare Part B, etc.

QUESTIONS AND ANSWERS

How do I participate?
First, you need to be eligible for all District benefits and, second, you must complete a Flexible Benefits "election form". You will be able to participate in any of the four flexible benefit programs listed above.

Must new employees wait until the open enrollment period?
New employees who are eligible for group benefits may elect to participate in the Flexible Benefits Plan by submitting a flexible benefit election form to the Employee Benefits Department within 31 calendar days of their eligibility date; otherwise, they must wait until the next annual open enrollment period.

When must I decide?
Federal law requires you to decide before the plan year begins, which means you must decide during the open enrollment period in November. You must decide 1) which benefits you want, and 2) how much should go toward each benefit.

Can I change my elections during the plan year?
Changes are only permitted due to a change in family status; i.e., marriage, divorce, birth, adoption, death, or employment change by you or your spouse. Benefit changes must be done within 31 days of the qualifying event that caused the change. (Consistency rules apply.)

Can I make new elections in future years?
Yes, for each new plan year you may change the elections that you previously made.

Must I enroll every single year I want to participate?
Yes and no. You do not need to enroll each year for the premium conversion portion of the plan. This will be continued automatically. However, you must sign a new election form each year for the reimbursement accounts. If you do not enroll each year, your participation in these accounts will automatically stop at the end of the year.

How does the plan operate?
There is an open enrollment period each November for an effective date of January 1st. You will be able to elect to have some of your upcoming pay contributed to the plan. Your money will then be deducted from your paycheck and placed in special accounts that are set up for you in order to pay for the benefits you have chosen. The portion of your pay that is paid to the plan is not subject to income or social security taxes.

How much can I put into the plan?
If you are like most people, you will be able to elect enough of your compensation to pay for the benefits you have chosen. The annual maximum for the dependent care account is $5,000 per year, and the annual maximum for the health care account is $3,600.

When will I receive payments from my accounts?
Expenses for health, dependent care or premium expense require a signed claim form, with written substantiation of the expense. Reimbursement for these expenses is made twice monthly, and you will receive a tax-free check payable to you for the claims you have submitted.
Expenses for your medical premiums (i.e., your premium conversion account) will automatically be handled through payroll. There is no reimbursement under this portion of the plan.

What happens if I don't use all of my contributions?
All money left unclaimed in your account will be forfeited to the plan. This is called "use it or lose it". Be conservative when you make your elections. You will have ninety (90) days, or until March 31 of each year, to submit expenses that were incurred during the last plan year.

Will my Social Security benefits be affected?
Your Social Security benefits may be slightly reduced because when you participate in the Flexible Benefits Plan you are reducing your contributions to Social Security.

Will I receive periodic statements that show my account balances?
You will be provided with a statement of your account each month during the plan year. It shows your account balance, your claims submitted, reimbursements made to you, and the amount you need to use by the end of the plan year.

What taxes will I avoid?
By participating in the Flexible Benefits Plan, you will avoid social security taxes and federal income taxes. For most people, these two taxes combined will either equal 22.65% or 35.65%, depending on your tax bracket. This means that for each $1,000 you put into the plan, you will either save $226.50 in taxes or $356.50 in taxes per year.

What if I terminate or retire and have money in my "Health Care" Flexible Spending Account?
Upon termination of employment or retirement, you have two (2) options:

1. Terminate participation in the plan - If you and your dependents choose this option, then you are eligible for reimbursement for all eligible expenses (up to your annual election amount) incurred by you prior to your termination date. If you have funds in the account and there has been no claim against them with eligible expenses that were incurred prior to your termination date, then those funds are forfeited to the Seattle School District. (IRS regulations)

2. Continue participation in the plan - You must notify the Employee Benefits department in writing prior to your final paycheck. If you and your dependents choose this option, you will continue participation in the plan until the plan year end and the difference between what you have contributed to date and your "Annual Election Amount". **Please note that this contribution will be in after-tax dollars.**

What if I terminate or retire and have money in my "Dependent Care" Flexible Spending Account?
Your contributions will cease and you will have until the end of the "Grace Day" period (90 days) at the end of the plan year to submit claims for eligible expenses incurred during the plan year. (Expenses must be related to work or to looking for work.)

What if I terminate or retire and have money in my "Premium Reimbursement" Flexible Spending Account?
Your contributions will cease and you will have until the end of the "Grace Day" period (90 days) at the end of the plan year to submit claims for eligible expenses incurred during the plan year.

Where can I learn more about the Flexible Benefits Plan?
Flex Plan Services, Inc. is the administrator of this plan. You can call them at 425-452-3500 or 1-800-699-FLEX or access their web-site (see page iv.). Additional information may also be received from Employee Benefits at 206-252-0292 or the District's insurance brokers, Sprague Israel Giles Inc. at 206-623-7035.

WASHINGTON DENTAL SERVICE DENTAL PROGRAM

WDS Dental Program #195
P.O. Box 75688, Seattle, WA 98125-0688
206-522-2300 or 1-800-554-1907

About Washington Dental Service (WDS)

Washington Dental Service is a not-for-profit dental service corporation. Nearly all licensed dentists in the state are members. Member dentists agree to follow certain uniform requirements such as filing their charges, completing claim forms and accepting direct payment from WDS.

How to File a Claim

You may select any licensed dentist. Tell your dentist you are covered by a WDS dental program and give your dentist the program name and identification number, which is #195.

Member dentists

Member dentists have contracted with Washington Dental Service to provide services. Members complete claim forms and submit them directly to Washington Dental Service. They receive payment based on the approved fees they have on file with us. You are responsible for copayments and for any elective care you choose to receive. To find out whether your dentist is a member, ask him or her, check your plan's Directory of Dentists or go online to the Washington Dental Service Web site at www.deltadentalwa.com and click on the "Find a Dentist" option.

DeltaPreferred Option (PPO) dentists must be Washington Dental Service member dentists in order to participate in the PPO network. PPO dentists receive payment based on their PPO filed fees at the percentage levels listed on your plan for participating PPO dentists. Patients are responsible for percentage copayments up to the PPO filed fees. DeltaPreferred Option is a point-of-service plan, meaning that you can choose any dentist — in or out of the PPO network — at the time you need treatment. However, if you select a dentist who is part of the DeltaPreferred Option network, your benefits will be paid at a higher level and your out-of-pocket expenses may be lower.

Non-PPO member dentists are members of Washington Dental Service, but they are not part of the DeltaPreferred Option (PPO) network. Non-PPO member dentists receive payment based on their approved fees or filed fees at the percentage levels listed on your plan for non-PPO dentists.

Out-of-state dentists
If you receive treatment from a dentist outside Washington State, you are responsible for having the dentist complete and sign a claim form. It is up to you to pay the dentist's bill and submit the claim to Washington Dental Service. Payment will be based upon actual charges or Washington Dental Service's allowable fees for out-of-state Dentists, whichever is less, at the percentage levels listed for PPO network dentists.

Copayments (Coinsurance)
A copayment policy is typical of most insurance plans. This means the insurance company (Washington Dental Service) will pay a predetermined percentage of the cost of your treatment, and you are responsible for paying the balance. What you pay is called the copayment. It is paid even after a deductible is reached.

American Dental Association approved claim forms may be obtained from Employee Benefits, 206-252-0282. WDS will not be obligated to pay for treatment performed in the event claim forms are submitted for payment more than 6 months after the date of such treatment.

Comment: WDS accepts ADA approved claim forms, which may also be received from the dentist.

Predetermination of Benefits
If your dental care will be extensive, you may wish to have the program benefits predetermined. A predetermination will allow you to know in advance exactly what procedures are covered, the amount WDS will pay toward the treatment, and your financial responsibility. To predetermine benefits, ask your dentist to complete and submit a standard WDS claim form. A predetermination of benefits is recommended for major procedures such as crowns, inlays, onlays and prosthetics.

How Your Dental Incentive DeltaPreferred Option Program Works

Your dental plan offers three classes of covered treatment. Each class also specifies limitations and exclusions (see the explanation of these terms elsewhere in this section)

Reimbursement Levels for Allowable Benefits for DeltaPreferred Option (PPO) Dentists

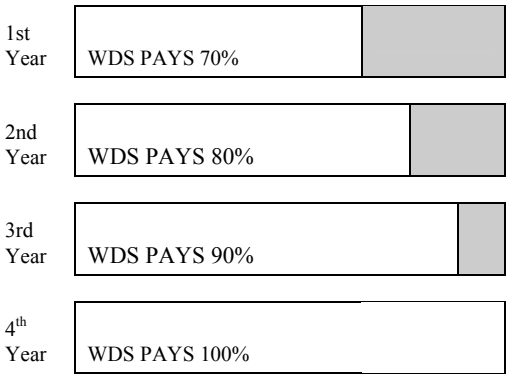
Class I (Diagnostic and Preventive)…….Incentive 70-100%
Class II (Basic Procedures)……..Incentive 70-100%
Class III (Major Procedures)…..……Constant 50%
Crowns & Onlays…….Incentive 70-100%

Reimbursement Levels for Allowable Benefits for Non-DeltaPreferred Option (Non-PPO) Dentists

Class I (Diagnostic and Preventive……Incentive 70-100%
Class II (Basic Procedures)……..Incentive 70-100%
Class III (Major Procedures)……Constant 50%
Crowns & Onlays……..……Constant 50%

The first year of coverage, 70% of covered benefits are paid for Class I and Class II services.

The 70% payment level increases 10% yearly, provided you receive covered dental care from a licensed dentist at least once each benefit period. Maximum benefits for Class I and Class II services would be 100% after three years. Failure to use the program once each benefit period causes your payment level to drop by 10% from the previous year's coverage, but never below the original 70%. Each eligible employee and each eligible dependent has individual incentive levels. New employees may transfer WDS levels they attained on a previous WDS group incentive program. An incentive transfer form can be obtained from Employee Benefits.



NOTE: Class III benefits for prosthetics (such as dentures, bridges, partial dentures, and related items and services) are not covered under the dental incentive program. Class III coverages are limited to a constant 50% payment level.

Dental plans typically include limitations and exclusions, meaning that the plans don't cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this booklet under the sections called "Benefits Covered by Your Program" and "General Exclusions." They warrant careful reading.

Program Maximum

The maximum amount payable by WDS for all covered dental benefits per eligible person is **$2,000** each benefit period as described above. Charges for dental procedures requiring multiple treatment dates shall be considered incurred, and shall be applied to the program maximum, on the date the service is completed.

COVERED DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS

The following are Class I, Class II and Class III covered dental benefits under this program that are subject to the limitations and exclusions contained in this booklet. Such benefits ***(as defined)*** are available only when rendered by a licensed dentist or other WDS-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS.

In the event an eligible person becomes ineligible, or in the event this dental program is terminated for any cause, Washington Dental Service will not be required to pay for services beyond the termination date, except for the completion (within three (3) weeks) of single procedures commenced while this dental program was in effect, which are otherwise benefits under the terms of this dental program.

The amounts payable by WDS for Class I, Class II and Class III covered dental benefits are described in the preceding section.

CLASS I

Diagnostic

Covered Dental Benefits: Routine examination. X-rays. Emergency examination and an examination by a specialist in an American Dental Association recognized specialty. WDS-approved caries susceptibility tests.

Limitations: Examination is covered twice in a benefit period (January 1 through December 31). Complete series (four bitewing x-rays and up to ten periapical x-rays) or panorex x-rays are covered once in a three (3) year period. Supplementary bitewing x-rays are covered twice in a benefit period. WDS-approved caries susceptibility tests.

Exclusions: Diagnostic services and x-rays related to temporomandibular joints (jaw joints). Consultations or elective second opinions. Study models.

Preventive

Covered Dental Benefits: Prophylaxis (cleaning) or periodontal maintenance (but not both), fissure sealants and topical application of fluoride. Space maintainers when used to maintain space for eruption of permanent teeth.
Limitations: Prophylaxis is covered twice in a benefit period (refer to Class II, Periodontics, Limitations for additional limitation information). Topical application of fluoride is covered twice in a benefit period when performed in conjunction with a prophylaxis, through age 18. Preventive therapies (e.g., fluoridated varnishes) approved by WDS are a covered benefit under certain conditions of oral health when performed at the suggested

regimen for that therapy. Children through age 18 are eligible for either topical application of fluoride or preventive therapies, but not both, as described above. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.* Fissure sealants are available for children through age 14. If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending Dentist. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit only once in a three year period.

Exclusions: Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits). Cleaning of a prosthetic appliance. Replacement of a space maintainer previously paid for by WDS.

Note: Refer Also To General Exclusions.

CLASS II

Covered Dental Benefits: Amalgam, composite or filled resin restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp). Stainless steel crowns. Crowns or onlays (whether they are gold, porcelain, WDS-approved gold substitute castings [except processed resin or combinations thereof) for treatment of carious lesions or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or filled resins.

Limitations: Restorations on the same surface(s) of the same tooth are covered once in a two (2) year period. If a composite or filled resin restoration is placed in a posterior tooth, an amalgam allowance will be made for such procedure. The difference in cost is your responsibility. Stainless steel crowns are covered once in a two (2) year period. Crowns and onlays on the same teeth are covered once in a five (5) year period. If a tooth can be restored with a filling material such as amalgam or filled resin, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided. WDS will allow the appropriate amount for an amalgam or composite restoration toward the cost of processed filled resin or processed composite restorations.

Exclusions: Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion. Overhang removal, re-contouring, or polishing of restoration. A crown used as an abutment to a partial denture for purposes of re-contouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required. Crowns used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or existing restorations with defective margins when no pathology exists. Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology.

Oral Surgery

Covered Dental Benefits: Removal of teeth and surgical extractions, preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures and treatment of pathological conditions and traumatic facial injuries. General anesthesia and intravenous sedation.

Limitations: General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered oral surgery procedures, as determined by WDS.

