SPOKANE FIREFIGHTERS UNION
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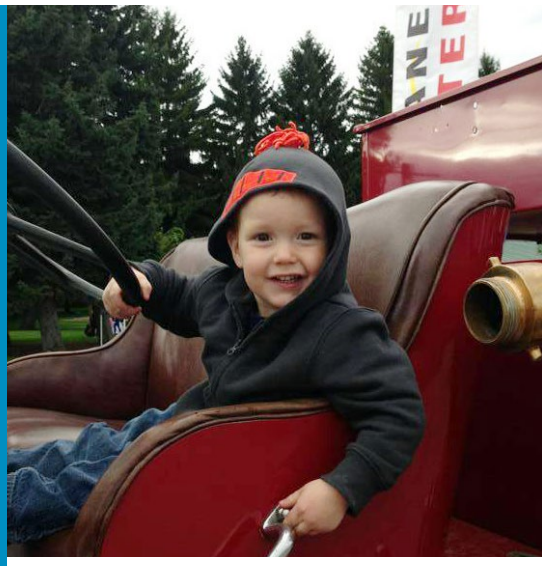
L29
BENEFIT TRUST

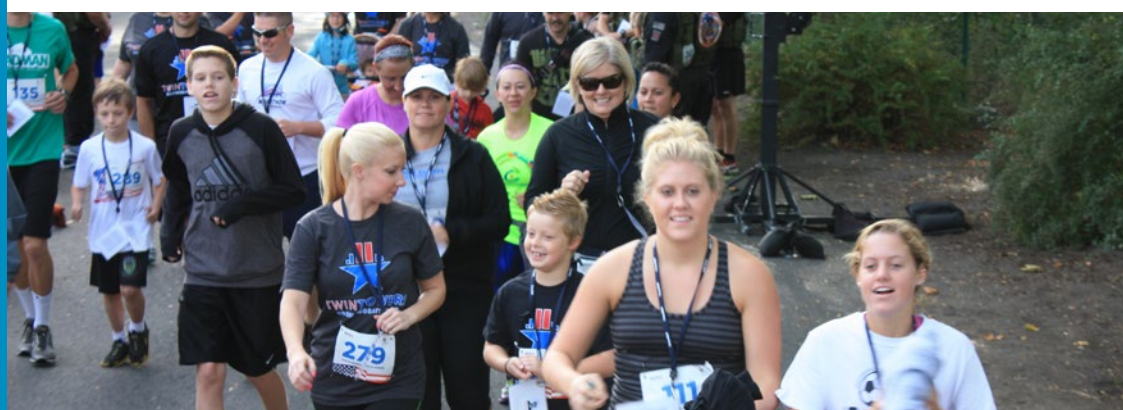
Understanding Your Trust and Benefits

CARE

COVERAGE

COSTS





Dear Fellow Members and Families,

The Spokane Fire Fighters Benefit Trust continues to solidify our own foundation for sustainable and comprehensive medical coverage. Healthcare is ever changing, so our Trust must accommodate change without losing sight of our goals and priorities. Your Trustees are fully engaged in assuring that our Trust continues to evolve and provide members with the best healthcare experience possible.

Regards,
Your Spokane Fire Fighters Benefit Trust Board of Trustees

Greg Haff, Chair
Nathan Cover
Marissa DeLaMatter
Mike Forbes
Randy Marler
Christopher Munoz
Shane Skipworth
Lee Venning

How to Use this Guide

This is a guide to your Trust benefits. From the day you become a Trust member, you are entitled to a range of health and welfare benefits that provide vital services and a safety net for you and your family. This guide distills the most important information from your benefit guides and walks you through the steps of enrolling for benefits, getting healthcare, paying bills, managing your benefits as life circumstances change, and saving for retirement. It also helps you understand how your Trust operates and works for all members.

The guide is divided into the following sections: Introduction, About Your Trust, Understanding and Managing Your Benefits, Getting Care, Paying Bills and Getting Reimbursed, and Tools and Resources. Each section includes handy features like frequently asked questions (FAQs), checklists, annual to-dos and dates to remember, and important contact information. You will also see snapshots of your health plan benefits for when you want to quickly check what is covered.

We hope this guide takes the effort and mystery out of navigating a complex health system, and makes it easier for you to understand and take full advantage of your Trust benefits. Your Trust works for you, and we welcome your feedback.

NOTE

Disclaimer

The following is a general description of the benefits available to eligible participants of the Spokane Fire Fighters Benefit Trust. It is not a contract and is not intended to be a definitive source, as the information contained herein is accurate to the best of our knowledge at the time of publication. Specific details about costs and general plan eligibility should be verified with the Trust Benefit Office. Benefit questions should be directed to the carriers or consult the plan booklets issued by those carriers.

Who is Eligible for Trust Benefits?

Eligible Members:

Eligibility begins first of the month following date of hire, as long as you are:

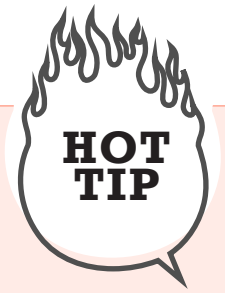
- A full-time, active LEOFF I member with established LEOFF I membership; or
- A full-time, active LEOFF II member with established LEOFF II membership, and
- Regularly scheduled to work a minimum of 30 hours per week for membership in Local 29.

Eligible Spouses/Registered Domestic Partners:

- Legal Spouse, which includes the legally formed marriage of two persons validly formed in any jurisdiction in the United States or in a foreign jurisdiction that is recognized under Washington law.
- Surviving Spouse of a deceased member (not divorced) who was enrolled for active or retiree coverage at the time of death or is a surviving spouse of a LEOFF I or LEOFF II member who was enrolled for coverage in the Plan prior to their death.
- Domestic Partner, registered pursuant to state law or domestic partners who have signed and meet all the requirements of the affidavit of Domestic Partnership established by the Trust.

Eligible Children:

- Natural children of the member or spouse
- Legally adopted children of the member or spouse
- Surviving children of deceased member
- Children of a registered Domestic Partner
- Child placed with the member and spouse for the purpose of legal adoption
- Foster children are not eligible.



Active members: When you and/or eligible family members are enrolled in the Trust's medical plan, you are also automatically enrolled in the Delta Dental plan.

NOTE

Your Employer Relationship

Remember, you are a member working for an employer that has a Collective Bargaining Agreement (CBA) with Local 29.

Enrollment Checklist

How do I start receiving health and welfare benefits?

Go to www.sffbt.com/forms to download an enrollment form. Be sure to select the one that applies to you: new hire, active, or retiree. While you're there, download this year's Enrollment Guide for active or retiree and find out more about the annual Open Enrollment period.

Enrollment forms:

- **Enrollment - Actives**
- **Enrollment Form for New Hire - Actives**
- **Enrollment Form - Retirees**

When can I change my coverage?

During the yearly open enrollment period in the fall. Or, if you have a qualifying event outside of open enrollment, please contact the Trust Office directly.

Any changes will be effective starting January 1.

You are committed to the enrollment selections you make for the entire Plan Year of January 1 through December 31, unless you have a "qualified change in status." Should you wish to make a mid-year enrollment change, you must complete and submit the Enrollment Application to the Trust Office within 60 days of the qualified change in status.

What is a qualified change in status?

- Marriage, divorce, legal separation, domestic partnership status change,
- Birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, commencement or termination of adoption proceedings,
- Change in residence due to an employment transfer for you, your spouse or domestic partner,
- Loss of coverage due to a change in your spouse's or domestic partner's employment status, or a loss of other coverage due to your spouse's or domestic partner's employer ceasing to make contributions toward their coverage.

This is what you will need to enroll:

For yourself:	Completed enrollment form
For yourself + your family:	Completed enrollment form
Spouse/domestic partner:	Copy of marriage certificate or domestic partnership declaration
Children:	Copy of birth certificate for you or your spouse's natural children, or adoption papers for adopted children

Note: *Loss of other coverage due to a failure to timely pay premiums or termination of coverage for cause is not a qualified change in status.*

NOTE

Open Enrollment

Every fall, near the end of the plan year, open enrollment will occur, giving you a window of opportunity to make changes to your plan before the upcoming renewal. The benefits you elect during open enrollment will be effective from January through December for the upcoming year. With few exceptions, this is the only time you can make changes to your plan, unless you have a qualifying event. Please watch for your annual open enrollment each fall for specific enrollment details.

What's New for 2023?

Strong Trust performance in 2022 allows us to continue offering the same high quality plans in 2023. Contributions will increase slightly (see below), as we budget to keep pace with the increasing cost of healthcare delivery. Please note the following, which are effective January 1, 2023:

VEBA Contribution Increase

Trustees made the decision to increase the VEBA contribution from the current levels to $3,500 for individual coverage and $7,000 for family coverage. This is based on their review of overall plan performance and recognition of the value members' place on the VEBA. See *2023 VEBA HRA Contributions* in the *Paying Bills & Getting Reimbursed* section.