Exclusions: Iliac crest or rib grafts to alveolar ridges. Ridge extension for insertion of dentures (vestibuloplasty). Tooth transplants.

Periodontics

Covered Dental Benefits: Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include examinations, periodontal maintenance, periodontal scaling/root planing, periodontal surgery, and general anesthesia/ intravenous sedation. WDS-approved site-specific therapies. Refer to Class III Periodontics for benefits and limitations on complete occlusal equilibration and the occlusal guard (night guard).

Limitations: Examinations are covered twice in a benefit period. Under certain conditions of oral health, periodontal maintenance and/or prophylaxis *may be* covered up to a total of four (4) times in a benefit period. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.* Periodontal scaling/root planing is

covered once in a three (3) year period. Site specific therapies approved by WDS are a covered benefit under certain conditions of oral health when performed at the suggested regiment for that therapy. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.* Periodontal surgery (per site) is covered once in a three (3) year period. Soft tissue grafts (per site) are covered once in a three (3) year period. Periodontal surgery and site-specific therapy must be preceded by scaling and root planing a minimum of six (6) weeks and a maximum of six (6) months prior to such treatment. General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered periodontal surgery procedures, as determined by WDS.

Exclusions: Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances. Gingival curettage. Site-specific therapy is not covered when used for the purpose of maintaining non-covered dental procedures or implants.

Endodontics

Covered Dental Benefits: Procedures for pulpal and root canal treatment. Services covered include pulp exposure treatment, pulpotomy and apicoectomy. General anesthesia and intravenous sedation.

Limitations: Root canal treatment on the same tooth is covered only once in a two (2) year period. General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered endodontic surgery procedures, as determined by WDS. Refer to Class III Limitations if the root canals are placed in conjunction with a prosthetic appliance.

Exclusions: Bleaching of teeth.

Prescription Drugs

Covered Dental Benefits: Drugs requiring a prescription by federal or state law will be provided when dispensed by a licensed pharmacist to treat a condition covered under this plan.

Limitations: Claims for prescription drug charges must be submitted within six (6) months from the date the prescription is filled.

Exclusions: Drugs or medications furnished or administered by a licensed dentist or any drugs not requiring a prescription shall not be covered. Experimental drugs are not covered.

Hospital Coverage

Hospital facility charges, dentist fees for hospital treatment and anesthesia charges will be covered for children age 6 and under when it has been determined procedures cannot be safely or reasonably performed in the Dentist's office.

Limitations: General anesthesia is covered only when administered by a licensed Dentist or other WDS approved Licensed Professional who meets the education, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington.

Note: Refer Also To General Exclusions.

CLASS III

Periodontics

Covered Dental Benefits: Under certain conditions of oral health, services covered are an occlusal guard (night guard) and complete occlusal equilibration. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

Limitations: Occlusal guards, including repairs, are covered once in a three (3) year period. Complete occlusal equilibration is covered once in a lifetime.

Exclusions: Periodontal splinting, crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances.

Prosthodontics

Covered Dental Benefits: Dentures, fixed bridges, inlays (only when used as an abutment for a fixed bridge), removable partial dentures and the adjustment or repair of an existing prosthetic device.

Surgical placement or removal of implants or attachments to implants.

Limitations: Replacement of an existing prosthetic device is covered only once every five (5) years and only then if it is unserviceable and cannot be made serviceable. Inlays are a covered benefit on the same teeth once in a five (5) year period only when used as an abutment for a fixed bridge. Replacement of implants and superstructures are covered only after five (5) years have elapsed from any prior provision of the implant.

Full, immediate and overdentures: WDS will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.

Temporary/interim dentures: WDS will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after twelve (12) months.

Root canal treatment performed in conjunction with overdentures is limited to two (2) teeth per arch and is paid at the Class III payment level.

Partial dentures: If a more elaborate or precision device is used to restore the case, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.

Denture adjustments and relines done more than six (6) months after the initial placement are covered, except as noted under Temporary/interim dentures. Subsequent relines or jump rebases, but not both, will be covered once in a twelve (12) month period.

Exclusions: Duplicate dentures, personalized dentures, cleaning of prosthetic appliances and crowns and copings in conjunction with overdentures.

Note: Refer Also To General Exclusions.

GENERAL EXCLUSIONS

Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396(a), section 1902 of the Social Security Act.

- Dentistry for cosmetic reasons.

- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth.

- Application of desensitizing agents.

- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation / observation. In determining whether services are experimental, WDS, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.

- Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental, may be appealed to WDS. By law, WDS must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual.

- General anesthesia/intravenous (deep) sedation, except as specified by WDS for certain oral, periodontal or endodontic surgical procedures. General anesthesia except when medically necessary for children through age 6 or a physically or developmentally disabled person when in conjunction with covered dental procedures.

- Analgesics such as nitrous oxide, conscious sedation, or euphoric drugs, injections or prescription drugs.
- In the event an Eligible Person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.

- Broken appointments.

- Patient management problems.
- Completing insurance forms.

- Habit breaking appliances.

- Orthodontic services or supplies.

- WDS shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in this contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.

- This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

- All other services not specifically included in this program as covered dental benefits.

GLOSSARY

Alveolar — Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam — A mostly silver filling often used to restore decayed teeth.

Bitewing x-ray — An x-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gumline, as well as a portion of the roots and supporting structures of these teeth.

Bridge — A replacement for a missing tooth or teeth. The bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

Caries — Decay. A disease process initiated by bacterially produced acids on the tooth surface.

Caries Susceptibility Test — A test done to determine how likely someone is to develop tooth decay. The test is usually done by measuring the concentration of certain bacteria in the mouth.

Composite — A tooth colored filling, made of a combination of materials, used to restore teeth.

Crown — A restoration that replaces the entire surface of the visible portion of tooth.

Denture — A removable prosthesis that replaces missing teeth. A complete (or "full") denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

Endodontics — The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Exclusions — Dental services not provided under a dental insurance plan.

Filed Fees — Approved fees that participating Washington Dental Service member dentists have agreed to accept as the total fees for the specific services performed.

Filled Resin — Tooth colored plastic materials that contain varying amounts of special glass-like particles that add strength and wear resistance.

Fluoride — A chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish — A fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

General Anesthesia — A drug or gas that produces unconsciousness and insensibility to pain.

Implant — A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

Inlay — A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intravenous (I.V.) Sedation — A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

Limitations — Restricting conditions, such as age, period of time covered and waiting periods, under which a group or individual is insured.

Localized delivery of chemotherapeutic agents — Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Maximum Allowable Fees — The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Nightguard — See "Occlusal Guard."

Occlusal Adjustment — Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal Guard —A removable dental appliance, sometimes called a nightguard, that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal guard is typically used at night.

Onlay — A restoration of the contact surface of the tooth that covers the entire surface.

Orthodontics — Diagnosis, prevention and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Overdenture — A removable denture constructed over existing natural teeth or implanted studs.

Panorex X-ray — An x-ray, taken from outside the mouth, that shows the upper and lower teeth and the associated structures in a single picture.

Periodontics — The diagnosis, prevention and treatment of diseases of gums and the bone that supports teeth.

Prophylaxis — Cleaning and polishing of teeth.

Prosthodontics — The replacement of missing teeth by artificial means such as bridges and dentures.

Restorative — Replacing portions of lost or diseased tooth structure with a filling or crown to restore proper dental function.

Root Planing — A procedure done to smooth roughened root surfaces.

Sealants — A material applied to teeth to seal surface irregularities and prevent tooth decay.

Temporomandibular Joints — The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

CLAIM REVIEW AND APPEAL

Initial Claims/Benefit Determination

An initial claim determination will be performed on all properly submitted claims within 30 days of receipt. The 30-day period may be extended for an additional 15 days, however, if the claim determination is delayed for reasons beyond our control. In that case, we will notify the subscriber prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from the subscriber, the notice will describe the specific information we need, and the subscriber will have 45 days from the receipt of the notice to provide the information. Without complete information, the subscriber claim will be denied.

If a claim is denied, in whole or in part, the Eligible Person will be furnished with a written notice of an adverse benefit determination that will include:

- the specific reason or reasons for the denial,
- reference to the specific plan provision on which the denial is based,
- a description of any additional material or information necessary for the Eligible Person to complete the claim and an explanation of why such material or information is necessary to process the claim, and
- the appropriate information as to the steps to be taken if the Eligible Person wishes to appeal the decision.

Predetermination of Claims

Predetermination of claims requires notification or approval prior to receiving dental care. The claims administrator will provide notice of the claim decision within 15 days after receiving the claim. If a predetermination is filed improperly, the claims administrator will provide notification of the improper filing and how to correct the filing within 5 days after receipt of the predetermination. If additional information is required, the claims administrator will notify the Eligible Person of what information is needed within 15 days after the claim is received. The claims administrator may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension the Eligible Person has 45 days to provide this information. Once the information is received the claims administrator will make a determination within 15 days. If the information is not provided within 45 days, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claim Review

Dental benefit coverage typically does not require urgent claim review. Urgent care claims require notification or approval prior to receiving dental care when a delay in treatment could seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician who has knowledge of the medical condition or a dentist who has knowledge of the dental condition. These are rare dental situations and require determination by a physician or dentist with knowledge of the condition.

WDS will provide notice of the benefit determination, in writing or electronically, within 72-hours after receipt of all necessary information. When practical, WDS may provide notice of denial orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain prior authorization in an emergency. The claim will be evaluated after treatment. The Eligible Person or the dental office may obtain information regarding covered benefits anytime prior to treatment.

If an urgent care claim is filed improperly, WDS will notify the Eligible Person within 24 hours along with instructions on how to file properly. If additional information is needed to process the claim, the Eligible Person will be notified of the information needed within 24 hours after the claim is received. The Eligible Person then has 48 hours to provide the requested information.

WDS will notify the Eligible Person of the determination no later than 48 hours after receipt of the requested information or at the end of the 48-hour period within which the Eligible Person was to provide the additional information.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Appeals

Should a claim be denied, in whole or in part, the Eligible Person has a right to a full and fair review. The request to have a denied claim reviewed must be in writing and must be submitted within 180 days from the date the claim was

denied. Further consideration will not be allowed after 180 days. A final benefit determination will be made within 60 days following receipt of an appeal.

An appeal must include name, identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits.

Send your appeal to:

Washington Dental Services
Appeals/Customer Service
Post Office Box 75688
Seattle, WA 98125-0688

Written comments, documents, or other information may be submitted in support of an appeal. Upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision will be provided. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any consideration.

Someone different from the original decision-makers and without deference to the initial decision will conduct the review. If the appeal is based in whole or in part on a medical judgment including a determination as to whether a particular treatment, drug or other item is experimental, investigational, or not dentally necessary or appropriate, WDS will consult with a dental professional who has appropriate training and experience. In such a case, the professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any expert whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination.

If after review the matter has not been resolved to the satisfaction of all parties, any person aggrieved thereby may submit the matter to nonbinding mediation conducted pursuant to mediation rules of the American Arbitration Association or the Judicial Arbitration and Mediation Service, or other such organization, as agreed to by both parties. If no agreement is reached between both parties on the desired mediation rules within 15 days, then WDS will choose from the above services.

Predetermination Appeals
If a predetermination is required by WDS or is requested by an Eligible Person, or his/her designee and an adverse decision is rendered, any person aggrieved thereby shall have the right to appeal the same to WDS in writing. In the event of such an appeal, the question will be re-evaluated and communicated to the appealing party within 15 days by the Dental Director, or his/her designee, unless WDS notifies the aggrieved person that an extension is necessary, in which case the decision shall be communicated within 30 days absent informed, written consent of the aggrieved person for a longer extension. An appeal shall be evaluated by a dentist who was not involved in the decision that is the subject of the appeal.

Authorized Representative
Eligible Person may authorize another person to represent them and with whom they want WDS to communicate regarding specific claims or an appeal. The authorization must be in writing, signed by Eligible Person, and include all the information required in an appeal. (An assignment of benefits, release of information, or other similar form that Eligible Person may sign at the request of their health care provider does not make your provider an authorized representative.) You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

SUBROGATION

Based on the following legal criteria, subrogation means that if you receive this program's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss any money recovered in excess of full compensation must be used to reimburse WDS. WDS will prorate any attorneys' fees against the amount owed.

To the extent of any amounts paid by Washington Dental Service for an eligible person on account of services made necessary by an injury to or condition of his or her person, WDS shall be subrogated to his or her rights against any third party liable for the injury or condition. WDS shall, however, not be obligated to pay for such services unless and until the eligible person, or someone legally qualified and authorized to act for him or her, agrees to:

- include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition
- repay WDS those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received;

- cooperate fully with WDS in asserting its rights under the Contract, to supply WDS with any and all information and execute any and all instruments WDS reasonably needs for that purpose.

Provided the injured party is in compliance with the above, WDS will prorate any attorneys' fees incurred in the recovery.

DISCLOSURE INFORMATION

In accordance with section 4 of ESSB 6392, Chapter 312, Laws of 1996, the Managed Care Entities Disclosure Act,

WDS is pleased to provide important information about our various dental care plans. The goal of this new law is to provide individuals who are making health care decisions for themselves and their families with as much information as possible to make the best decisions. Washington Dental Service fully supports this principle and supplies most of the required information in enrollee benefit booklets, which are supplied to each enrollee at the start of their coverage.

The items of information that you may request Washington Dental Service to provide you are:

1a) the availability of a point of service plan and how the plan operates within the coverage

1b) documents, instruments or other information referred to in the enrollment agreement

1c) procedures to be followed for consulting a provider other than the primary care provider (applies primarily to capitation plans)

1d) existence of plan list or formulary for prescription drugs, for plans with that specific benefit

1e) procedures that must be followed for obtaining prior authorization for health care services

1f) reimbursement or payment arrangements, between a carrier and a provider

1g) circumstances under which a plan may retrospectively deny coverage for care that had prior authorization

1h) copy of all grievance procedures for claim or service denial and for dissatisfaction with care

1i) description and justification for provider compensation programs, including any incentive or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists

2) Enrollees of Washington Dental Service dental care plans may, at any time, freely contract to obtain other forms of dental care or health care services outside Washington Dental Service plan coverage for any reason they choose, however, the enrollee must pay for all such services.

In order to obtain this information, you must call 1-800-367-4104. A Washington Dental Service employee will take your name and send you the information you requested. If you are an enrollee of a dental care plan with Washington Dental Service, we may also refer you to your benefit booklet for additional information about your plan that may be useful. You can also write Washington Dental Service and request the above information at P.O. Box 75688, Seattle, WA 98125-0688.

NORTHWEST BENEFIT NETWORK (NBN)
SEATTLE SCHOOL DISTRICT
VISION CARE PLAN

2323 Eastlake Avenue East
Seattle, Washington 98102
(206) 726-3278
1-800-732-1123

THE NBN VISION PLAN IS SELF-FUNDED BY THE SEATTLE SCHOOL DISTRICT. THIS MEANS THAT YOUR VISION CLAIMS ARE PROCESSED BY NORTHWEST BENEFIT NETWORK AND PAID FOR BY THE SEATTLE SCHOOL DISTRICT.

PLEASE READ CLAIM FILING PROCEDURES BEFORE USING THESE BENEFITS

The Northwest Benefit Network (NBN) Vision Plan features a panel of providers who provide vision care for you and your dependents. Going to a panel provider assures that you will receive quality, professional care and eyewear at a controlled cost. Contact the administration office at your work place or Employee Benefits for a list of Panel Providers, or obtain this information online at www.nwadmin.com.

BENEFITS WHEN USING A PANEL PROVIDER

When a panel NBN provider is used, the following services are covered:

Copayment: $10 per person, per year. Applies to materials (frames and/or lenses) only.

A. Complete examination, for refraction only
Once every 12 consecutive months. Paid in Full

B. Lenses
Single vision.....Basic Lenses Paid in Full
Bifocal.....Basic Lenses Paid in Full
Trifocal.....Basic Lenses Paid in Full
Lenticular.....Basic Lenses Paid in Full

Lenses are covered once every 12 consecutive months when visual analysis indicates new lenses are necessary to correct refractive error. Basic lenses are those necessary for proper visual health and welfare. Basic lenses do not include cosmetic extras that are not covered by the plan but may be purchased at your expense. Scratch coating of plastic lenses is covered by your plan.

C. Frames are covered once every 24 consecutive months from the date of last like service when a change of prescription is indicated. The Plan offers a selection of frames that will be covered in full; however, if you select a frame that costs more than the amount allowed by the Plan, there will be an additional charge. When you are selecting your frame, ask the provider if there is an additional charge for your choice.

D. Contact Lenses – The Plan provides a benefit for both elective and medically necessary contacts. When you choose elective contacts, the Plan will pay up to $175 for the examination and lenses. Please note that the $175 allowance includes the examination and fitting fee. The patient must pay any charges in excess of the $175 allowance. The individual must be eligible for both examination and lenses to be considered eligible for contact lenses. Payment of this benefit will be in lieu of all other services for one year from the date the examination is performed.

E. Contact Lenses as Subnormal Vision Aids - Contact lenses as subnormal vision aids will be supplied after cataract surgery or when visual acuity is not correctable to 20/70 or better by the sole use of conventional lenses. If necessary, NBN will provide lenses and frames in addition to contact lenses after cataract surgery. However, prior approval must be obtained. You would again be eligible for annual examinations and lenses after 12 consecutive months, frame after 24 consecutive months, and contact lens replacement every 24 consecutive months if a change in prescription so indicates.

Note: NBN doctors are not required to fill prescriptions from another doctor, but many will agree to fill a prescription for a NBN patient. Check with the doctor in advance.

BENEFITS WHEN USING A NON-PANEL LICENSED PROVIDER

In the event the individual chooses to use the services of a non-participating licensed provider, benefits will be paid up to the amounts shown below.

A. Complete examination, for refraction only
Once every 12 consecutive months…….$35.00
B. Lenses
Single vision.....$15.00 per lens
Bifocal.....$20.00 per lens
Trifocal.....$22.50 per lens
Lenticular.....$45.00 per lens
C. Frames
Once every 24 consecutive months……..$30.00
(Frames are covered once every 24 consecutive months from the date of last covered frame when a change of prescription is indicated.)

D. Contact Lenses - Covered up to $90.00 a pair. Any charges in excess of this amount will be the responsibility of the individual. This $90.00 allowance includes the examination and fitting fee. The individual must be eligible for both examination and lenses. **Payment of this benefit will be in lieu of all other services for one year from the date the examination is performed.**

E. Contact Lenses as Subnormal Vision Aids - Contact lenses as subnormal vision aids will be supplied after cataract surgery or when visual acuity is not correctable to 20/70 or better by the sole use of conventional lenses. Maximum coverage is $200.00 a pair. Any charges in excess of this amount will be the responsibility of the individual. If necessary, NBN will provide lenses and frames in addition to contact lenses after cataract surgery. However, prior approval must be obtained. You would again be eligible for an annual examination and lenses after 12 consecutive months, frames after 24 consecutive months, and contact lens replacement every 24 consecutive months if a change in prescription so indicates. **Note: Contact lenses must be ordered within 6 months of the exam to be eligible for coverage.**

CLAIM FILING PROCEDURES - PANEL DOCTOR

PLEASE NOTE: IF YOU ARE UNCERTAIN ABOUT YOUR ELIGIBILITY, YOU OR THE PANEL PROVIDER CAN CALL NBN TO VERIFY ELIGIBILITY. CLAIMS WILL BE DENIED IF THE CLAIMANT IS NOT ELIGIBLE FOR SERVICES. THERE IS NO "GRACE PERIOD".

IF YOU DO NOT GIVE THE NBN CLAIM FORM TO THE PROVIDER IN ADVANCE, BUT VISIT THE PANEL DOCTOR AS A PRIVATE PATIENT, THE PANEL DOCTOR IS NOT OBLIGATED TO ACCEPT NBN FEES AS FULL PAYMENT FOR THESE SERVICES, BUT MAY ELECT TO CHARGE USUAL AND CUSTOMARY FEES.

1. When you or your eligible dependent need vision care, you should obtain an NBN vision claim form from the administration office at your work place or from Employee Benefits before going to the vision care provider.

2. You should complete the top portion of the NBN vision claim form. The signature of the employee must be included on the claim form where indicated.

3. You should then make an appointment with any one of the participating NBN vision plan providers (a list of panel providers may be obtained from Employee Benefits or online at www.nwadmin.com). When making an appointment with an NBN panel provider, please be sure to tell him that you have coverage under the Northwest Benefit Network (NBN) Vision Care Plan. Since changes to the provider list may occur, please confirm that the provider is on the panel of the NBN Vision Plan when you make your appointment. **YOU MUST BRING YOUR NBN CLAIM FORM TO THE PROVIDER ON ALL VISITS AND GIVE IT TO HER TO SUBMIT OR THE PROVIDER MAY CHARGE YOU USUAL AND CUSTOMARY FEES.**

4. After your services are completed, the panel provider completes the NBN vision claim form and returns it directly to the NBN claims office. Pay the provider the $10 copayment (if you ordered lenses and/or frames) and the fee for any services or eyewear you ordered that are not covered by your plan. Any additional care, service and/or materials not covered by the Plan may be arranged between you and the provider at your expense. If there are uncovered out-of-pocket fees, the provider will itemize these charges on the back of the first page of the claim form. You should review these charges and sign the claim form in the appropriate place, indicating that you agree to these uncovered expenses. NBN will then review the provider's charges for accuracy when the form arrives at the claims office for processing. NBN will pay the panel provider directly for the professional services and eyewear covered under this plan.

CLAIM FILING PROCEDURES - NON-PANEL DOCTOR

1. For reimbursement of a non-panel provider's charges, you will be paid in accordance with the non-panel schedule.

2. Submit your itemized statement along with your vision claim form to the NBN claims office. You are responsible for payment to a non-panel provider. Claims must be submitted within twelve (12) months of the date of service.

CLAIM REVIEW PROCEDURES

The Seattle School District has adopted a formal appeals procedure for employees who feel that the District or the claims processors have improperly denied an NBN vision claim. To obtain a written copy of this procedure, contact Employee Benefits.

EXCLUSIONS

1. The replacement of lenses or frames that have been lost, broken, or damaged, except during the normal time periods when services are otherwise eligible.

2. Safety glasses.

3. Two pair of glasses in lieu of bifocals.

4. Plano (non-prescription) lenses, non-prescription sunglasses or non-prescription photosun lenses.

5. Glasses secured when no prescription change is warranted.

6. Special procedures, such as orthoptics, visual training, contact lenses, except as previously noted, other subnormal vision aids, aniseikonia or similar procedures.

7. Any medical or surgical treatment of the eyes, beyond those services normally provided in the basic examination for refraction.

8. Services or materials for which the individual may be compensated under Workers' Compensation laws, or employer's liability laws, regardless of jurisdiction or services for which the individual, without cost, obtains the needed care from any of the federal government organizations, state, county municipality or special service district. If the individual receives treatment or materials that are so compensated and said compensation is not sufficient to defray the incurred expenses insofar as they are covered under this plan, and all other conditions are complied with, the balance of the fee for the services or materials excluded under this provision will be included in this agreement.

9. Eye examinations required (a) by an employer as a condition of employment or which the employer is required to provide by virtue of a labor agreement, or (b) by a government body.

LIMITATIONS

This plan is designed to cover visual need rather than cosmetic extras. If you select cosmetic features such as the following, you must pay the "extra" charge: for non-covered items such as special lens edging, faceting, engraving, laminated lenses, extra thin lenses, plastic photochromatic lenses (e.g. Transitions) or a frame which costs more than the plan allowance. The charges for non-covered items will also include an additional “non-covered extras” fee. Remember to see an NBN panel provider, because most non-covered services will be covered at discounted prices.

Any additional care, service and/or materials not covered by the plan may be arranged between you and the provider at your expense.

Benefits are described as being available "once every 12 consecutive months" or "once every 24 consecutive months." Twelve consecutive months means that at least 365 days have passed since the last service was obtained. Twenty-four consecutive months means that at least 730 days have passed since the last service was obtained. There is no "grace period".

This information summary is intended to describe in general terms the main features of the plan and does not constitute a contract. The specific terms and conditions are set forth in the contract and are the basis on which all claims are paid.

The Standard

P.O. Box 711
Portland, OR 97207

LONG TERM DISABILITY, LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT
Policy #353414

This plan provides benefits for long term disability (LTD), life and accidental death and dismemberment (AD&D).

You may change, in writing, your beneficiary for Life/AD&D insurance at any time. Forms are available from Employee Benefits, 206-252-0282.

LONG TERM DISABILITY BENEFITS

You must be a citizen or resident of the United States or Canada to be eligible for Long Term Disability insurance (LTD). This insurance provides you with income protection if you become totally disabled from a covered sickness, accidental bodily injury or pregnancy. If you become totally disabled, the insurance will provide you with a monthly benefit equal to (a) 60% of your insured earnings, reduced by (b) your income from other sources. The minimum benefit is $100.00 per month.

Your insured earnings are the first $16,667 of your monthly earnings, including deferred compensation but excluding bonuses, overtime pay and any other extra compensation.

The maximum benefit payable under this policy is $10,000 a month, regardless of your salary on the date of disability.

Your elimination period is the first 45 calendar days of each period of continuous disability. Your elimination period begins on the date you become disabled, except if you become totally disabled during a leave of absence without pay, in which case your elimination period will not begin until the date you are scheduled to return to work. For purposes of the elimination period, disabled means totally disabled or partially disabled as defined below:

Totally Disabled: During the elimination period and the next 24 months of each period of continuous disability, total disability means your complete inability as a result of sickness, accidental bodily injury or pregnancy to work at your own occupation. Thereafter, total disability means your complete inability as a result of sickness, accidental injury or pregnancy to work at any occupation for which you are or become reasonably fitted by your education, training and experience.

Partially Disabled: Your disability is a partial disability if you are working in your own occupation, but as a result of sickness, accidental bodily injury or pregnancy, you are unable to work at your own occupation on a full-time basis.

Reduction of Benefits
Your disability benefits will be reduced by income you receive from other sources, or are eligible to receive while LTD benefits are payable. Included are:

a. One-half the amount of your earnings from work while you are totally disabled.

b. Workers' Compensation benefits, including amounts for partial or total disability, whether permanent or temporary.

c. Any amount you, your dependents or any other person receives or is eligible to receive because of your disability or retirement under the Federal Social Security Act or any similar plan or act.

d. Disability benefits you, your dependents or any other person receives or is eligible to receive because of your disability, from any group insurance coverage other than credit insurance or group mortgage disability insurance.

e. Unemployment benefits.

f. Benefits from other disability or retirement plans under which you are covered as a result of your employment with your employer.

g. Any sick pay or salary continuation paid to you by your employer, but not including vacation.

Note: You are obligated to immediately reimburse The Standard for any overpayment of your claim that results when you receive a retroactive award of income from other sources.

Exclusions and Limitations

Long Term Disability insurance does not cover any disability caused or contributed to by any of the following:

1. War or an act of war.

2. A self-inflicted injury.

3. Committing or attempting to commit a felony or active participation in a violent disorder or riot. (Active participation does not include being at the scene of a violent disorder or riot in the course of your duties).

Your LTD insurance is also subject to the following limitations:

1. No LTD benefits will be paid for any period when you are on an unpaid leave of absence under the terms of your employment.

2. No LTD benefit will be paid for any period when you are not seen regularly and treated by a physician or when you are confined for any reason in a penal or correctional institution.