Additional VEBA Contributions tied to Annual Exam completion

For 2023, if members completed their fire fighter exam in 2022, prior to the September 30th deadline, they earned an additional $500 VEBA contribution. For 2024, we're happy to announce we are once again offering an incentive to earn a VEBA bonus by completing your fire fighter exam. In order to **earn the additional $500 bonus contribution in 2024**, members will need to complete their annual exam between **October 1, 2022 and September 30, 2023**.

2023 Member Contributions

Your monthly contributions will change modestly so that we can keep up with our expected costs for 2023. The amount of change varies based on which bargaining group you belong to and which family members you are covering. For a breakdown of 2023 member contributions, please refer to the table *How Much Does Coverage Cost?* in the *Understanding and Managing Your Benefits* section.

There are no other changes to our plans for 2023. However, please take the time to review this Guide as it contains useful information on a number of items, including::

- Plan Highlights for your Medical/Vision, Prescription Drug and Dental Plans
- Information on your VEBA Benefit
- Trust Eligibility
- Teladoc Virtual Health Services
- The Trust's partnership with MultiCare Rockwood Spokane Valley Primary Care (formerly known as Spokane Internal Medicine or SIM) for our Annual Fire Fighter Exams

Tax Note

NOTE

Affordable Care Act (ACA) Tax Requirements

The Trust Office will provide you with Form 1095-B, which shows the month you and your family had qualifying health coverage for the previous year.

You DO NOT need Form 1095-B to file your taxes. Just like last year, you can check a box on your tax return verifying you had qualifying health coverage.

You can expect to receive Form 1095-B for the previous tax year in the mail by the end of January of the current year. Check to make sure it's accurate and keep it with the rest of your tax documents.

If you have any questions about Form 1095-B, please contact the Trust Office at (888) 563-0665.

Contacts

Trust Office

Welfare & Pension Administration Service, Inc. (WPAS)

P.O. Box 34203

Seattle, WA 98124-1203

Phone (888) 563-0665, Ext. 3320

Fax (206) 505-9727

Email: gdimof@wpas-inc.com

Benefits Consultants

DiMartino Associates

1325 Fourth Ave, Suite 1705

Seattle WA 98101

(206) 623-2430 or

(800) 488-8277

www.dimarinc.com

Created by firefighters,
managed by firefighters,
for firefighters.

Our Priorities

Your Trustees work hard to keep pace with the ever-changing healthcare system and provide members with the best healthcare experience possible. To ensure we never lose sight of these goals, the Trust is guided by five key priorities.

1. To provide the highest level of benefit to our members while minimizing out-of-pocket costs whenever possible.
2. To provide the highest level of integrated services to meet our members' needs.
3. To provide the highest level of customer service and satisfaction to our members, recognizing that they are the owners of our products.
4. To follow union ideals in business decisions whenever practical.
5. To provide health insurance to retired members at a level that is financially practical.

Your Trustees

Greg Haff, Chair
Nathan Cover
Marissa DeLaMatter
Mike Forbes
Randy Marler
Christopher Munoz
Shane Skipworth
Lee Venning

How Your Trust Works

What is the purpose of the SFFBT?

The Spokane Fire Fighters Benefit Trust (SFFBT) was established to provide comprehensive, best-in-class health and welfare benefits for Local 29 members and their families, from active employment through retirement.

Why do we have our own plan?

We wanted to create a health and welfare plan that addressed the unique risks firefighters face every day. Unlike other city employees, firefighters have more rigorous work requirements, unique working hours and conditions, and occupational hazards and health risks that are more likely to affect us for the rest of our lives.

What benefits do the Trust provide?

- Medical plan through WPAS/Premera Blue Cross
- Virtual care through Teladoc
- Prescription drug coverage through Sav-Rx
- Dental coverage from Delta Dental
- Generous VEBA HRA contributions managed by BPAS
- Annual firefighter medical exams through Spokane Internal Medicine
- $50,000 of Life/AD&D insurance from The Standard
- Long-term disability insurance from The Standard

We are always on the lookout for other unique plans and benefits to offer members.

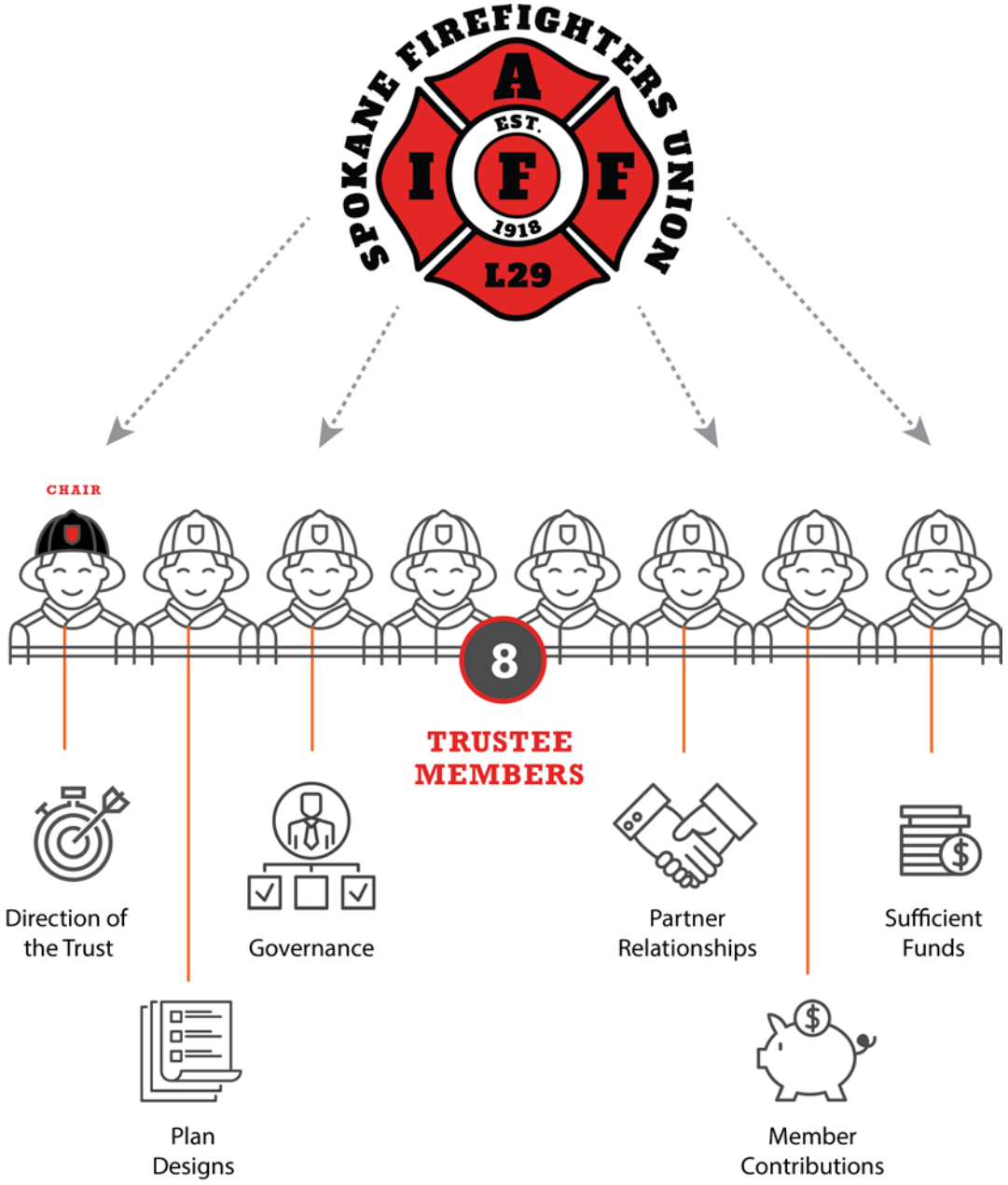
History of Your Trust

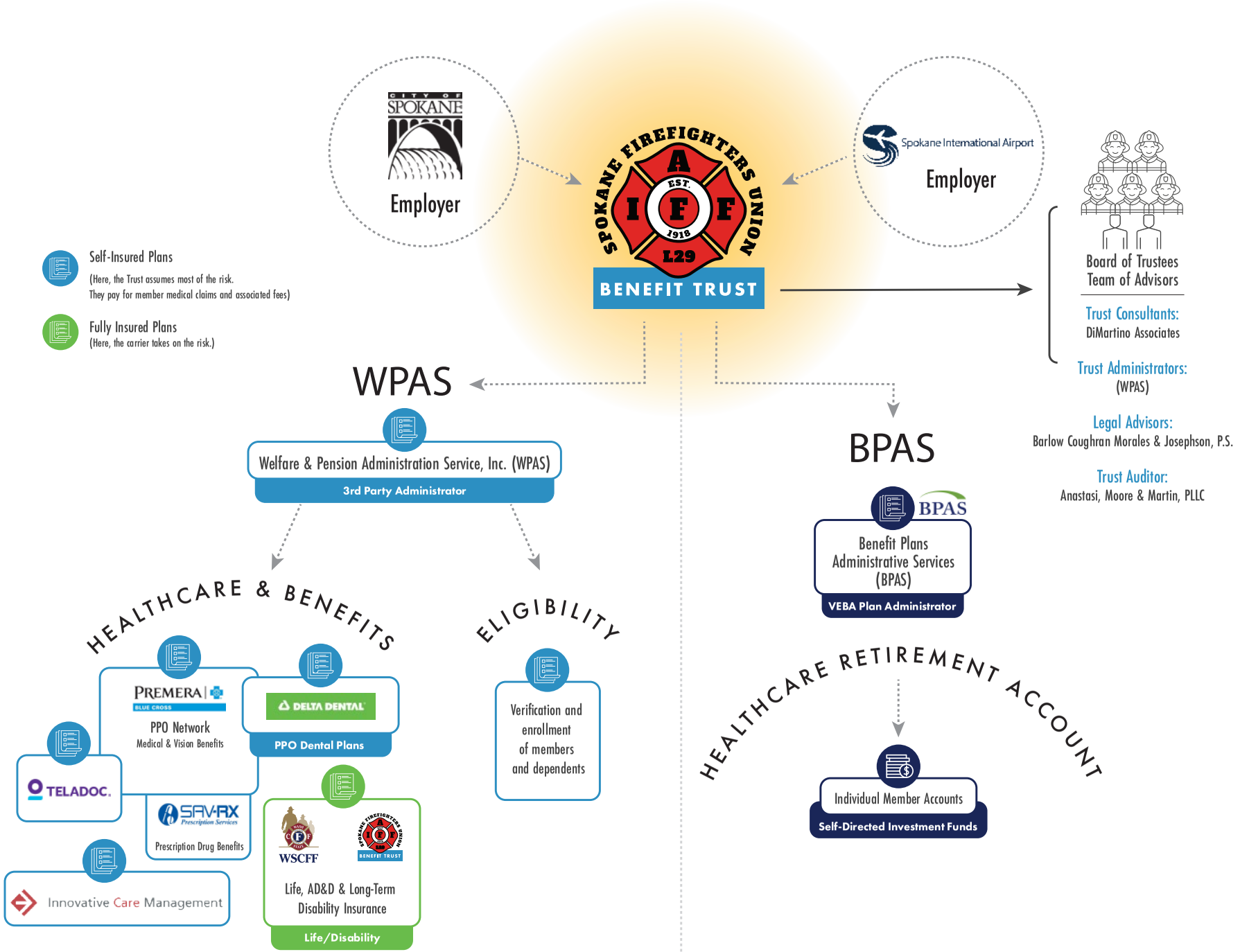
The Spokane Fire Fighters Benefit Trust was established on January 1, 2013. The Trust is the legal vehicle for the union to manage its own health and welfare plan. Today, the SFFBT provides coverage for medical, vision, prescription drugs, dental, VEBA Health Reimbursement Arrangement and life/AD&D and long-term disability to over 1,000 members, including retirees and their families.

How Does the Trust Operate?

A board of seven trustees is elected or appointed from the Local 29 membership plus one chair position. The Trustees are responsible for the governance and direction of the Trust, including plan designs, partner relationships, member contributions, and ensuring we have sufficient funds.

A group of advisors is retained to assist with the daily operational, legal, and consulting aspects of managing the Trust. Trustees meet four to five times a year, although they consult with the advisors several times a week.




Employer
Employer
Spokane International Airport
SPOKANE FIREFIGHTERS UNION
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BENEFIT TRUST
Board of Trustees
Team of Advisors
Trust Consultants:
DiMartino Associates
Trust Administrators:
(WPAS)
Legal Advisors:
Barlow Coughran Morales & Josephson, P.S.
Trust Auditor:
Anastasi, Moore & Martin, PLLC
Self-Insured Plans
(Here, the Trust assumes most of the risk.
They pay for member medical claims and associated fees)
Fully Insured Plans
(Here, the carrier takes on the risk.)
WPAS
Welfare & Pension Administration Service, Inc. (WPAS)
3rd Party Administrator
HEALTHCARE & BENEFITS
PREMERA BLUE CROSS
PPO Network
Medical & Vision Benefits
DELTA DENTAL
PPO Dental Plans
TELADOC.
SAV-RX Prescription Services
Prescription Drug Benefits
Innovative Care Management
WSCFF
Life, AD&D & Long-Term
Disability Insurance
Life/Disability
ELIGIBILITY
Verification and
enrollment
of members
and dependents
BPAS
BPAS
Benefit Plans
Administrative Services
(BPAS)
VEBA Plan Administrator
HEALTHCARE RETIREMENT ACCOUNT
Individual Member Accounts
Self-Directed Investment Funds

Your Benefits, Your Trust

You work hard. You shouldn't have to spend time reading the fine print of benefit guides to understand what care you and your family are eligible for, what expenses are covered, and how to manage your plans. In this section, we give you the big picture of your benefit plans and how the different pieces and players fit together.

The Big Picture

The Trust does not manage your benefit plans or accounts directly. Instead, we have hired two professional benefit administrators to do this on our behalf: **WPAS** and **BPAS**.

Read on to learn what WPAS and BPAS do for you, but if you're wondering who does what, here are a few shortcuts:

Want to see your claim history, coverage, or submit an insurance claim?

Go to our website at: **www.sffbt.com**

Want to be reimbursed for an out-of-pocket medical expense?

Go to **BPAS** to submit a claim: **www.bpas.com**

Want to save for medical expenses in retirement through your VEBA HRA account?

Go to **BPAS** to manage your investments: **www.bpas.com**

WPAS

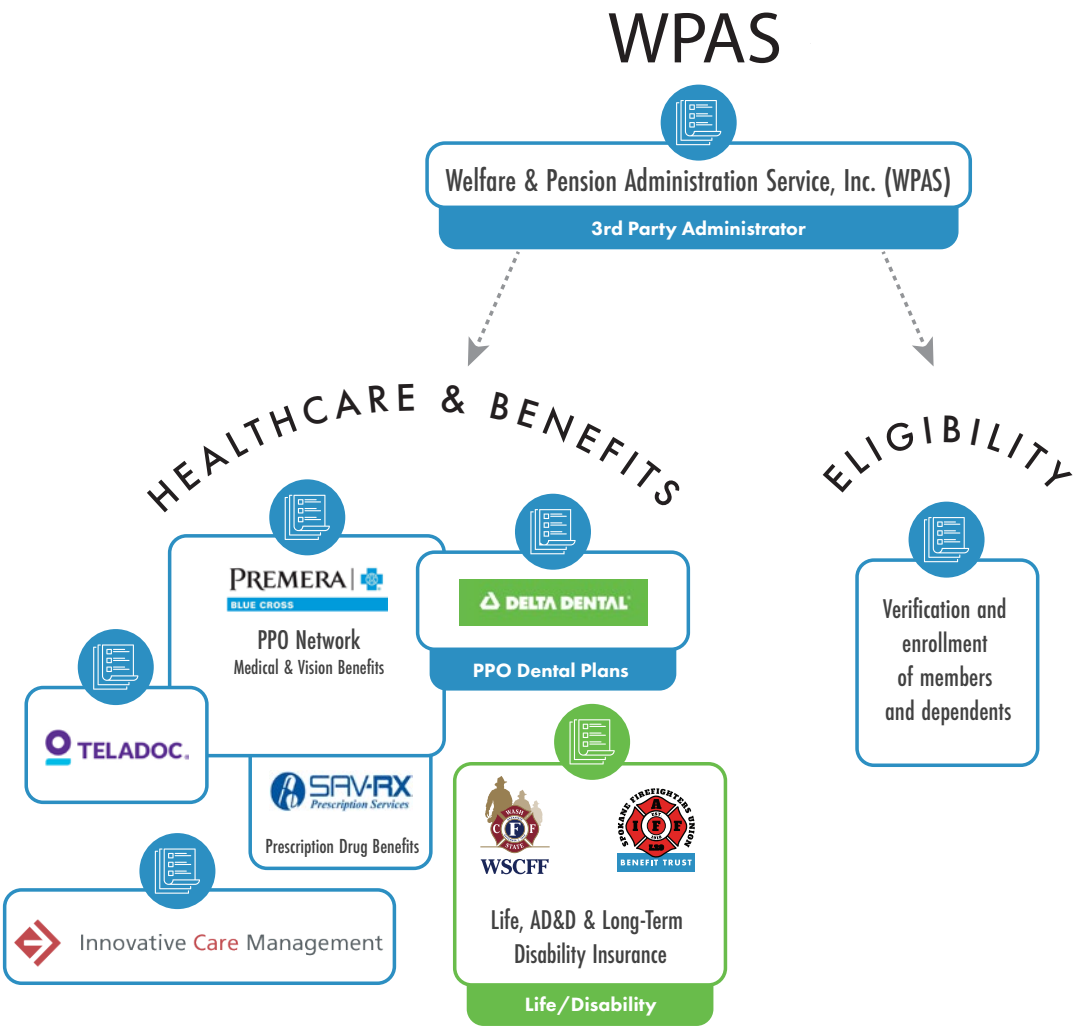
What is WPAS?