3. LTD benefits for total disability caused or contributed to by alcoholism, drug addiction, or use of any hallucinogen are limited to 24 months during your entire lifetime.

4. LTD benefits for total disability caused or contributed to by a mental disorder are limited to 24 months for each period of total disability.

5. LTD benefits are limited to 12 months while you are continuously residing outside the United States and Canada.

6. No LTD benefits are payable for the elimination period or after the end of the maximum benefit period.

Survivors Benefit
If you die while you are receiving LTD benefits, there may be a monthly survivors benefit payable for up to three months after your death to your surviving spouse, domestic partner (provided an Affidavit of Domestic Partnership is on file), or unmarried child under age 21. The survivors benefit will equal your LTD benefit without any reduction by income from other sources.

Waiver of Premium
Long Term Disability insurance in effect when you become totally disabled will be continued without payment of premiums while LTD benefits are payable.

If you become totally disabled while insured under the Life Insurance Plan and before your 65th birthday, your Life insurance will be continued without payment of premiums while you remain continuously totally disabled, but not beyond your 65th birthday.

ASSISTED LIVING BENEFIT

The Assisted Living Benefit is an additional 40% of the first $16,667 of your Predisability Earnings, but not to exceed $5,000. The Assisted Living Benefit is not reduced by Deductible Income.

Assisted Living Benefit Requirements

If you meet the requirements in 1 through 3 below, we will pay Assisted Living Benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

1. You are Totally Disabled and LTD Benefits are payable to you.
2. While you are Totally Disabled:
   a. You, due to loss of functional capacity as a result of Physical Disease or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
   b. You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Physical Disease or Injury.
3. The condition in 2.a or 2.b above is expected to last 90 days or more as certified by a Physician in the appropriate specialty as determined by us.

Payment Of Assisted Living Benefits

We will pay Assisted Living Benefits within 60 days after Proof Of Loss is satisfied. Your Assisted Living Benefits will be paid to you at the same time LTD Benefits are payable.

Time Limits On Filing Proof Of Loss

Proof Of Loss for the Assisted Living Benefit must be provided within 90 days after the date the inability to perform Activities Of Daily Living or the Severe Cognitive Impairment begins. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

When Assisted Living Benefits End

Assisted Living Benefits end automatically on the earlier of the date you no longer meet the requirements in item A. above or the date your LTD Benefits end.

Assisted Living Benefits After Insurance Ends Or Is Changed

Your right to receive Assisted Living Benefits will not be affected by the occurrence of the events described in 1. or 2. below that become effective after you become Disabled.

1. Termination or amendment of the Group Policy or your Employer's coverage under the Group Policy.
2. Termination of Assisted Living Benefit coverage while the Group Policy or your Employer's coverage under the Group Policy remains in force.

Limitations And Exclusions

No Assisted Living Benefit will be paid for any period when you are confined for any reason in a penal or correctional institution. No Assisted Living Benefit will be paid if your inability to perform Activities Of Daily Living or your Severe Cognitive Impairment is caused or contributed to by:

1. War or any act of War whether declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

2. Any intentionally self-inflicted Injury, while sane or insane.

3. A Mental Disorder.

4. Use of alcohol, alcoholism, use of any drug, including hallucinogens, or drug addiction.

5. A Preexisting Condition.

   a. Definition: For purposes of the Assisted Living Benefit, Preexisting Condition means a mental or physical condition for which you have done, or for which a reasonably prudent person would have done any of the following:

      i. consulted a physician or other licensed medical professional,

      ii. received medical treatment or services or advice,

      iii. undergone diagnostic procedures, including self-administered procedures, or

      iv. taken prescribed drugs or medication during the 3 months just before your Assisted Living Benefit coverage is effective.

   b. Period Of Exclusion:

      This exclusion will not apply after the Assisted Living Benefit coverage has been continuously in effect for a period of 12 months, if after that period you have been Actively At Work for at least one full day.

6. Committing or attempting to commit an assault or felony, or active participation in a violent disorder or riot. (Active participation does not include being at the scene of a violent disorder or riot while performing official duties.)

Definitions For Assisted Living Benefit

Activities Of Daily Living means Bathing, Continence, Dressing, Eating, Toileting, or Transferring.

1. Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

2. Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.

3. Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.

4. Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.

5. Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic-depressive illness, depression and depressive disorders, anxiety and anxiety disorders.

6. Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.

7. Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

8. Hands-on Assistance means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

9. Standby Assistance means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured throat if the insured chokes while Eating).

10. Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning. Severe Cognitive Impairment does not include loss or deterioration as a result of a Mental Disorder.

11. Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

Your maximum benefit period is determined by your age on the date you become totally disabled, as follows:

61 or younger.....To age 65
62.....3 years 6 months
63.....3 years
64.....2 years 6 months
65.....2 years
66.....1 year 9 months
67.....1 year 6 months
68.....1 year 3 months
69 or older.....1 year

LIFE INSURANCE BENEFITS

Life insurance provides benefits to your beneficiary if you die while insured. There are no exclusions or limitations to Life insurance.

The amount of your Life insurance before your 70th birthday is 150% of your annual earnings, rounded to the next higher multiple of $1,000, if not already a multiple of $1,000.

The amount of your Life insurance after your 70th, but before your 75th, birthday is reduced to 65% of the original amount. The amount of your Life insurance after your 75th birthday is reduced to 50% of the original amount.

If your Life insurance coverage ends or is reduced you may have a right to buy an individual policy without submitting evidence of health status, if you apply for this right within 31 days of termination or reduction.

Annual earnings means your annual rate of earnings including commissions and deferred or voluntarily reduced compensation but excluding bonuses, overtime pay and any other extra compensation.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Accidental Death and Dismemberment insurance (AD&D) provides benefits to you or your beneficiary for dismemberment or death resulting from accidental bodily injuries.

The maximum amount of your AD&D insurance before your 70th birthday is 150% of your annual earnings, rounded to the next higher multiple of $1,000, if not already a multiple of $1,000.

The maximum amount of your AD&D insurance after your 70th birthday, but before your 75th birthday, is reduced to 97.5% of your annual earnings. The maximum amount of your AD&D insurance after your 75th birthday is reduced to 75% of your basic annual earnings.

The full amount is payable for accidental death or if accidental bodily injury results in loss of: (a) both hands; (b) both feet; (c) sight of both eyes; or (d) any two of them. One-half the full amount is paid if accidental bodily injury results in loss of: (a) one hand; (b) one foot; or (c) sight of one eye. "Loss" means actual severance through or above the wrist or ankle joint, or entire and irrecoverable loss of sight.

Seat Belt Benefit
A seat belt benefit is also payable if you die as a result of an automobile accident and you were wearing a seat belt at the time of the accident. The benefit equals $50,000, or the amount of the AD&D insurance benefit paid because of the accidental death, whichever is less.

Exclusions and Limitations
The death or dismemberment must occur as the direct result of the accidental bodily injury, independent of all other causes and within 90 days of the accident. No benefit will be paid if either the accidental bodily injury or the loss is caused or contributed to by: (a) insurrection, war or an act of war; (b) suicide or any other intentionally self-inflicted injury; (c) self-destruction or any other self-inflicted injury, occurring while the individual is unable to form the intent to harm himself or herself; (d) committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot ("active participation" does not include being at the scene of a violent disorder or riot in the performance of official duties); (e) the voluntary use or consumption of any drug, poison or chemical compound (including but not limited to prescribed medications); (f) any sickness, illness or disease existing at the time of the accident; (g) heart attack or stroke; (h) medical or surgical treatment for any of the above.

There is no waiver of premium or conversion privilege with respect to the Accidental Death and Dismemberment insurance.

DEPENDENTS LIFE INSURANCE

Dependent Life insurance is provided for your spouse, domestic partner, for whom you have filed an affidavit, and an unmarried child under age 23 who is a) your child or stepchild or b) a child or stepchild of a domestic partner for whom you have filed an affidavit. Insurance for a handicapped child may be continued beyond age 23, provided that evidence of eligibility for continued coverage is provided to The Standard within 31 days of the child's 23rd birthday.

If you enroll in the Life insurance plan and your Life insurance becomes effective, each of your eligible dependents will be insured for an amount of Dependents Life insurance equal to the lesser of:

1) One-half the amount of your Life insurance, or
2) $4,000

WHEN INSURANCE ENDS

Your insurance under the Life and Long Term Disability insurance plan will end on the earliest of the following dates:
a. The date you cease to be an eligible employee.
b. The date you enter into full-time military service.
c. The date the group policies terminate.
You may become insured again under the group policies after your insurance ends. You may become insured again on the same basis as a new employee, but with the following exceptions:

1) If your insurance ends because you cease to be an eligible employee for any reason except as described in

2) below, you will be immediately eligible if you are rehired within 90 days after your insurance ends.

2) If your insurance ends because your employment is terminated and you are reinstated to employee status as a result of any court action, binding arbitration or established grievance procedure which requires reinstatement of your salary and fringe benefits, then your insurance may be retroactively reinstated, effective as of the date on which your employment is reinstated.

Right to Convert

If your Life insurance ends or is reduced, you may have a right to buy an individual policy of life insurance without providing evidence of insurability. You must apply for the insurance within thirty-one (31) days after your insurance ends or is reduced. Contact Sprague Israel Giles Inc. at 206-623-7035 for details.

Accelerated Benefit

The receipt of an Accelerated Benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

If you qualify for Waiver of Premium and give The Standard proof of having a Qualifying Medical Condition while you are insured, you may have the right to receive during your lifetime a portion of your Life Insurance as an Accelerated Benefit. You must have at least $10,000 of Life Insurance in effect to be eligible.

"Qualifying Medical Condition" means you are terminally ill with a life expectancy of less than 24 months. If your insurance is scheduled to end within 24 months following the date you apply for the Accelerated Benefit, you will not be eligible for the Accelerated Benefit.

You may receive an Accelerated Benefit of up to 75% of your Life Insurance. The maximum is $500,000. The minimum is $5,000 or 10% of your insurance, whichever is greater. If the amount of your insurance is scheduled to reduce within 24 months following the date you apply for the Accelerated Benefit, the Accelerated Benefit will be based on the reduced amount. The benefit will be paid to you once in your lifetime in a lump sum.

No Accelerated Benefit will be paid if:

1. All or part of your insurance must be paid to your child(ren), or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.

2. You are married and live in a community property state unless you give us a signed written consent from your spouse.

3. You have made an assignment of all or part of your insurance unless you give us a signed written consent from the assignee.

4. You have filed for bankruptcy, unless you give The Standard written approval from the Bankruptcy Court for payment of the Accelerated Benefit.

5. You are required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement.

6. You have previously received an Accelerated Benefit under the Group Policy.

How To File A Claim

For disability claim information and forms, contact Employee Benefits at 206-252-0282. You must have your doctor document your condition before receiving benefits and during any period of time during which you are claiming benefits, you must be under the regular care and attendance of your doctor.

Application for death benefits requires a certified death certificate. Contact Employee Benefits for procedures.

Claim Review Procedures

You have the right to a review of any denial by The Standard of all or any part of your claim.

If you do not receive a written decision on your claim within 90 days after your claim is received, you will have an immediate right to ask for a review under the review procedure, as if your claim had been denied.

To obtain a review, you should send a written request for review to The Standard within 60 days after you receive notice of the denial. No special form is required.

As a part of your request for review, you may submit issues and comments in writing and provide additional documentation in support of your claim. You may review pertinent documents related to your request for review.
The Standard will review your claim promptly after receiving your request for review. You will receive written notice of The Standard's decision within 60 days after your request for review is received, or within 120 days if special circumstances require an extension. The written decision you receive will include the reasons for the decision and reference to the provisions of the Group Policy on which the decision is based.

No action at law or in equity may be brought to recover under the Group Policy until 60 days after written proof of loss has been provided to The Standard. No such action may be brought more than three years after the time within which proof of loss is required to be furnished.

EMPLOYEE ASSISTANCE PROGRAM

Phone #: 206-252-4800

WHAT IS THE EMPLOYEE ASSISTANCE PROGRAM?

The Employee Assistance Program (EAP) is a resource for District employees and their family members to help them deal with personal and/or job related problems in a confidential manner. Personal difficulties can, and often do, affect job performance. The District's EAP counselor can assist in developing a plan to resolve the problems.

WHAT EAP SERVICES ARE AVAILABLE?

* **ASSESSMENT** - The EAP counselors work with the individual or family member to determine the nature and extent of the problems and to develop a plan to resolve the issues.

* **COUNSELING** - Counseling is usually limited to three sessions. If more counseling is desired, then the EAP counselor will help locate an appropriate referral resource.

* **REFERRAL SERVICES** - Finding the right resource can be confusing or even overwhelming. The EAP counselors have experience identifying qualified resources and are knowledgeable about health insurance benefits. They can assist in finding the resources that best meet the needs of the individual or family - including geographic or financial concerns.

* **INFORMATION** - Often an employee will have a question about District policy and will not know the right person or department to call. The EAP counselor can assist that employee by either answering the question or identifying the best individual to respond to the question. This service is particularly helpful to employees wishing to maintain their confidentiality.

* **FOLLOW-UP** - When indicated, the EAP counselor follows up individual sessions to assure that all needed services are being provided and to maintain up-to-date information on the quality of the resources to which employees are referred.

* **EVALUATION** - When employees use EAP services, they receive an evaluation form to return anonymously. These evaluations assist the EAP in continuously updating and refining resources, making more accurate referrals and better responding to employees' needs.

* **TRAINING AND WORKSHOPS** - The EAP sponsors workshops throughout the year on issues associated with stress management, substance abuse, improving wellness and other topics. Supervisor Training Seminars are available to supervisors and managers to assist them when dealing with a troubled employee.