WPAS, or the Welfare and Pension Administration Service, administers your medical and other welfare benefits on behalf of the Trust. Every month, a contribution is deposited into your WPAS account to cover medical/vision, dental, prescriptions, and life and long-term disability. Your employer, the City of Spokane or Spokane Airport, makes the bulk of this monthly contribution. The remainder comes out of your paycheck.

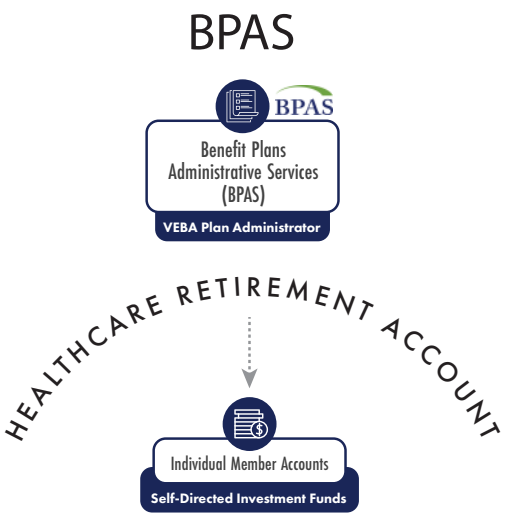
Go to our website [**www.sffbt.com**] to view eligibility and coverage by month for you and your dependents and Explanation of Benefits (EOB) for claims over the last 24 months, amounts paid, and what you are responsible for paying. You will also receive EOBs and statements in the mail.

HOT TIP

Dependents over the age of 13 will need to sign up for individual access to their WPAS account. They, will then receive a PIN and can log in to view their claims. Go to: **www.sffbt.com**.



BPAS



What is BPAS?

BPAS stands for Benefit Plan Administrative Services. BPAS was hired by the Trust to administer your health reimbursement arrangement (HRA), which you can use to cover qualified, out-of-pocket medical expenses for you and your eligible dependents.

Sign in to your account at: www.bpas.com

How does it work?

Your HRA account, which you may know as a VEBA or VEBA HRA, is funded by your employer. Every month, BPAS makes a deposit to your VEBA account on behalf of your employer. BPAS is responsible for handling all your claims, including medical, vision, prescription, and dental. After you have seen a provider and paid the bill, you can submit your claim to BPAS and they will reimburse you from your HRA, usually as a direct deposit to your bank account.

How do I submit a claim?

There are three ways to submit a claim: online, by mail, and through the BPAS app. For more information on how to submit a claim, see *Get Reimbursed for Expenses through BPAS* in the *Paying Bills & Getting Reimbursed* section.

Want to skip filing a claim?

BPAS issues you a benefits card – the Benny – which acts just like a debit card. Simply swipe the card at the provider's office to pay for your co-pay or prescription directly from your HRA. More and more providers are accepting Benny cards, especially pharmacies, and it can be a quick and convenient way to pay.

Is there a time limit for making a claim?

There is no time limit on making a claim. If you have a bill from several years ago that you paid yourself, you can still submit a claim and be reimbursed from your HRA.

NOTE

Using a benefits card is convenient, but paying upfront can create a paperwork headache down the line if your provider does not submit the correct code for the service you received. For example, if your provider submits a code that is not approved by your plan, BPAS will not authorize the transaction. You would then be responsible for requesting documentation from your provider and submitting it to BPAS to support your claim. Failure to do this by a certain date can lead to your card being frozen and declined the next time you use it.

How You and The Trust Share Costs – Example

How Your Co-pay Works

Before deductible

Jane pays her co-pay | Her plan pays the difference

Jane hasn't reached her $1,500 deductible yet.

Office visit costs:	$200
Jane pays her co-pay:	$20
Her plan pays:	$180

After deductible is met

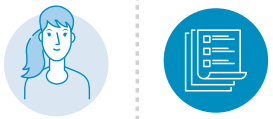
Jane pays her co-pay | Her plan pays the difference

Jane has reached her $1,500 deductible.

Office visit costs:	$200
Jane pays her co-pay:	$20
Her plan pays:	$180

Jane pays her co-pay in both scenarios

After you reach your out-of-pocket maximum*



Jane pays no co-pay | Her plan pays the full cost

Jane has reached both her $1,500 deductible and $2,250 out-of-pocket maximum.

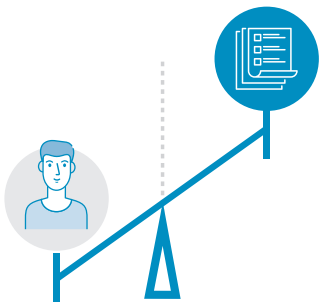
Remaining healthcare costs:	$200
Jane pays her co-pay:	$0
Her plan pays:	$200

*If you have met your out-of-pocket limit, or think you are getting close, please DO NOT pay your co-pay when you check in. This will prevent the need for reimbursement later.

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

How Your Co-insurance Works



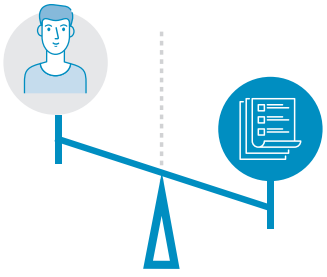
Joe pays **100%** | His plan pays **0%**

Joe hasn't reached his $1,500 deductible...**yet**.

He has gone in for a first procedure. His plan doesn't pay any of the cost.

Procedure cost:	$1,000
Joe pays:	$1,000
His plan pays:	$0

+ MORE COSTS



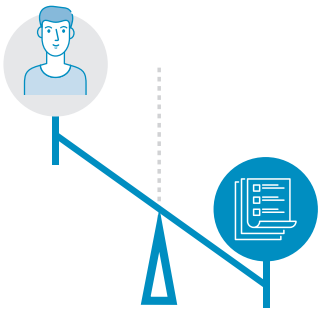
Joe pays **20%** | His plan pays **80%**

Joe finally reaches his $1,500 deductible, so his co-insurance begins.

His plan now pays some of the costs for his next procedure.

Procedure cost:	$3,000
Joe pays:	$600
His plan pays:	$2,400

+ MORE COSTS



Joe pays **0%** | His plan pays **100%**

Joe reaches his $2,250 **out-of-pocket** limit. His plan now pays 100% going forward.

Joe has gone in for two more procedures and paid $2,250 in total. His plan pays the full cost of his covered health care services for the rest of the year.

Remaining healthcare costs:	$5,000
Joe pays:	$0
His plan pays:	$5,000

How Much Does Coverage Cost?

Your 2023 Monthly Member Contributions for Medical/Dental/Vision Coverage:

SFF LEOFF II Active Monthly Contribution	Medical 2023	Dental 2023	Total 2023	*Total 2022*	2023 Change
Employee Only	$60.06	$4.50	$64.56	*$62.25*	$2.31
Employee/Spouse	$182.36	$11.00	$193.36	*$186.35*	$7.01
Employee/Child	$121.21	$14.00	$135.21	*$130.55*	$4.66
Employee/Children	$155.06	$14.00	$169.06	*$163.10*	$5.96
Employee/Spouse/Child	$243.52	$20.50	$264.02	*$254.65*	$9.37
Employee/Spouse/Children	$277.37	$20.50	$297.87	*$287.20*	$10.67

SAFO LEOFF II Active Monthly Contribution	Medical 2023	Dental 2023	Total 2023	*Total 2022*	2023 Change
Employee Only	$126.84	$4.50	$131.34	$126.03	$5.31
Employee/Spouse	$238.64	$11.00	$249.64	$239.63	$10.01
Employee/Child	$188.49	$14.00	$202.49	$194.83	$7.66
Employee/Children	$218.34	$14.00	$232.34	$223.38	$8.96
Employee/Spouse/Child	$300.30	$20.50	$320.80	$308.43	$12.37
Employee/Spouse/Children	$330.15	$20.50	$350.65	$336.98	$13.67

SIA LEOFF II Active Monthly Contribution	Medical 2023	Dental 2023	Total 2023	*Total 2022*	2023 Change
Employee Only	$41.27	$4.50	$45.77	$39.46	$6.31
Employee/Spouse	$91.57	$11.00	$102.57	$91.56	$11.01
Employee/Child	$66.42	$14.00	$80.42	$71.76	$8.66
Employee/Children	$81.27	$14.00	$95.27	$85.31	$9.96
Employee/Spouse/Child	$120.73	$20.50	$141.23	$127.86	$13.37
Employee/Spouse/Children	$141.58	$20.50	$162.08	$147.41	$14.67

When you and/or eligible family members are enrolled in the Trust's medical plan, you and those eligible family members are also automatically enrolled in the Delta Dental plan.

Planning Your Future

The one constant in life is change. We may get married, start families, go through a divorce, experience an illness or disability, or face the death of a loved one. The benefits plan you signed up for when you were hired may not be suitable as your healthcare needs and responsibilities change.

To navigate these changes and ensure your benefits plan is always working for you and your family, read on.

Common Life Changes

Adding a new spouse or child to your benefits plan

If you have recently changed your marital status, or adopted or given birth to a child, you should complete a new enrollment form listing all your current dependents. The new enrollment form should be submitted within 30 days of the marriage license or birth certificate being issued. After 30 days, new dependents can only be added during open enrollment. You can find the enrollment forms on the website.

Adding a dependent to your VEBA

A VEBA account does not have dependent assignments. However, if you have a spouse or eligible dependent (age 26 and under), you can add them to your VEBA account to request reimbursements.

1. Log in to your account at: **www.bpas.com**
2. Once logged in, select "BPAS Claims Portal".
3. Navigate to your "PROFILE" and then access your dependent(s).
4. Click on the "Add Dependent" link.
5. The dependent's name, SSN, date of birth, and relationship information are all required.

If you need additional assistance, please contact BPAS customer service at (855) 404-8322 (VEBA) from 8am to 8pm ET.

VEBA HRA

What is an HRA?

An HRA, or Health Reimbursement Arrangement, is a tax-free* account funded by your employer that you can use to pay for eligible out-of-pocket medical expenses. It is not a savings or insurance program, but rather a financial reimbursement plan that covers eligible medical, vision, and prescription costs up to your deductible.

There are different types of HRAs. The type you have is a **VEBA HRA**.

VEBA = Voluntary Employees' Beneficiary Association

How does my VEBA HRA account work?

Your VEBA HRA is funded by contributions from your employer. Contributions go into your individual VEBA account at BPAS. BPAS was hired by the Trust to administer your VEBA HRA account. You can find details about your VEBA HRA account by logging in at www.bpas.com. **Note: You cannot make a personal contribution to your HRA.**

NOTE

Some members prefer to pay for their own medical expenses and use their HRA to save for retirement instead. It is up to you. Your VEBA HRA is investable, tax-free, and rolls over from year to year, so you can choose to leave your HRA alone and grow over time.*

What are the benefits of a VEBA HRA?

A VEBA HRA is a unique kind of HRA that has two main advantages. The first is that unused funds in your VEBA account roll over from year to year, which gives you the option to invest a portion of this money in the stock market and save for medical expenses in retirement. The other benefit is that a VEBA HRA saves you money because you pay no tax on what your employer contributes, your account earnings, or the funds you withdraw for medical claims.

What if I'm new to the job?

If you are new to the job and your HRA has not accumulated enough to cover your out-of-pocket expenses, the Trust may be able to advance you the funds, as you will accrue the money eventually.

**VEBA money used for inelegible expenses becomes taxable income in the year spent. In addition, there is a penalty tax applied to the gross amount.*

Life and Long-Term Disability Insurance - Policy & Plans

Protect what matters most

When life doesn't go as planned, insurance is a safety net that can help protect you and your loved ones.

Life insurance helps provide support and stability to your family if something were to happen to you, your spouse, or your children. It can help your family financially through a difficult time and provide support into the future.

Accidental Death and Dismemberment (AD&D) insurance helps protect against a sudden financial loss brought on by an accidental death. It can also help pay for the high cost of living associated with surviving an accident that results in a severe physical loss.

Long-Term Disability insurance is designed to pay a monthly benefit to you in the event you cannot work for 120 or 180 days or longer because of a covered illness or injury.

Your insurance benefits

Local 29 members are eligible for the following insurance benefits on the date they become a member:

- Basic Life and AD&D Insurance
- Basic Dependent life Insurance
- Long-Term Disability (LTD) Insurance

This insurance coverage is provided through two different policies – one through the Trust and another through the Washington State Council of Fire Fighters (WSCFF). The Standard is the insurance provider for both policies.

Policy #1: Your Insurance through the Trust

Basic Life/AD&D and Basic Dependent Life Insurance

You are automatically enrolled in this insurance plan on the date you become a member of the Trust. This insurance coverage comes at no cost to you and is provided through the Trust and insured by The Standard. The policy includes basic coverage for you, your spouse, and dependent children (up to age 26). The only thing you need to do to manage this coverage is designate your beneficiaries. The coverage amount is described below.

Eligibility

Definition of a Member	You are a member if you are a member in good standing with Spokane Fire Fighters Union Local 29. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the date you become a member.

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $50,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is $50,000. For other covered losses, a percentage of this benefit will be payable.
Basic Dependents Life Coverage Amount	The Basic Dependents Life coverage amount for your eligible spouse is $1,000. Your spouse is the person to whom you are legally married, or your domestic partner as recognized by law. The Basic Dependents Life coverage amount for each of your eligible children is $1,000.

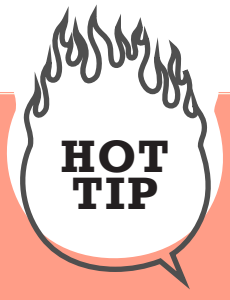
Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag Benefit
- Family Benefits Package
- Line of Duty Benefit
- Seat Belt Benefit

Be sure your beneficiary designation is up to date. To designate or make changes to your beneficiaries, or for general questions about your plan, contact the Trust office at (888) 563-0665. Life insurance proceeds are payable to the last person you listed as your beneficiary, so check periodically and make changes if necessary.



Purchasing additional life insurance

If you want more coverage than your basic life insurance plan provides, you have the option to purchase additional "Voluntary Life Insurance" for yourself, your spouse, and/or dependent children. You can increase or decrease this coverage as needed, over the years with life changes like marriage, divorce, or the birth of children.

You can apply for additional life insurance at any time. Begin by contacting the Trust Office, which will provide you with more information, an Enrollment Change Form, and a form for designating your beneficiaries. They will also be able to tell you what documentation The Standard requires for purchasing additional life insurance. For example, if the coverage purchased is over $50,000 for yourself or over $20,000 for your spouse, you will need to provide Evidence of Insurance (EOI) and a Medical History Statement. To complete your medical history, visit: **www.standard.com/mhs**.

"How much life insurance do I need?"

After a death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Burial expenses
- Medical bills
- Your children's education
- Daily expenses

The amount of insurance you need will depend on your unique circumstances, but consider how much would be needed to cover these and other types of expenses, and maintain your family's standard of living.

How much can I apply for?
The coverage amount for your spouse and for your children cannot exceed 100% of your additional life insurance coverage.

For You:	**$10,000 – $300,000 in increments of $10,000**
For Your Spouse:	**$10,000 – $300,000 in increments of $10,000**
For Your Child(ren):	**$2,000, $5,000 or $10,000**

How much would additional life insurance coverage cost?

Use this formula to calculate your premium payment:

_____ ÷1000 = _____ x _____ = _____

Enter the amount of coverage you are requesting (see benefit amounts in the *About This Coverage* section of The Standard guide).

Enter your rate from the rate table.

This amount is an estimate of how much you would pay each month.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your spouse's rate.

If you buy coverage for your child(ren), your monthly rate is $0.20 per $1,000, no matter how many children you're covering.

Age (as of last January 1)	Your Rate (Per $1,000 of Total Coverage)		Your Spouse's Rate (Per $1,000 of Total Coverage)	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<30	$0.12	$0.08	$0.12	$0.08
30-34	$0.14	$0.09	$0.14	$0.09
35-39	$0.14	$0.09	$0.14	$0.09
40-44	$0.24	$0.16	$0.24	$0.16
45-49	$0.44	$0.29	$0.44	$0.29
50-54	$0.70	$0.46	$0.70	$0.46
54-59	$1.12	$0.81	$1.12	$0.81
60-64	$1.45	$0.97	$1.45	$0.97
65-69	$2.38	$1.71	$2.38	$1.71
70-99	$3.83	$2.85	$3.83	$2.85

Questions?

If you have changes or questions about your Trust-provided insurance plan, including purchasing additional life insurance, contact the Trust Office at: (888) 563-0665.

NOTE

But wait, there's more!

The information here is only a brief description of the group Basic Life/AD&D and Basic Dependents Life Insurance policy sponsored by the Trust. For complete details of coverage and the nitty gritty details of your plan, have a look at The Standard benefits booklet you received in your new employment packet.

Policy #2: Your Insurance through the Washington State Council of Fire Fighters (WSCFF)

As a Trust member, you are also enrolled in long-term disability (LTD) insurance through the Washington State Council of Fire Fighters (WSCFF). This is part of a group plan for Washington firefighters that also comes with some basic life insurance coverage for you and your dependents. You are automatically enrolled in the plan if you were hired after 2010, as part of your initial onboarding. Premiums are based on your salary, and there is nothing you need to do to manage this plan, other than adding and updating your beneficiaries.

WSCFF Life & Disability Program - Plan 2 Benefit Summary

Life/AD&D and Long Term Disability Insurance

Standard Policy #771100

Effective 1/1/2019

For copies of policy certificates and/or help filing a claim, please contact DiMartino Associates.