* **SUPERVISORS** - Consultation for supervisors is provided to assist administrators and managers in their supervisory relationship with their employees. Supervisors often consult with the EAP counselors on referral strategies.

EAP AND CONFIDENTIALITY

Everything discussed during the counseling session is held in strict confidence except when Washington State mental health laws require disclosure of information related to the immediate safety of individuals.

THE EAP CAN OFFER ASSISTANCE FOR:

*Stress	*Difficulties with Children
*Anxiety	*Burnout
*Family Problems	*Depression/Suicide
*Emotional Pain	*Legal/Financial Concerns
*Alcohol Problems	*Other Drug Problems
*Career Decisions	*Grief and Loss
*Divorce	*Anger
*Health Issues	*Self-Esteem

*Conflicts Between Employees
*Problems Affecting Job Performance
*Other Problems
*Concern for others who may be experiencing one or more of the above

HOW DOES ONE TALK WITH AN EAP COUNSELOR?

A simple phone call is all that is needed to get started. If the EAP staff is not available when you call, a confidential message of any length may be left on our voice mail. Your call will be returned as soon as possible.

You may be asked a few questions about your situation before scheduling an appointment. Unless there are extenuating circumstances, people are seen at the EAP office. The appointments are generally one hour in length.

EAP OFFICE HOURS

The EAP office is open 5 days a week, 12 months a year except during regular holidays. Appointments can be scheduled at times that are convenient and that avoid conflict with one's work schedule.

The Employee Assistance Program is voluntary, free, and, above all*, confidential.*

WORKER'S COMPENSATION PROGRAM

Berkley Administrators
PO Box 88842
Seattle, WA 98138-2842
Phone: 206-575-2303 Fax: 206-575-2308

In accordance with the industrial insurance laws of the State of Washington, Seattle School District No.1 provides a Self-Insured Worker's Compensation program for District employees who are injured on the job or who incur a job-related disease. Claims are administered by Berkley Administrators through the Risk Management Department.

BENEFITS
Benefits for valid claims may include:

1. Medical coverage for job-related injury or illness while receiving professional medical care.

2. Medically authorized time-loss compensation while off duty resulting from job-related injury or illness.

3. Permanent partial disability award if the injury or illness results in a permanent disability.

4. Pension benefits for employees who may become totally disabled by job-related disability or illness, including permanent partial disability awards.

5. Survivor benefits.

6. Vocational assistance if found unemployable.

PAYMENTS

1. Worker's Compensation time loss payments are processed in accordance with Washington State industrial insurance laws and contract language. Failure of the employee and/or attending physician to complete required forms will cause delay.

2. "Loss of Earning" wages are paid if the injured worker returns temporarily to light duty with restricted hours.

3. Time-loss benefits are nontaxable, under current tax law.

4. Employees are responsible for maintaining their own voluntary deductions.

5. Casual Employees and Work Training Program enrollees are eligible for all statutory Worker's Compensation Benefits.

6. Registered volunteers are covered for medical expenses only.

7. Depending on the union contract, employees may be entitled to additional benefits. Consult the appropriate union contract.

PROCEDURE FOR FILING A CLAIM

1. The employee must immediately report an injury or illness to his/her principal/supervisor.

2. The employee should also report the injury to the Risk Management Department, 206-252-0710. Custodians should report to Operations, 206-252-0517. Food Service Workers should report to Food Services, 206-252-0675. Maintenance Employees should report to Maintenance, 206-252-0515.

3. Within 24 hours of any injury, the employee or supervisor must complete a Seattle School Accident/Injury Report or Occupational Illness Report and mail the first two copies to the Risk Management Department-Mail Stop-AF-361.

4. In the event of an injury that requires a physician's care, it is compulsory that the employee apply for Worker's Compensation (RCW 51.28.010). The Self Insurer Accident Report form (SIF-2) and the Physician's Initial Report form are required in order to apply for Worker's Compensation. Please obtain a Worker's Compensation claims packet from your school secretary. You have one year from the date of occupational injury to file a claim. You have two years from the date you are first notified in writing by a doctor that you have an occupational exposure to file a claim for an occupational exposure.

5. Contact Berkley Administrators to report any accident requiring medical attention.

6. The attending physician must complete the Physician's Initial Report form within five days of the first date of treatment. The physician retains the pink copy and mails the white and canary copies to Berkley Administrators. You may choose any doctor who is recognized by State regulations as qualified to treat your condition and is reasonably convenient to you. All approved medical costs for a valid claim are paid by Berkley Administrators. To transfer from one physician to another, you must request the change in writing. The transfer must be approved by Berkley Administrators before a transfer can take place.

7. Supervisory personnel will assist the injured employee in completing the Seattle School District Illness/Occupational Injury Report that is contained in the Worker's Compensation claims packet. This form should be forwarded to the Risk Management Department as soon as possible.

8. In the event medical attention is needed, the SIF-2 will be mailed to the work location or the employee's home for completion of the Workers' Compensation form. The principal/supervisor shall complete the "employer" section of the Self Insurer Accident Report (SIF-2) and then forward the canary and white copies of the Self Insurer Accident Report form (SIF-2) to the Berkley

Administrators as soon as possible after the accident. The injured employee retains the pink copy.
Upon receipt and evaluation of the Self Insurer Accident Report form (SIF-2), and the physician's Initial Report form, Berkley's claims adjudicators determine validity of claims and make payment for physician's services and time-loss compensation to the injured employee when properly authorized by the employee's treating physician.

Employees on time loss must be seen by their attending physician at least once a month. The attending physician should send medical reports monthly to Berkley Administrators. Time-loss payments are authorized for the period of time the attending physician has allowed due to the total temporary disability of the patient. The physician's authorization must be submitted in writing to Berkley Administrators with the substantiating objective findings of disability. It is imperative that Berkley Administrators is notified by the principal/supervisor when the injured employee returns to work in order to avoid overpayment of benefits that are reimbursable by the employee. Injured employees must maintain monthly contact with their principal/supervisor and Berkley Administrators.

Employees may be required to attend independent medical exams scheduled by Berkley Administrators for clarification of claim issues. Employees are kept on salary for independent medical exams scheduled during work hours. Travel expenses may be reimbursed in accordance with Department of Labor and Industries' allowances.

Your claim is closed when medical opinion indicates your condition is stable, when any covered employability issues are resolved, and when an assessment of any permanent disability has been made. A notice of closure will be sent either by Berkley Administrators or by the Department of Labor & Industries. After your claim has been closed, if objective medical evidence shows the *condition caused by your injury or disease* has worsened and requires additional medical attention, you may apply for a reopening of your claim. You have seven years from the date your first claim closure becomes final to request reopening. In the case of an eye injury, you have 10 years. In most cases, Berkley Administrators will make a decision on your request within 90 days. A letter will serve as a request to reopen your claim, however, Labor & Industries will not take action until an official reopening application and medical information are submitted. You will be notified if more information is required. Please send additional information requested to Berkley Administrators in a timely manner. If they do not have the information they need within the 90-day limit, your request may be denied.

Reopening application forms are available through your doctor's office. If your doctor doesn't have the form, you can request one by writing or calling Berkley Administrators. The reopening application should be completed and sent to the Self-Insurance Section, 724 Quince Street SE, Mail Stop HC-233, Olympia, WA 98504-4401.

Every claim decision requires the use of judgment, and you may not always agree with those decisions. If you believe a decision is wrong, you may challenge it in one of two ways - you can either protest to Labor & Industries or appeal to the Board of Industrial Insurance Appeals. Before you take formal action, however, it may help to talk with your employer or an adjudicator in Labor & Industries' self-insurance section. If you are still dissatisfied, you should send a formal protest to Labor & Industries within 60 days of receiving the order. Send your protest to the Self-Insurance Section, 724 Quince Street SE, Mail Stop HC-221, Olympia, WA 98504-4401. Explain in detail why you think the decision is unfair, supply any additional information you may have and tell them what you think would be fair.

Your claim will be reviewed, and you will receive another written decision in response to your letter. If you disagree with this decision, you may appeal in writing to the Board of Industrial Insurance Appeals in Olympia. You must send your letter to the board *within 60 days of receiving the Department's decision*. The Board of Industrial Appeals is separate from the Department of Labor & Industries. It is a three-member board that conducts hearings on claims issues that cannot otherwise be settle to the satisfaction of you, your employer, or the Department. The Board issues a written decision about your case after personal arguments and testimony have been taken. This decision may be appealed to the Washington State Superior Court. You can contact the Board by writing to the Board of Industrial Appeals, Mail Stop FL-13, 2430 Chandler Court SW, Olympia, WA 98504-2401. Or call (360) 753-6823. For detailed information, ask them for their pamphlet "Your Right to be Heard".

If you need to inquire about a Worker's Compensation claim, you may call Berkley Administrators.

OTHER IMPORTANT ADDRESSES AND TELEPHONE NUMBERS

Seattle School District No. 1
Mail Stop 33-361
PO Box C34165.
Seattle, WA 98124
Attn: Worker's Compensation Office
Risk Management Department 206-252-0710

Department of Labor and Industries
Self Insurance Claims Compliance
PO Box 44892
Olympia, WA 98504-4892
Fax: (360) 902-6900

SEATTLE PUBLIC SCHOOLS
COMPARISON OF MEDICAL BENEFITS
October 1, 2003 – September 30, 2004

This comparison is for information only and does not constitute a contract.
Please refer to the appropriate plan booklets for details and a full list of limitations and exclusions.

	PREMERA BLUE CROSS WEA SELECT PPO 2 Group # 8000207	**KPS HEALTH PLANS** Group #22165	**AETNA HEALTH, HMO PLAN** Group # 56659	**GROUP HEALTH ORIGINAL OPTION** Group # 008700	**GROUP HEALTH $500 DEDUCTIBLE PLAN #** 1175600	**PACIFICARE HMO Plan** Group # 801173
Annual Deductible	None	$200 per person $600 per family	None	None	$500 per person $1500 per family	None
Your Annual Out of Pocket Expense Limit	In-Network: 80% allowable charges, Out-of-Network: 60% allowable charges, 100% of allowable charges paid after combined plan payments of $5,500. **Inpatient copay:** $150 per day to $450 maximum per person, per calendar year.	Participating: $1,500 per person, $3000 per family Non-Participating: $3,000 per person, $6,000 per family (Excludes annual deductible)	$1,500 per person; $3,000 per family.	$2,000 per person; $4,000 per family.	$2,000 per person; $6,000 per family	PCP directed, $1,500 per person, $3,000 per family
Lifetime Benefit Max	$5,000,000, revolving each 5 years.	$5,000,000 per enrollee	Unlimited	Unlimited	Unlimited	Unlimited
BENEFITS						
1. Physician Visits in Office, Clinic & Hospital	100% allowable charge after: $25 copay—In-Network $30 copay—Out-of-Network	Office or Clinic-copay: Participating- $20 copay Non-Participating: $25 copay. Inpatient visits subject to deductible	$15 copay per office or clinic visit. $100 copay for Inpatient Hospital visits; $50 copay for Outpt. Hospital visits.	$20 copay per visit.	$20 copay per visit then deductible then covered at 80%	$15 copay
2. Chiropractors; Manipulations Of Spine And Extremities	100% allowable charge after: $25 copay—In-Network $30 copay—Out-of-Network	Participating: $20 copay Non-Participating: $25 copay	$20 copay per office visit. Limit 20 visits per calendar year at an Aetna designated chiropractor.	Self-referrals to GHC providers $20 copay to a maximum of 10 visits per calendar year.	$20 copay per visit then deductible then covered at 80% to maximum of 10 visits per calendar year	$15 copay. Must use contracted providers.
3. Alternative Care Providers	**Acupuncture:** Limited to 12 visits per calendar year. 100% allowable after $25 copay—In-Network $30 copay—Out-of-Network **Naturopath:** 100% allowable after $25 copay—In-Network $30 copay—Out-of-Network	**Acupuncture/Massage therapy:** 12 visits maximum per contract year, $20 copay participating, $25 copay non-participating **Naturopath:** $20 copay participating, $25 copay non-participating	$20 copay, limitations apply. PCP referral necessary for acupuncture, naturopathy, or massage therapy.	$20 copay. Massage PCP referral. Must meet GHC medical protocol. Self-referral to participating naturopaths for 2 visits per condition per cal. yr, 5 visits per condition per cal. yr. for acupuncturist.	Deductible then 80%. Massage therapy requires PCP referral, must meet GHC medical protocol. Can self-refer to participating naturopaths providers for 2 visits per condition per cal. yr, to acupuncturist for 5 visits per condition per calendar year.	$15 copay. Must use contracted providers.