Phone (206) 623-2430 or toll-free at (800) 488-8277

Basic Term Life Insurance	
Employee Basic Life Benefit	$15,000; paid to your beneficiary if you die for any reason
Dependent Life Benefit—Spouse and Dependent Child to age 26	$1,000; paid to you if your spouse or dependent child die for any reason
Benefit Reduction Schedule	Amount your benefit reduces to if you are still working: 50% at age 70, 40% at age 75 and 20% at age 80+
Waiver of Premium	Your Basic Life insurance will continue without payment of premiums while on long-term disability with The Standard; must be disabled prior to age 60
Portability	Employee and covered dependents may port Basic Life insurance until age 70; see Portability rates in your Policy Certificate
Accelerated Death Benefit	You may be eligible to receive an accelerated benefit of 75% to a maximum of $500,000 of your Basic Life insurance if you have a qualifying medical condition; must be under age 60 to qualify
Conversion	Included. Member may convert to a whole life policy upon termination; subject to market rates.

Basic Accident Insurance		
Employee Basic AD&D Benefit	$15,000; paid to your beneficiary if you die as a result of an accident; partial benefit paid for certain dismemberments. See Schedule of Coverage.	
Schedule of Coverage *(Refer to Policy Booklet for full Schedule of Coverage)*	Loss of one hand or one foot	50% of Principal Amount
	Loss of sight in one eye, speech or hearing in both ears	50% of Principal Amount
	Two or more of the above losses	100% of Principal Amount
	Thumb & index finger on same hand	25% of Principal Amount
	Quadriplegia	100% of Principal Amount
	Paraplegia	50% of Principal Amount
	Hemiplegia	50% of Principal Amount
Benefit Reduction Schedule	Amount your benefit reduces to if you are still working: 50% at age 70, 40% at age 75 and 20% at age 80	
ADDITIONAL BENEFITS:		
Child Care Benefit	The total child care expense incurred by your spouse within 36 months after the date of your death for all children under age 13, but not to exceed $5,000 per year or the cumulative total of $10,000 or 25% of the AD&D benefit, whichever is less	
Public Transportation Benefit	The lesser of (1) $200,000 or (2) 100% of the AD&D benefit otherwise payable for the loss of your life	
Occupational Assault Benefit	The lesser of (1) $25,000 or (2) 50% of the AD&D benefit otherwise payable for the loss of your life.	
Line of Duty Benefit	Additional 100% of Principal Amount payable upon receipt of due proof that covered person, while serving in the Line of Duty, suffers a covered loss that results directly and independently of all other causes from a covered accident	
Seat Belt Benefit	The lesser of (1) $10,000 or (2) the amount of AD&D benefit otherwise payable for the loss of your life	
Higher Education Benefit	The tuition expenses for training incurred by your spouse within 36 months after the date of your death, exclusive of room and board, but not to exceed $5,000 per year, or the cumulative total of $10,000 or 25% of the AD&D benefit, whichever is less	

Questions?

For questions about your plan, benefits, and filing a claim, contact the Washington State Council of Fire Fighters Account Specialist, Teri Nisbett, at teri@dmarinc.com.

Long-Term Disability Insurance	
Benefit Waiting Period	90 days Number of calendar days you must be disabled before a benefit is payable
Maximum Benefit Duration	To age 62
Monthly Benefit	60% of Covered Earnings; maximum $5,000/month
Minimum Benefit	$100/month
Definition of Disability	24 month Own Occupation; followed by Any Occupation for the remainder of the benefit period. **Own Occupation Period:** For the first 24 months of your long term disability, you are disabled if you are unable to perform the material duties of your "own" occupation. **Any Occupation Period:** After 24 months, you are disabled if you are unable to perform the material duties of "any" occupation which you are reasonably suited for, based on education or experience, and at which you can be expected to earn at least 60% of what you were making prior to becoming disabled.
Deductible Income	Your benefit will be reduced by certain other income you are eligible to receive from other sources: Work Earnings, Sick Leave, LEOFF/PERS Retirement Benefits, Worker's Compensation, Other Group Disability Benefits and Washington State PFML benefits. See Policy Certificate for full list of Deductible Income sources.
LEOFF Integration	For the first 12 months that you are receiving your LEOFF or PERS retirement benefit, you may keep up to 100% of pre-disability earnings between the two. After 12 months, your LTD benefit is reduced by the amount you receive in LEOFF or PERS benefits, dollar for dollar.
Pre-Existing Condition Limitation	3 month look back / 3 month symptom free / 12 months insured
Mental Illness/ Substance Abuse Limitation	24 months per incident benefit for disabilities arising from a mental illness or from substance abuse.
Subjective Condition Limitation	24 months per incident for disabilities arising from a musculoskeletal issue or other subjective condition. See Policy Certificate for more information.
Taxation of Benefit	If monthly LTD premiums are paid with post-tax dollars, the LTD benefit will be tax-free to the member. If premiums are paid pre-tax, the benefit will be taxable.

This benefit summary is only a summary of the benefits and not intended to replace the specifics of the Plan Contract. If there is a discrepancy , the Plan Contract will supersede this summary.

LONG-TERM DISABILITY CLAIMS

FAQs

QUESTION	ANSWER
When should I report a claim?	Report a claim as soon as you believe you will be absent from work. Contact DiMartino Associates for more information on your benefit waiting period. If you are not sure how long you will be absent or whether you should file a claim or not, we suggest that you file your claim. This offers you some peace of mind and allows The Standard to begin its review and issue a timely payment if appropriate.
How do I file a claim?	To file a paper claim, contact Washington State Council of Fire Fighters Account Specialist, Teri Nisbett at teri@dimarinc.com or call DiMartino Associates at (206) 623-2430. A typical application for disability benefits contains the following documents: • Employee's Statement • Employer's Statement • Attending Physician's Statement (APS) • Authorization to Obtain and Release Information
When I report my claim, what information will I need to provide?	You will be asked to provide the following information - in addition to other questions about your absence: • Policyholder: Washington State Council of Fire Fighters • Group ID: 10141971 • Name and Social Security number • Last day you were at work • Nature of claim/medical information • Physician's contact information (name, address, phone and fax number)
Where do I send the completed forms?	Completed forms may be mailed to: Standard Insurance Company P.O. Box 2800 Portland, OR 97208 Or if you prefer, fax the completed forms to (800) 378-6053

LONG-TERM DISABILITY CLAIMS

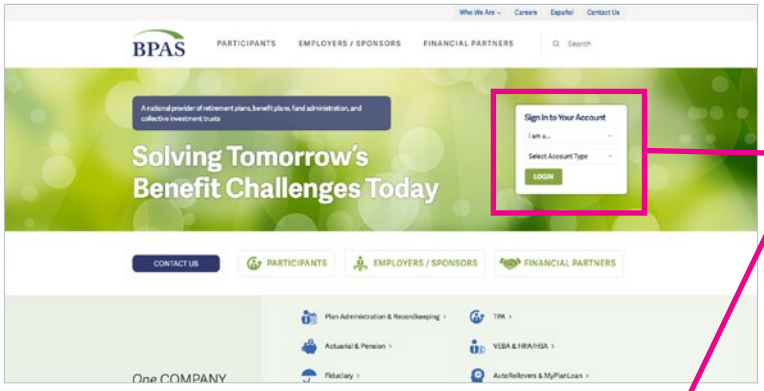
FAQs *continued*

QUESTION	ANSWER
What can I expect after I submit the completed forms?	Once The Standard receives the required paperwork, which includes the Employee's Statement, Employer's Statement, Attending Physician's Statement and Authorization to Obtain and Release Information, your benefits analyst will contact you to discuss any additional information that may be necessary to complete the processing of your claim and to answer any of your questions.
If my claim for benefits is approved, how long will it take to receive my first check?	After the Benefit Waiting Period as outlined in your group policy is served, LTD benefit payments are paid in arrears on a monthly basis based on the date of disability and are mailed directly to your residence. LTD benefit payments that are payable for retroactive claims will be paid immediately following claim approval.
Who should I call with questions about my claim?	If you have already filed a claim, please call The Standard's Disability Benefits toll-free number, (800) 368-1135. If you are looking for general information, please contact the Washington State Council of Fire Fighters.
Who Is responsible for notifying my employer of my absence?	It is your responsibility to follow your employer's absence reporting procedures by notifying your manager or supervisor of your absence.
Where do I send the completed forms?	Completed forms may be mailed to: **Standard Insurance Company** P.O. Box 2800 Portland, OR 97208 Or if you prefer, fax the completed forms to (800) 378-6053.