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4. Preventive Care, Well-Baby Care	In-Network , paid in full. Out-of-Network, constant 80%. Limited to $200 per person (well baby to $500 through age 3) each cal. year	100% participating, 70% non-participating. Limited to $200 per person (well baby to $500 through age 3) each contract year	Allowed frequency based on age. $15 copay per office visit for preventive care. For newborns, covered in full as recommended by a Plan Physician.	$20 copay per outpatient visit. Most immunizations and routine mammography screenings are covered. Well-baby care includes nursery service.	$20 copay per visit then covered at 100% (Deductible waived.)	$15 copay
5. Diagnostic Testing	In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter.	80% participating 70% non-participating Subject to deductible	$20 copay	Covered in full.	Deductible then 80%	100%
6. Routine Vision & Hearing Exam, Vision & Hearing Hardware	Routine vision exams not covered. Hearing exams and hardware paid at a constant 80% up to $400 maximum every 3 consecutive calendar years.	Routine vision exams not covered. Hearing exams and hardware paid at 80% up to $125 maximum per contract year. Subject to deductible	Exams: $20 copay per visit. One vision exam per calendar year and no limit for hearing exams. No coverage for any hardware.	Exams: $20 copay per visit, limited to once every 12 months. Hearing screening is covered. Hearing exams subject to $20 copay. No coverage for hardware.	Vision and Hearing Exams: $20 copay per visit, limited to once every calendar year (Deductible waived.) No coverage for hardware.	Vision exam $15 copay through VSP provider every 12 months. Hearing exam $15 copay. No hardware coverage
7. Prescription Drugs & Insulin (Unless Otherwise Specified) At Pharmacy	At Participating Pharmacies, up to 34 day supply, paid in full after: $7 copay - Generic drugs $20 - Preferred brand name drugs $30 – Non-preferred brand name drugs	$7 copay generic, $20 copay brand name formulary and $35 copay non-formulary brand name. Not subject to deductible. Maintenance drugs - 1 copay for 3-mo supply, Tiers 1 & 2 only.	$10 copay generic / $20 formulary brand name / $35 non-formulary per prescription or refill. Limited to 30-day supply.	$15 copay generic, $30 brand name for 30-day supply or refill. Drugs must be prescribed by a GHC provider, obtained at GHC pharmacies and included in GHC formulary.	$15 copay generic, $30 brand name for 30-day supply or refill. Drugs must be prescribed by a GHC provider, obtained at GHC pharmacies and included in GHC formulary.	At Plan retail pharmacies, $15 copay for formulary generic drugs, $25 for formulary brand name drugs, $40 for non-formulary drugs, up to a 30-day supply.
8. Prescription Drugs & Insulin (Unless Otherwise Specified) By Mail Order	Mail Order: Up to a 100 day supply, paid in full after: $10 copay - Generic drugs $15 - Preferred brand name drugs $25 – Non-preferred brand name drugs	Mail order through Walgreens. Same copays as #7 above.	Mail Order Prescriptions provided through Aetna Rx Home Delivery up to a 90-day supply for 2 times retail copays; or $20 copay generic/ $40 copay formulary brand name/ $75 non-formulary.	$15 copay generic, $30 brand name for each 30-day supply/refill if obtained through GHC mail service program. Must be prescribed by GHC provider and included in GHC formulary.	$30 copay generic, $60 brand name for 90-day supply or refill if obtained through GHC mail service program. Must be prescribed by a GHC provider and included in GHC formulary.	Mail Order Prescriptions $30 copay for formulary generic drugs, $50 copay formulary brand name drugs, and $80 copay for non-formulary drugs, up to a 90 day supply.
9. Outpatient Surgery and Surgery Centers	$100 copay per surgery; In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter.	80% participating 70% non-participating Subject to deductible	$50 copay per surgery	$20 copay per visit.	$20 copay then deductible then covered at 80%	$50 copay

	PREMERA BLUE CROSS WEA SELECT PPO 2 Group # 8000207	**KPS HEALTH PLANS** Group #22165	**AETNA HEALTH, HMO PLAN** Group # 56659	**GROUP HEALTH ORIGINAL OPTION** Group # 008700	**GROUP HEALTH $500 DEDUCTIBLE PLAN #** 1175600	**PACIFICARE HMO Plan** Group # 801173
10. Chemical Dependency (*Combined benefits to $11,285 every 24 months, unless stated otherwise)*	**In and Outpatient:** Inpatient services subject to inpatient copay. Detoxification paid as any other condition.	**Inpatient:** $150 copay per day to $450 maximum per year, then 80% participating, 70% non-participating **Outpatient:** Deductible then 80% participating, 70% non-participating.	$100 copay for Inpatient Detoxification. Outpatient detoxification and rehabilitation have $20 copay	Inpatient: No copay. Outpatient: $20 copay per visit. All services must be pre-authorized by GHC.	Inpatient: deductible then covered at 80%. Outpatient: $20 copay then deductible then 80%.. All services must be pre-authorized by GHC	Inpatient 45 days per year at 100% Residential care 45 days per year at 100% Outpt visits 45 visits per year at 100% after $15 copay.
11. Inpatient Mental Health Care	Constant 80% allowable charges. Subject to inpatient copay.	$150 copay per day to $450 max. per contract year, then 80% Participating, 70% non-participating Subject to deductible	$100 copay. Limited to 30 days per calendar year. Mental Health Services must be preauthorized.	Covered at 80% for up to 12 days per calendar year when referred in advance by GHC for treatment in a GHC approved facility.	Deductible then covered at 80% up to 12 days per calendar year	$100 copay per admit then 80% to 20 days per cal. year. Requires use of PacifiCare Behavioral Health service.
12. Outpatient Mental Health Care	In-Network, constant 70%. Out-of-Network, constant 50%. Limited to 50 one-hour visits per calendar year	80% participating 70% non-participating Subject to deductible 25 one-hour visits maximum per contract year	$25 copay, limited to 30 visits per calendar year. Mental Health Services must be preauthorized.	$20 copay per individual visit or a $10 copay per group visit. Covered up to a maximum of 20 visits per member per year.	$30 copay per individual visit, $20 copay per group visit then deductible then covered at 80% up to a max of 20 visits per member per year.	$30 copay to 30 visits per calendar year. Requires use of PacifiCare Behavioral Health service
13. Ground and Air Ambulance	In-Network 80%, Out-of-Network 60%	80% participating, 70% non-participating Ground-$2,000 max per contract year. Air - $5,000 max per trip. Subject to deductible	Covered in full	Emergency ambulance transportation covered at 80%. GHC initiated non-emergent transfers are covered in full.	80% (Deductible waived.)	100%
14. Emergency Room Use, in and out of Service Area	$75 emergency room copay, waived if admitted. After copay, paid at: In-Network 80%, Out-of-Network 60%, of allowable charges to $5,500 in plan payments, 100% thereafter.	$75 emergency room copay, waived if admitted.	$50 copay, waived if admitted. (Requires hospital observation for a minimum of 23 hours.)	$75 copay per visit at GHC, waived if admitted. Out of area or at a non-GHC facility in area, $125 deductible per emergency, not waived if admitted. Calling GHC within 24 hours after inpatient admission is required.	GHC $75 copay per visit, then deductible then covered at 80%.. Out of area or non-GHC facility in area, $125 ded. per emergency, then ded. then covered at 80%. Calling GHC within 24 hrs. after inpatient admission is required.	$50copay worldwide, waived if admitted. Urgent care has $25 copay if PCP directed.
15. Outpatient Physical, Speech & Occupational Therapy	**Physical Therapy**: Network 80%, Out-of-Network 60% of allowable charges to $5,500, then 100%. **Speech, Massage & Occ Therapy**, 25 copay In-Network, $30 copay -Out-of-Network to 45 visits per cal yr.	**Physical Therapy:** 80% participating, 70% non-participating. **Speech & Occ Therapy** up to $60 plan payment per day, 45 days max per contract year, Subject to deductible.	$20 copay per visit. Must be authorized by PCP and consists of treatment within a 60 consecutive day period per incident.	$20 copay per visit. Limit is 60 visits per condition per calendar year.	$20 copay per visit then deductible then covered at 80% to 60 visits per condition per calendar year	$15 copay

	PREMERA BLUE CROSS WEA SELECT PPO 2 Group # 8000207	**KPS HEALTH PLANS** Group #22165	**AETNA HEALTH, HMO PLAN** Group # 56659	**GROUP HEALTH ORIGINAL OPTION** Group # 008700	**GROUP HEALTH $500 DEDUCTIBLE PLAN #** 1175600	**PACIFICARE HMO Plan** Group # 801173
16. Inpatient Occupational, Speech & Physical Therapy	In-Network 80%, Out-of-Network 60%,to $5,500 in plan payments, 100% thereafter. Limited to 120 days each calendar year. Subject to inpatient copayment.	120 days maximum per contract year $150 per day, $450 per contract year copay, then 100% participating, 70% non-participating. Subject to deductible	120 days maximum per contract year $50 per day, $150 per contract year copay, then 100% participating, 70% non-participating. Subject to deductible	Covered in full up to 60 inpatient days per condition per calendar year.	Deductible then covered at 80% up to 60 days per condition per calendar year	$100 copay per admit then 100%
17. Radiation & Chemotherapy Services	In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter.	80% participating 70% non-participating Subject to deductible	80% participating 70% non-participating Subject to deductible	Inpatient: Covered in full. Outpatient: $20 copay per visit.	Inpatient: Deductible then covered at 80% . Outpatient: $20 copay per visit then deductible then covered at 80%	100%
18. Inpatient Hospital Room and Board, and Ancillaries	In-Network 80%, Out-of-Network 60% to $5,500 in plan payments, 100% thereafter. Subject to inpatient copayment.	$150 copay per admission to $450 max per person per contract year, then 80% participating, 70% non-participating Subject to deductible	$150 copay per day to $450 max per person per contract year, then 80% participating, 70% non-participating Subject to deductible	Covered in full.	Deductible then covered at 80%	$100 copay per admit then 100%
19. Durable Medical Equipment, Supplies & Prostheses	In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter.	80% participating 70% non-participating Prior authorization required $2,500 maximum per contract year Subject to deductible	Covered in full except for diabetic supplies that have a $15 copay.	Covered at 80%. Includes DME, orthopedic appliances, prosthetic devices, ostomy supplies, oxygen, external insulin pumps and diabetic monitoring equipment when determined medically necessary and approved by a GHC provider	Covered at 80%. Ded. waived. Includes DME, ortho appliances, prosthetic devices, ostomy supplies, oxygen, external insulin pumps and diabetic monitoring equipment when determined medically necessary and approved by a GHC provider	100%
20. Temporoman-dibular Joint Disorder (TMJ)	Non-surgical treatment paid at constant 50% of allowable charges up to a lifetime max. of $1,000. Surgical Treatment – In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter.	$1,000 maximum per contract year, $5,000 lifetime maximum benefit 80% participating 70% non-participating Subject to deductible	Not covered.	Limited to $1,000 per calendar year with a lifetime maximum of $5,000. GHC referral required. TMJ appliances are covered at 50%	$20 copay per visit then deductible then covered at 80% limited to $1,000 per calendar year with a lifetime maximum of $5,000. GHC referral required.	$15 copay then covered at 100% to $1,000 per year, $5,000 lifetime maximum.
21. Accidental Injury To Natural Teeth	In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter, if treatment received within 12 months of accident.	80% participating 70% non-participating Subject to deductible	Not covered.	Not covered.	Not covered.	Stabilization services covered within 48 hours of injury.

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22. Organ Transplants ***Please see certificate for details.***	In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter. Inpatient copayment applies. 12 month waiting period may apply. If so, benefits are subject to the lesser of the prior plan's limit or this plan's benefits for the first 12 months. Coverage is limited to a $250,000 lifetime maximum. Refer to the benefit booklet for other specific restrictions.	Prior Authorization required. $250,000 lifetime maximum for preferred and non-preferred combined. (includes $25,000 lifetime max for donor organ procurement). 12 month waiting period applies for newly hired employees. 80% participating, 70% non-participating Subject to deductible	Covered subject to inpatient hospital copay. Physicians Office Visit: $20 copay. Pre-authorization by Aetna is required. No 12-month waiting period.	Covered subject to applicable copayments. Must be GHC pre-authorized. Time under another District plan credited toward the 12-month waiting period. No waiting period for children continuously enrolled since birth and for members with sudden unexpected conditions occurring after the effective date of coverage.	Deductible then covered at 80%. Must be GHC pre-authorized. Time under another District plan credited toward the 12-month waiting period. No waiting period for children continuously enrolled since birth and for members with sudden unexpected conditions occurring after the effective date of coverage.	100% subject to applicable copayments, to $250,000 lifetime maximum for all transplants combined. There is no 12-month waiting period.
23. Obstetrics; Initial Newborn Care for Dependent Daughters; Facility and Professional Services	In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter. No coverage for newborns after the first 3 weeks unless the dependent eligibility and enrollment requirements are met.	**Maternity care:** 80% participating, 70% non-participating. **Newborn Nursery Care:** 80% participating, 70% non-participating, newborns covered first 3 weeks from birth. Well-baby nursing care not subject to ded. Dependent daughters not covered	$100 Inpatient copay. $15 copay for initial OB-GYN office visit only. Newborns of dependent daughters are covered in the first three weeks from birth.	Inpatient: Covered in full. No copay for newborn. Outpatient: $20 copay per visit. Newborns of dependent daughters are covered in the first three weeks from birth.	Covered same as any other condition. Newborns of dependent daughters are covered in the first three weeks from birth.	$15 copay per pregnancy. No copay for newborn. Newborns of dependent daughters are covered in the first three weeks from birth.
24. Neuro-developmental Therapies (Age 6 And Under)	In-Network 80%, Out-of-Network 60%, to $5,500 in plan payments, 100% thereafter, up to 120 days each calendar year. Subject to inpatient copayment. **Outpatient:** $30 per day up to 45 visits each calendar year.	Speech, physical, occupational therapies (to age 7) **Inpatient:** 80% participating, 70% non-participating .Subject to deductible **Outpatient:** 45 days max per contract year, $30 plan payment per day. Not subject to ded.	$20 copay per visit. Must be authorized by PCP and consists of treatment within a 60 consecutive day period per incident.	Inpatient covered at 60 days per condition per calendar year. Outpatient subject to $20 copay per visit, up to 60 visits per condition per calendar year.	Inpatient: deductible then 80% up to 60 visits per condition per calendar year. Outpatient: $20 copay then deductible then 80% up to 60 visits per condition per calendar year.	$100 copay per admit then 100% inpatient, $15 copay outpatient. Outpatient maximum of 60 visits per calendar year for all therapies combined.
25. Skilled Nursing Facility Care	$50 copay per calendar year, then 100% allowable charges. (Custodial care not covered) Subject to plan limitations.	$50 copay per contract year, then 100%, in lieu of hospitalization, prior authorization required Subject to deductible	$100 copay. Covered as authorized by PCP.	Covered in full in lieu of hospitalization in acute care facility to 60 days per cal. year when authorized by a GHC provider.	Deductible then covered at 80% up to 60 days per calendar year	100% to 100 days per calendar year if in lieu of hospitalization.

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26. Home Health Care	$50 copay per calendar year, then skilled care paid at 100% of allowable charges (Custodial care not covered.) Subject to plan limitations.	Prior authorization required, 130 visits maximum per contract year. Skilled care, $50 copay, then 80% participating, 70% non-participating Custodial care not covered Subject to deductible	Covered in full as authorized by PCP.	Covered in full. No visit limit.	Covered in full. No visit limit.	100% if in lieu of hospitalization
27. Hospice Care (Including Respite Care)	Paid in full up to 6-month lifetime maximum. Inpatient: up to 10-day maximum. Respite Care: 120-hour maximum each 3-months.	Prior authorization required, 6 months per year maximum $50 copay, then 80% participating, 70% non-participating Subject to deductible	$100 copay for Inpatient care. No copay for Outpatient care. Covered as authorized by PCP.	Covered in full. Inpatient respite care is covered for a maximum of 5 consecutive days per occurrence.	Covered in full. Inpatient respite care is covered for a maximum of 5 consecutive days per occurrence.	100% to 6 months lifetime maximum if in lieu of hospitalization.
28. Rules for Out of Area Care	In-Network benefits available nationwide through BlueCard Program. Network providers submit claims for you and agree to accept established allowable charges to reduce out-of-pocket expenses. Worldwide coverage available at Out-of-Network benefit levels.	Participating Provider benefits available nationwide through the Multiplan network of providers. Emergency care is covered Worldwide	Emergency care is covered outside the plan service area. Members must call customer service within 24 hours of an emergency hospital admission to guarantee coverage. Non-emergency care is not covered.	Emergency care at non-GHC designated facilities subject to $125 deductible per emergency and notification to GHC within 24 hours of inpatient admission.	Emergency care at non-GHC designated facilities subject to $125 deductible per emergency and subject to deductible then covered at 80%. Must notify GHC within 24 hours of inpatient admission.	Members living outside service area: 80% of after $100 ded., $3,000 out-of-pocket max. ER care paid at PCP-directed levels. Excess charges may be member's responsibility. ER Worldwide care $50 copay for all members.

This comparison is for information only and does not constitute a contract.

Please refer to the appropriate plan booklets for details and a full list of limitations and exclusions.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

IT IS VERY IMPORTANT THAT YOU READ YOUR CONTRACT CAREFULLY.
THE FOLLOWING IS A PARTIAL LIST OF EXCLUSIONS.

No benefits are provided for the following, unless specifically stated otherwise below or unless specifically provided in the contracts.

PREMERA BLUE CROSS
Partial list of exclusions and limitations

- Services, supplies and procedures related to altering the refractive character of the cornea, and their results, including but not limited to, radial keratotomy, corneal modulation, keratomileusis, refractive keratoplasty.
- Any service or supplies for which no charge is made, or would not have been made if this program were not in effect, or for charges for services or supplies for which you are not legally liable.
- Services, supplies or drugs for the treatment of caffeine dependency or abuse.
- Conditions caused by or arising from acts of war (declared or undeclared), or armed invasion or aggression excluding an act of terrorism, and a member's voluntary participation in a riot or insurrection or commission of an act of terrorism.
- Services or supplies not medically necessary even if ordered by court of law for treatment of disease, injury, illness or pregnancy.
- Experimental or investigative services.
- Services, supplies or drugs for sex transformations.
- Milieu therapy (treatment intended primarily to provide a change in environment or a controlled environment).
- The extra cost of a private hospital room.
- Services, supplies and procedures for cosmetic, plastic or reconstructive purposes and their complications are not covered benefits, except to repair a defect caused by an accidental injury if the services, supplies and procedures are started within 12 months of the accident; to treat functional disorders; reconstructive breast surgery in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit; and to repair a dependent child's congenital anomaly, as defined.
- Services or supplies for learning disabilities, except therapy services as stated under the Neurodevelopmental Therapy Benefit.
- Vocational counseling; outreach; job training; and other counseling or training services except as specifically covered by your program.
- Services or supplies received in and billed by a nonparticipating hospital owned or operated by a county, state or federal agency, except for treatment of a medical emergency or as otherwise required by state or federal law. All services and supplies must be furnished and billed by the hospital.
- Custodial care and services of a rest home, a home for the aged, a nursing home, or a convalescent home or any of like character, except as specifically covered by your program.
- Smoking cessation or treatment of tobacco dependency or abuse, except as specified.
- Routine physical and marital examinations, other than routine mammography
- screening, unless related to a specific illness, injury, pregnancy or a definitive set of symptoms or as specified in the "Preventive Medical Care Benefit".
- Hospital care for the extraction of teeth or other dental procedures, except when adequate treatment cannot be provided without the use of hospital facilities and when there is a coexisting medical condition that makes hospitalization necessary for health and safety.
- Services of a Dentist (D.M.D. or D.D.S.) except as specified. Routine dental services, dental implants to replace missing teeth, except as part of medically necessary treatment of a dental injury and preauthorized by Premera Blue Cross.
- Services or supplies for nonsurgical treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain-dysfunction (MPD), except as specified.
- Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage or adoption. Example...spouse, parent or child.
- Routine foot care.
- Hearing examinations; hearing aid, new or replacement, except as specified in the "Audio Benefit"
- Inpatient and outpatient neurodevelopmental therapy, except as specified under the "Neurodevelopmental Therapy Benefit".
- Organ and Bone marrow transplants, except as specified.
- Services, supplies, drugs and procedures for reproductive and sexual disorders and defects, whether or not the consequence of illness, disease or injury, including, but not limited to, impotence (except as specified), frigidity, infertility, reversal of surgical sterilization, artificial insemination and in-vitro fertilization.
- Any services or supplies not specifically listed as covered benefits; any expenses for professional nursing care, except as specified.
- Services and supplies for which the enrollee is entitled to receive benefits from any federal, state or governmental program, excluding Medicare, except as otherwise required by law.
- Nonsurgical treatment, including drugs, of obesity or morbid obesity, except as specified.
- Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering:
- Motor vehicle medical, motor vehicle no-fault, or personal injury protection (PIP) coverage; or,
- Commercial premises or homeowner's medical premises coverage, or other similar type of contract or insurance.
- Fertility drugs, regardless of their intended use; over-the-counter drugs, supplies, food supplements; and vitamins.

- **AETNA HEALTH, INC**
- **Partial list of exclusions and limitations**

- Services and supplies that are not provided by or under the direction of Plan Providers and preauthorized by Aetna, where required, except as provided for under Emergency Coverage from Non-Aetna Providers.
- Temporomandibular joint disorders (TMJ) and dental services related to TMJ.
- Dental care and oral surgery.
- Examinations requested by third parties. Only services that would normally fall under a routine physical exam are covered.
- Experimental or investigational services, treatments, facilities, procedures, equipment, drugs, drug usages, medical devices, or supplies, and including participation in experimental or investigational research activities.
- Treatment of obesity.
- Sex transformation surgery, or any services or supplies related to sex transformation, except as medically necessary to establish an identity as in the case of congenital anomaly.
- Treatment or hospitalization for treatment of impotency and infertility, except services in connection with the diagnosis and treatment of the underlying medical cause of infertility
- Hypnotherapy; sedative or palliative massage therapy; botanical and herbal medicines, vitamins and food supplements.
- Medical services provided by a friend or relative whether residing with the Member or elsewhere.
- Court ordered services not judged to be Medically Necessary by Plan Providers.
- Services not Medically Necessary for the diagnosis, treatment, or prevention of injury, illness, or condition, or services that are primarily educational or non-medical in nature.
- Any medical treatment, supply, service, surgery, or complications of surgery that are related to a noncovered or exhausted benefit. Services and supplies not specifically listed as covered in the Schedule of Benefits.
- Work-related conditions, illnesses, or injuries that are eligible for coverage under Worker's Compensation programs; Services provided by government agencies, except as required by federal or state law.

- **<u>GROUP HEALTH COOPERATIVE ORIGINAL AND $500 DEDUCTIBLE PLANS</u>**
- **Partial list of exclusions and limitations**

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- Services or programs not provided or authorized by GHC staff (except as specified).
- Drugs not listed as covered in GHC's Drug Formulary or drugs not requiring a prescription; Travel medications.
- Investigational or experimental procedures, drugs, devices and biological products.
- Procedures, services and supplies related to sexual reassignment surgery, such as sex change operations or transformations, and procedures or treatments designed to alter physical characteristics.
- Procedures and services to reverse a therapeutic or nontherapeutic sterilization.
- Diagnostic testing and treatment of infertility, sterility, or sexual dysfunction.
- Hearing aids and examinations; Eyeglasses; Contact lenses, including services associated with their fitting, except following cataract surgery performed at GHC.
- Mental health, except as specified.
- Cosmetic services.
- Dental care.
- Arch supports and orthopedic shoes that are not attached to an appliance.
- Corrective appliances and artificial aids except as specified.
- Supplies, dressing, appliances, devices or services that are not for specific treatment of disease or injury
- Coverage for growth hormone treatment is excluded until the member has been continuously enrolled under a GHC plan for 12 consecutive months.
- Treatment of obesity, except as noted in contract.
- Convalescent or custodial care; Skilled nursing facility services (except as specified).
- Services rendered as a result of work-incurred injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment.
- Services covered by first-party insurance.
- Employment, license, immigration or insurance examinations, reports and immunizations.
- Services covered by government or military programs.
- The cost of services and supplies due to loss or damage.
- Orthoptic (eye training) therapy.
- Orthognathic (jaw) surgery.
- Transplants (except kidney, simultaneous pancreas/kidney, cornea, heart, heart-lung, single lung, double lung, bone marrow and liver) in accordance with criteria established by GHC.
- Services required as a result of war, whether declared or not declared. Care needed for injuries or conditions resulting from active or reserve military service.
- Specialty treatment programs such as weight reduction, rehabilitation (including cardiac rehabilitation) and "behavior modification programs".

- **PACIFICARE**
- **Partial list of exclusions and limitations**

- Charges in excess of the Usual, Customary, or Reasonable (UCR) charge for benefits that are based on UCR.
- Dental services except stabilization services to treat an accidental injury to the mouth and natural teeth that are rendered within 48 hours of the injury.
- Orthognathic surgery except when Medically Necessary to treat a Member continuously covered on this Plan either from birth or from the date of placement with the employee for legal adoption.
- Educational or self-help training.
- Dyslexia, attention deficit disorder and other rehabilitative therapy services for hyperkinetic syndromes of childhood.
- Routine foot care and prosthetics and appliance or orthotics connected with or inserted in shoes, and impression casting for them.
- Cosmetic, plastic or reconstructive services, supplies, and drugs except treatment of a birth defect in a dependent who was born after the effective date of the employee's coverage, and continuously covered by the Plan from birth, treatment for an injury within six months after an accident giving rise to such injury; reconstructive breast surgery following mastectomy necessitated by disease, illness, or injury, including reduction of the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.
- Treatment for obesity. Bariatric surgery for obesity is covered if medically necessary
- Services for sexual reassignment. Services or treatment for sexual disorders and defects, whether or not the consequence of illness, disease or injury.
- Prescription medication for the treatment of sexual dysfunction including erectile dysfunction, impotence and anorgasmy or hyporgasmy.
- Care for a dependent child's pregnancy, including complications of pregnancy.
- Procedures that are experimental or investigational.
- Occupational injury or disease when fully covered by Worker's Compensation, any Federal act or similar laws.
- Any condition resulting from military service, declared or undeclared war, or voluntary participation in a riot, insurrection, or act of terrorism.
- Any services or supplies for which no charge is made.
- Convalescent or custodial services, regardless where such services are provided, or any portion of a Hospital stay that is primarily convalescent or custodial, except home health and hospice benefits that are part of an approved treatment plan.
- Home health and hospice care, Skilled Nursing Facility care, Chemical Dependency treatment, rehabilitative care, neurodevelopmental therapies, and services or supplies for or related to organ and bone marrow transplants, except as provided under the specific benefits that name such services.
- Prescription and nonprescription drugs and medicines for outpatient use, other than drugs covered under specific benefits of this Plan. Other than PKU formula and nutritional supplements covered under the Home Health Care and Hospice Benefits, this Plan never covers food supplements and drugs that have not been preauthorized by PCW as required in "Preauthorization for Certain Drugs."

- **KPS HEALTH PLANS**
- **Partial list of exclusions and limitations**

- Services and supplies to the extent they are not medically necessary for treatment of an illness, injury or physical disability.
- Custodial Care except as provided under the Hospice and Home Health benefit.
- Unnecessary duplicate diagnostic services for a single continual illness and hospitalization solely for diagnostic purposes.
- Any results of war or military service.
- Any illness, condition or injury that is work related.
- Services for which the covered person has not incurred an expense; expenses for charges the covered person is not legally required to pay. Any service provided by a person who is related by blood or marriage or who resides in your home.
- Services for non-acute care.
- Services for the treatment of self-inflicted injuries when both the cause and outcome are intentional.
- Any service or supply that is experimental and/or investigational as defined in the Contract Booklet.
- Personal comfort items while in the hospital, such as radio, television or telephone. Conditions requiring specialized institutional care, except for covered treatment in a skilled nursing facility, and “approved treatment program,” or an accredited or licensed general hospital.
- Speech, occupational, education, or milieu therapy (except as provided under

the Neurodevelopmental Therapy benefit or Rehabilitation benefit of this contract), or any form of non-medical self-care, self-help training, marital or sexual counseling.

- Biofeedback.
- Services for obesity including but not limited to surgical procedures, weight reduction, or dietary control programs.
- Complications arising from non-covered services or procedures (except Complications of Pregnancy).
- Developmental delay, speech delay, or learning disabilities (except as provided under the Neurodevelopmental therapy benefit of this contract).
- Arch supports, shoe orthotics, corrective shoes, elastic stocking, air conditioners, dehumidifiers, purifiers, heating pads, enuresis training equipment, exercise equipment, whirlpool baths.
- Vision exams and hardware, orthoptics (eye exercise programs).
- Over-the-counter Contraceptive devices, or supplies.
- Artificial insemination or in vitro fertilization; sexual transformation; reversal of sterilization procedures or removal of contraceptive devices. Sterility; infertility, impotency or frigidity.
- Care for any illness, injury or physical disability received prior to your effective date of coverage.
- Dental care (including services in connection with care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth), and malocclusion (including operations for developmental abnormalities of upper and lower jaw), except as specifically provided under the temporomandibular joint (TMJ) benefit of this contract.
- The additional portion of a routine physical exam (including immunizations) specifically required for the purpose of employment, travel, immigration, licensing, or insurance related reports.
- Services and supplies not specifically described in the Contract Booklet.

Waiting Periods

- The benefits of this contract are subject to waiting periods for listed conditions, services, and procedures as follows:
- During the first twelve (12) months a Covered Person is covered under this contract, benefits are not provided for the following conditions, services,
  and procedures: Bone Marrow and Cornea Transplantation and Solid Organ Transplants
- Credit to the waiting period for the *listed conditions, services, and procedures* will be given to current employees who have had prior health coverage. Credit is limited by the length of time employees were continuously covered by the prior contract. The 12-month waiting period applies to newly hired employees regardless of their prior health care coverage.

SEATTLE SCHOOL DISTRICT NO. 1
MONTHLY COSTS
October 1, 2003 - September 30, 2004

The medical plans are ordered from least expensive to most expensive:

EMPLOYEE ONLY

Group Health – $500 Deductible Plan	$232.50
Group Health – Original Option	300.37
PacifiCare Health Plan	324.30
Aetna Health	328.08
KPS Health Plans	339.60
Premera Blue Cross Select Health Plan 2	398.35

EMPLOYEE AND SPOUSE OR DOMESTIC PARTNER

Group Health – $500 Deductible Plan	$451.03
Group Health – Original Option	558.86
PacifiCare Health Plan	578.02
Aetna Health	636.47
KPS Health Plans	658.33
Premera Blue Cross Select Health Plan 2	772.95

EMPLOYEE WITH ONE CHILD

Group Health – $500 Deductible Plan	$325.02
Group Health – Original Option	395.67
Aetna Health	458.65
KPS Health Plans	474.54
PacifiCare Health Plan	545.37
Premera Blue Cross Select Health Plan 2	556.95

EMPLOYEE WITH TWO OR MORE CHILDREN

Group Health – $500 Deductible Plan	$325.02
Aetna Health	458.65
KPS Health Plans	474.54
Group Health – Original Option	537.19
PacifiCare Health Plan	545.37
Premera Blue Cross Select Health Plan 2	556.95

EMPLOYEE, SP/DP, AND ONE CHILD

Group Health – $500 Deductible Plan	$543.55
Group Health – Original Option	688.82
Aetna Health	767.05
KPS Health Plans	793.27
PacifiCare Health Plan	799.00
Premera Blue Cross Select Health Plan 2	931.55

EMPLOYEE, SP/DP, AND TWO OR MORE CHILDREN

Group Health – $500 Deductible Plan	$543.55
Group Health – Original Option	758.13
Aetna Health	767.05
KPS Health Plans	793.27
PacifiCare Health Plan	799.00
Premera Blue Cross Select Health Plan 2	931.55

Note: SP/DP means spouse or domestic partner

Important medical plan policy numbers: PacifiCare # 801173; Aetna Health, Inc. # 56659; Premera Blue Cross # 8000207; Group Health Coop Original Option # 008700, Group Health Coop $500 Deductible Plan # 1175600, KPS Health Plans #22165

DENTAL AND VISION

WASHINGTON DENTAL SERVICE

Policy # 195

Employee with or without dependents. $86.00

NBN VISION PLAN

Employee with or without dependents . . . . . $ 7.00

THE STANDARD
LIFE/LONG TERM DISABILITY

Policy # 35341

Basic Annual Earnings			Monthly Cost
$5,001	but less than	$6,001	$0.00
$6,001	but less than	$7,001	$0.00
$7,001	but less than	$8,001	$0.00
$8,001	but less than	$9,001	$0.00
$9,001	but less than	$10,001	$0.00
$10,001	but less than	$11,001	$0.15
$11,001	but less than	$12,001	$1.03
$12,001	but less than	$13,001	$1.70
$13,001	but less than	$14,001	$2.59
$14,001	but less than	$15,001	$3.26
$15,001	but less than	$16,001	$4.15
$16,001	but less than	$17,001	$4.82
$17,001	but less than	$18,001	$5.70
$18,001	but less than	$19,001	$6.37
$19,001	but less than	$20,001	$7.26
$20,001	but less than	$21,001	$7.93
$21,001	but less than	$22,001	$8.82
$22,001	but less than	$23,001	$9.49
$23,001	but less than	$24,001	$10.38
$24,001	but less than	$25,001	$11.04
$25,001	but less than	$26,001	$11.93
$26,001	but less than	$27,001	$12.60
$27,001	but less than	$28,001	$13.49
$28,001	but less than	$29,001	$14.16
$29,001	but less than	$30,001	$15.05
$30,001	but less than	$31,001	$15.71
$31,001	but less than	$32,001	$16.60
$32,001	but less than	$33,001	$17.27
$33,001	but less than	$34,001	$18.16
$34,001	but less than	$35,001	$18.83
$35,001	but less than	$36,001	$19.72
$36,001	but less than	$37,001	$20.38
$37,001	but less than	$38,001	$21.27
$38,001	but less than	$39,001	$21.94
$39,001	but less than	$40,001	$22.83
$40,001	but less than	$41,001	$23.50
$41,001	but less than	$42,001	$24.39
$42,001	but less than	$43,001	$25.06
$43,001	but less than	$44,001	$25.94
$44,001	but less than	$45,001	$26.61
$45,001	but less than	$46,001	$27.50
$46,001	but less than	$47,001	$28.17
$47,001	but less than	$48,001	$29.06
$48,001	but less than	$49,001	$29.73
$49,001	but less than	$50,001	$30.62
$50,001	but less than	$51,001	$31.28
$51,001	but less than	$52,001	$32.17
$52,001	but less than	$53,001	$32.84
$53,001	but less than	$54,001	$33.73

Basic Annual Earnings			Monthly Cost
$54,001	but less than	$55,001	$34.40
$55,001	but less than	$56,001	$35.29
$56,001	but less than	$57,001	$35.95
$57,001	but less than	$58,001	$36.84
$58,001	but less than	$59,001	$37.51
$59,001	but less than	$60,001	$38.40
$60,001	but less than	$61,001	$39.07
$61,001	but less than	$62,001	$39.96
$62,001	but less than	$63,001	$40.62
$63,001	but less than	$64,001	$41.51
$64,001	but less than	$65,001	$42.18
$65,001	but less than	$66,001	$43.07
$66,001	but less than	$67,001	$43.74
$67,001	but less than	$68,001	$44.63
$68,001	but less than	$69,001	$45.30
$69,001	but less than	$70,001	$46.18
$70,001	but less than	$71,001	$46.85
$71,001	but less than	$72,001	$47.74
$72,001	but less than	$73,001	$48.41
$73,001	but less than	$74,001	$49.30
$74,001	but less than	$75,001	$49.97
$75,001	but less than	$76,001	$50.86
$76,001	but less than	$77,001	$51.52
$77,001	but less than	$78,001	$52.41
$78,001	but less than	$79,001	$53.08
$79,001	but less than	$80,001	$53.97
$80,001	but less than	$81,001	$54.64
$81,001	but less than	$82,001	$55.53
$82,001	but less than	$83,001	$56.19
$83,001	but less than	$84,001	$57.08
$84,001	but less than	$85,001	$57.75
$85,001	but less than	$86,001	$58.64
$86,001	but less than	$87,001	$59.31
$87,001	but less than	$88,001	$60.20
$88,001	but less than	$89,001	$60.86
$89,001	but less than	$90,001	$61.75
$90,001	but less than	$91,001	$62.42
$91,001	but less than	$92,001	$63.31
$92,001	but less than	$93,001	$63.98
$93,001	but less than	$94,001	$64.87
$94,001	but less than	$95,001	$65.54
$95,001	but less than	$96,001	$66.42
$96,001	but less than	$97,001	$67.09
$97,001	but less than	$98,001	$67.98
$98,001	but less than	$99,001	$68.65
$99,001	but less than	$100,001	$69.54
$100,001	or more		Call Payroll

SEATTLE SCHOOL DISTRICT
MONTHLY COST WORKSHEET

Use this worksheet to determine your total monthly cost for the District's group benefits program. Enrollment in the dental, vision, and life/long term disability plans is mandatory and automatic. Medical coverage is voluntary.

The District provides a monthly benefit contribution that will help pay all or part of your total cost. Current monthly premiums are indicated on the appropriate rate pages. If you have questions about your benefits or how to complete this worksheet, please contact Employee Benefits at 206-252-0282 or 206-252-0292.

Group Benefit Plan	**Enrollment**	**Monthly Premium**	
Dental	Automatic	$ 86.00	(a)
Vision	Automatic	+ $ 7.00	(b)
Add: Life/Long Term Disability (*See rate page 42*)	Automatic	+ $_____	(c)
Add: Medical coverage (*See rate page 41*)	Optional	+ $_____	(d)
Total Monthly Cost (add lines a+b+c+d)		= $_____	(e)

FUNDING: The District's Monthly Contribution plus Demutualization Interest

Certificated: $480.00 Classified: $486.00

Note: The above District Contributions are established for eligible employees for the school year beginning October 1, 2003 and will change January 1, 2004 based on the actual health plan enrollment. These amounts include the "Demutualization Interest" of $5.49 per month, your share of the interest generated by the proceeds from Standard Insurance Company's demutualization. The District holds the principal for this purpose and allocates the interest on an annual basis to help reduce employees' share of premium costs.

If Your Monthly Cost On Line (e) Exceeds Your Funding Amount, The Difference is your Monthly Payroll Deduction Cost For Benefits.

Notes:

Dental and Vision - You and your eligible dependents are automatically enrolled. There are no enrollment forms required for group dental and vision coverage. The cost for these plans, as well as your optional choices, is charged against your District benefit contribution allowance.

Life and LTD - Your premium for the Life/LTD coverage is based on your basic annual earnings. Make sure to have a current life insurance beneficiary card filed with the Benefits Office.

Medical - The cost for medical coverage is based on the plan you select and whether or not you elect to enroll eligible dependents. Be sure to submit the proper medical enrollment form to Employee Benefits.

If your Total Monthly Cost (line e) is greater than your funding amount, then the difference is your monthly share of the cost for your benefits. This amount will be deducted from your pay warrant each month. Your payroll deductions for benefits will be made through the District's Flexible Benefits Plan on a pre-tax basis (i.e., you will not pay taxes on this expense) unless you choose to have your payments made on an after-tax basis. Contact Employee Benefits for an explanation.

GLOSSARY OF KEY TERMS

MANAGED CARE

Managed care means that your health care plan is designed to give you high quality, appropriate services in a financially sound manner. True managed care will provide comprehensive coverage and coordinated services while following strict performance standards. This can take many forms, ranging from pre-approval for a hospital admission to having all your care provided by, or authorized by, a primary care physician. It is important to remember that all six plans offered at the District have some form of managed care, and you must follow the health plan's rules in order to get the most out of your coverage, or to avoid having coverage denied altogether.

PPO - PREFERRED PROVIDER ORGANIZATION PLANS

Preferred providers are the doctors, hospitals, and clinics meeting the quality standards established by the insurance companies. They have also agreed to accept lower reimbursement levels for their services. PPO health plan benefits give you both a choice and an incentive. If you see a doctor or other provider on the preferred provider list, you get very good benefits and if you choose a provider who is not on the list, your benefits are reduced. The Premera Blue Cross Select Plan 2 and the KPS Health Plan are PPO plans.

PCP - PRIMARY CARE PHYSICIAN (OR PERSONAL CARE PHYSICIAN)

A Personal Care Physician, or PCP, is the doctor responsible for your health care. With some of the District's health plans you must select a PCP when you sign up for coverage. (You will notice a place for this on the enrollment form.) In addition, in order to get the best out of these plans most care has to be provided by (or authorized by) your PCP. The rules depend on the plan you choose, so consider this carefully. Different members of your family can have different primary care physicians, and you are able to change PCPs if you need to.

HMO - HEALTH MAINTENANCE ORGANIZATION

An HMO is a type of medical plan that offers integrated health care coverage at a prepaid fee. HMOs not only pay for your covered medical services, they also provide these services to you. Group Health Cooperative, PacifiCare and Aetna Health, Inc. are offering HMO coverage to District employees. With these plans there are no deductibles and coverage is quite comprehensive. In order to have your benefits covered, you need to see the providers that are part of the HMO plan. (There are some exceptions for emergencies.) Both Group Health plans, PacifiCare and Aetna Health, Inc. ask you to choose a primary care physician before receiving services.

POS - POINT OF SERVICE PLANS

Point of Service plans are like two plans in one, combining the features of an HMO with those of a traditional plan. They are called point of service plans because each time you need to see a doctor you are free to decide which one to see (i.e., you decide at the point of service).

Your decision about which doctor to see determines whether your health benefits will be paid as HMO benefits or traditional plan benefits. If you see your primary care physician or if you get referred to any other providers on the health plan's list, your coverage will usually be provided in full after a modest copay. But you are never restricted to just these doctors - you can go to any other licensed provider, any time you want. If you do self-direct or go "out of network", you will have traditional benefits with an annual deductible followed by coverage where you share a percentage of the cost.

The District currently does not offer a point of service plan.