How to manage your HRA investments

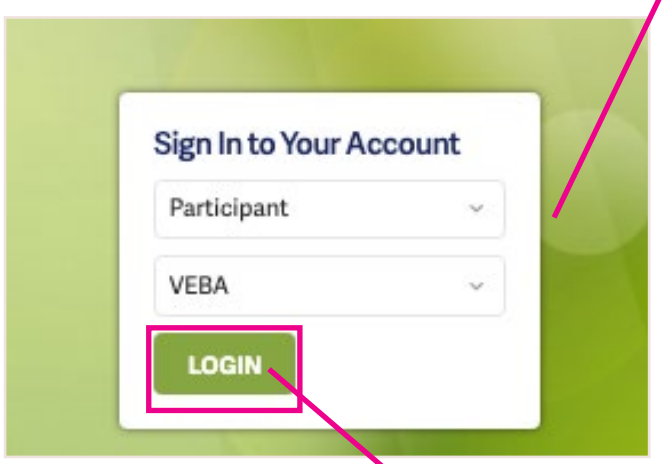
Although your VEBA HRA can be used to pay for out-of-pocket medical expenses, many Trust members choose to use their account to save for medical expenses in retirement. Selecting and managing your investment allocations and rates of return will help you to make the most of your money. This is called a 'Fund Election Change', and this is how you do it:

BPAS Home Page



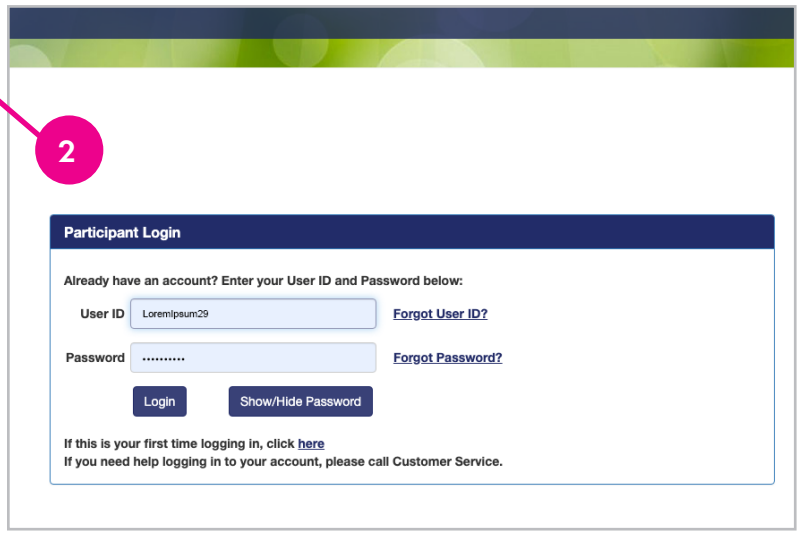
1 *Start at the BPAS.com home page*

BPAS Claims Portal

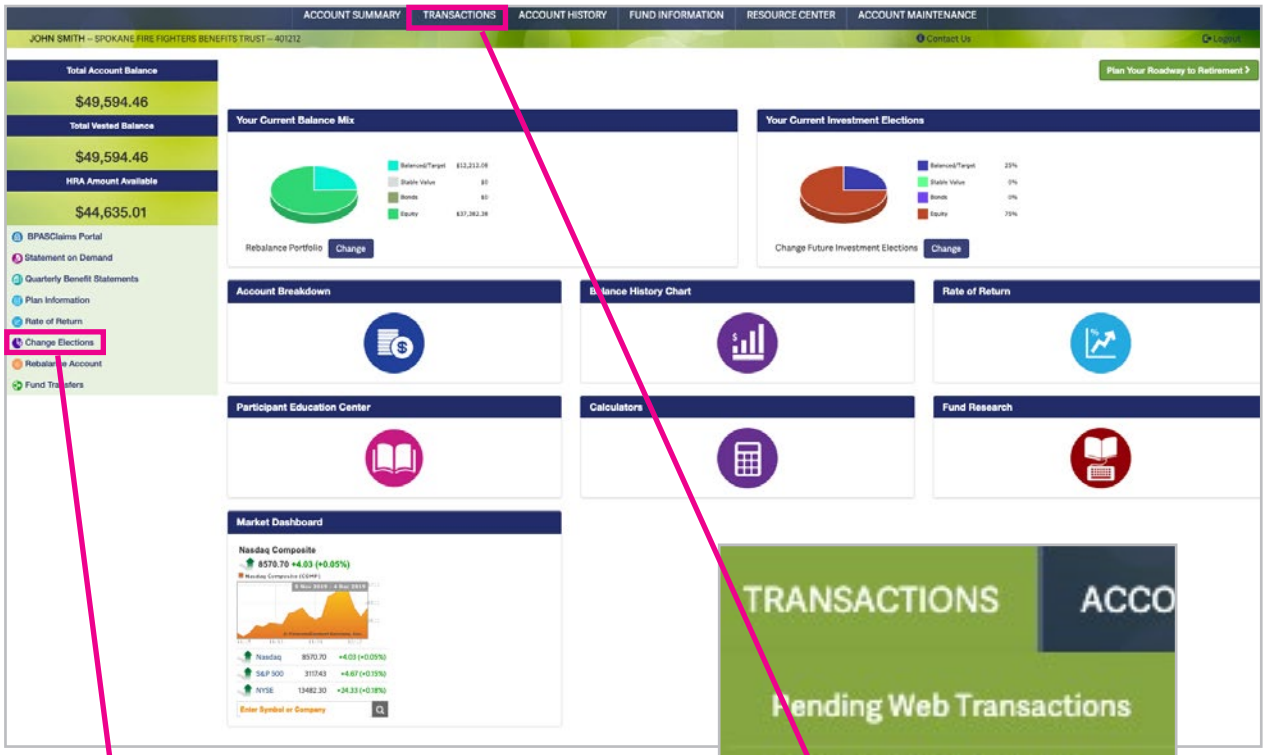


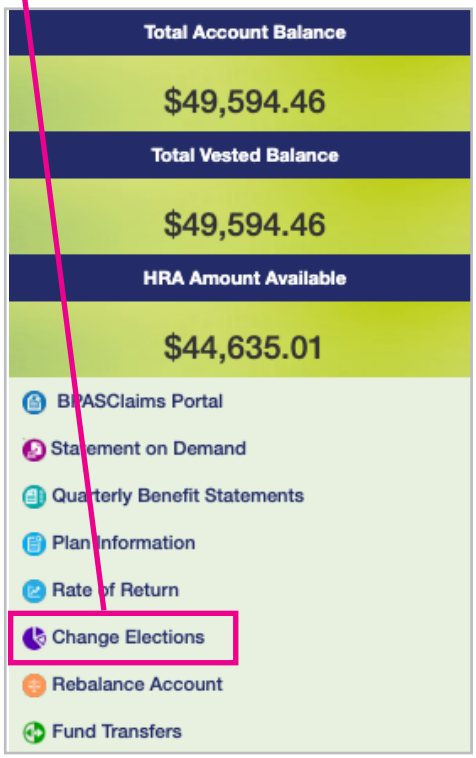
Make sure **Participant** *is selected in the first dropdown and* **VEBA** *is selected in the second dropdown. Then click LOGIN.*

2 *Enter your user ID and Password. This will take you to your dashboard.*



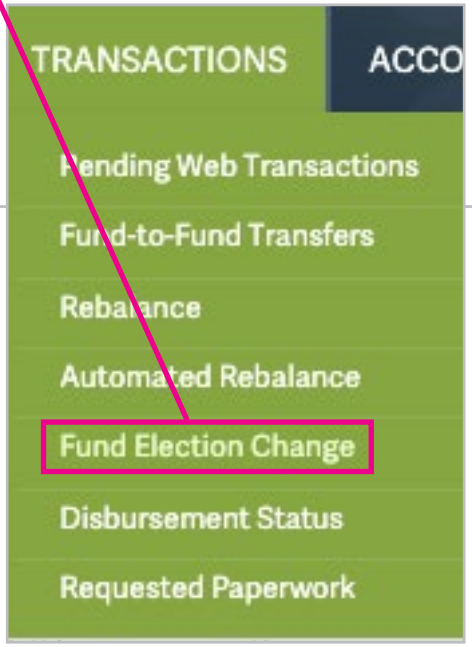
There are two ways to get to your Fund Election Change page from the dashboard:



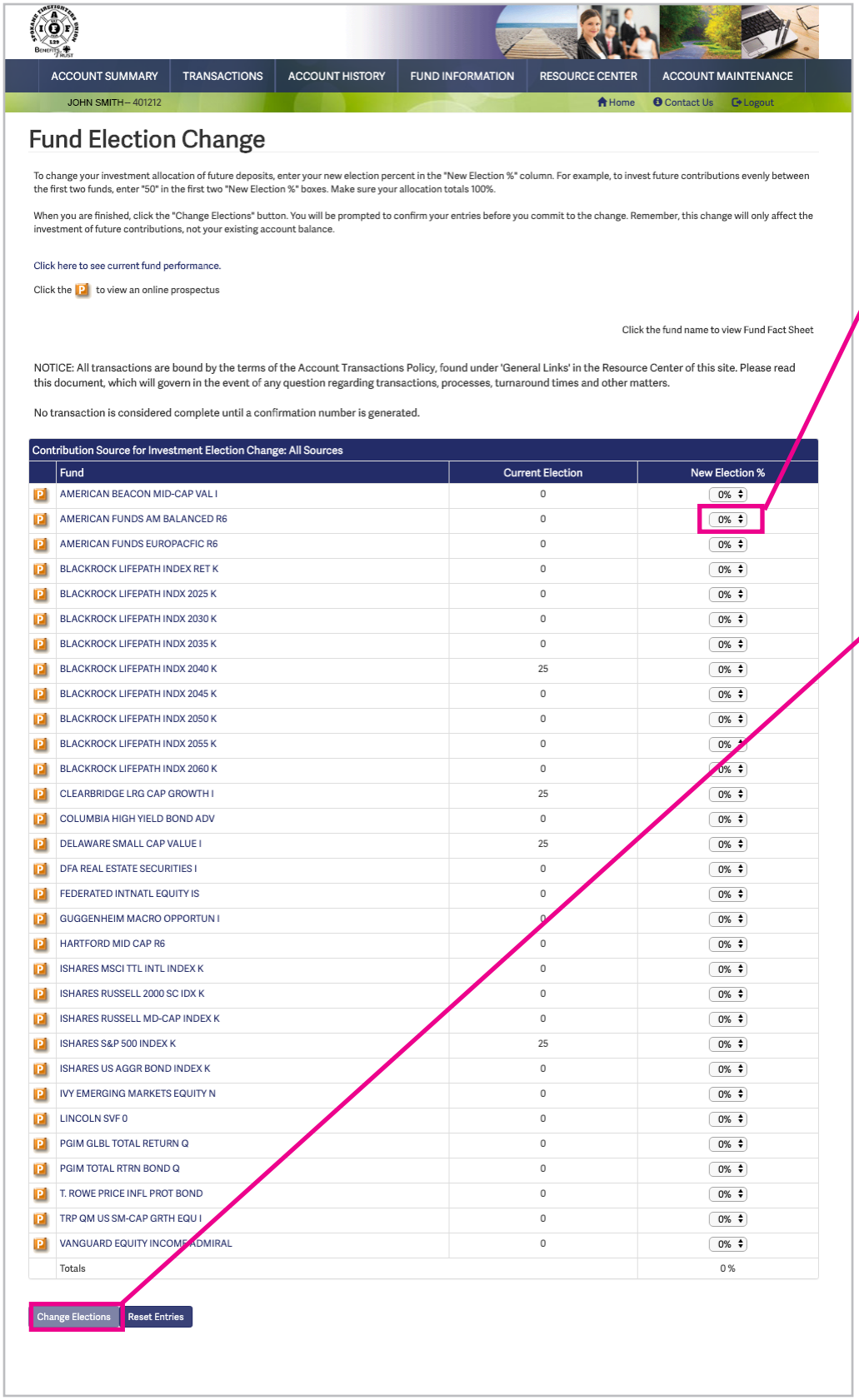


FUND ELECTION CHANGES
On the left side of the screen, click on **Change Elections**.

3



Or... *at the top you can click on* **Transactions** *then select* **Fund Election Change** *from the dropdown menu.*



4

On the **Fund Election Change** *page, you can change the percent of your contributions to different funds.*

*Once you've made changes, don't forget to click the "***Change Elections,***" button at the bottom of the page.*

RETIREMENT & SPOUSAL BENEFITS

FAQs

QUESTION	ANSWER
Can I have my retiree premium deducted from my DRS check?	Yes, if you authorize a deduction, your premium can be deducted.
When I reach Medicare age, can my spouse continue this policy until they reach Medicare age?	Yes, your spouse can continue the under 65 retiree coverage until they are eligible for Medicare themselves.
Will the Trust offer a Medicare supplement plan? Will my spouse be eligible for that?	All retired IAFF Fire Fighters and their eligible spouses are eligible to purchase MediGap and Medicare Supplemental coverage offered through the Northwest Fire Fighters Trust. Contact their office at: (866) 265-5231.
Who do I contact for retiree health information?	Contact the Trust Office at (888) 563-0665 ext. 3320
Can my spouse continue my retiree benefits coverage after my death?	Yes, spouses of retired members can continue the under 65 retiree coverage or the Medicare options (if spouse is Medicare eligible) even after the death of the firefighter.

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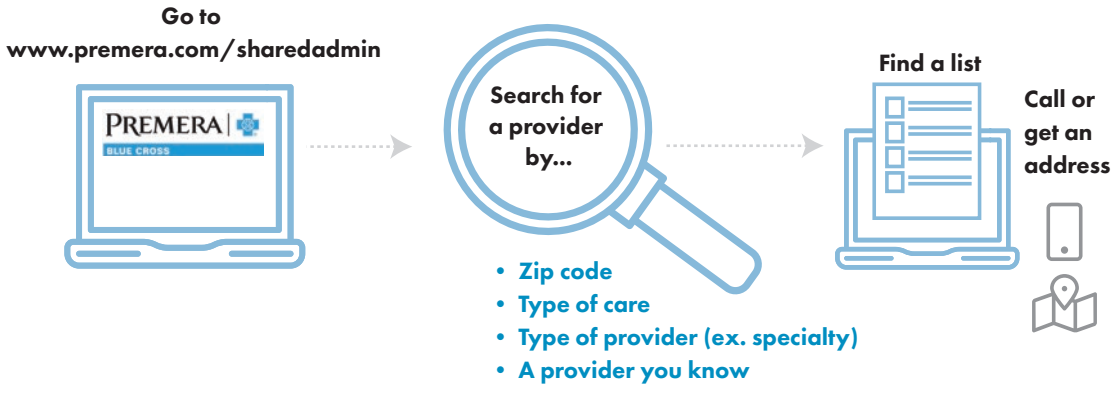
Overview

Navigating the healthcare system and health insurance is a full-time job. This is why the SFFBT exists: to negotiate excellent medical and other welfare benefits for our members at competitive costs, and to provide the information and resources you need to access care and make the experience as smooth as possible.

Here, we walk you through the steps of finding a doctor and getting care, from your annual firefighters medical exam to check-ups for your kids.



Preparing for Your Visit

Ask yourself and write down the answers to the following questions before your visit:.

- What is the reason for my visit?
- What are my main questions and concerns (try to limit to one sentence, if possible)?
- What symptoms am I having?
- When did my symptoms start?
- Other healthcare providers I have seen recently
- Family history & medical history
- Medication list – include OTC and supplements
- Is there anything else my provider should know?

ER vs. Urgent Care vs. Primary Care

EMERGENCY CARE is for severe, life-threatening conditions	Emergency departments are open 24 hours a day, seven days a week. They offer the widest range of services for emergency, after hours care, including diagnostic tests and access to specialists. It is the most expensive option.
URGENT CARE is for quick, non-emergency treatment	Urgent care centers provide same-day care for many illnesses and injuries. Urgent care is good when you need treatment fast, but it's not an emergency. Go there if it's after hours or you can't wait for an appointment or the on-call doctor to return your call on weekend.
PRIMARY CARE is for everyday healthcare	Your primary care doctor is the best place to start because they manage your care, know your medical history, and have full access to your patient records.
TELADOC is care is provided via phone call, online video, or other online media	Virtual care is not meant to replace your relationship with your primary care provider or to replace all in-person, face-to-face visits. It is just another option for you to receive healthcare services. In some cases, it can also help you and your family avoid a trip to the emergency room for non-emergency care.

Annual Firefighter Medical Exam

The SFFBT has partnered with MultiCare Rockwood Spokane Valley Primary Care (formerly known as Spokane Internal Medicine or SIM) to offer Local 29 members a comprehensive firefighter medical exam at no cost.

Who is eligible?

The medical exam is available to all active Local 29 members and retired members who are non-Medicare eligible retirees participating in a SFFBT health plan.

Why is there a medical exam specifically for firefighters?

We have developed this program because of the specific risk factors associated with being a fire fighter. We are at elevated risk for certain types of cancer, respiratory issues, arthritis, allergic reactions and depression, often linked with higher suicide rates. Early detection and treatment is critical to addressing these diseases successfully. Our goal is to remove as many barriers as possible from the process.

We have worked closely with MultiCare physicians to develop an exam profile that meets our clinical needs as firefighters. Our goal is to remove as many barriers from this process as we can.

IMPORTANT: Your exam and the results are completely confidential. Your results will not be shared with the City, the Local, the Trust or anyone else you do not specifically authorize in writing. Under federal law, MultiCare can only share your results with your written consent.

Please review the FAQs on the next page for information on how to schedule the exam and what to expect before, during, and after the exam.

Make your appointment by September 30th

Fire fighters, you must complete your appointment before the September 30th deadline to earn your bonus VEBA contribution for the year.

Members can book an appointment by calling ***(509) 598-7749.***

Generally, appointments are only a couple of weeks out.

ANNUAL FIRE FIGHTER MEDICAL EXAM

FAQs

MultiCare

Question	Answer
How do I make an appointment?	Contact MultiCare Rockwood Spokane Valley Primary Care at (509) 598-7749
Who can I contact at MultiCare if I have questions about my exam?	Ask for Maranda, or please leave a voicemail and she'll return your call within 2-3 business days.
At what location will my exam take place?	Exams will be done at: 1215 N McDonald Rd #101
Will this exam cost me anything?	The exam itself is fully paid for by SFFBT. In the event you are referred out for additional testing or procedures, coverage will depend on the diagnosis or reason for the referral. Please contact WPAS at 888-563-0665 if you have additional questions regarding outside services.
Will I (or my primary care physician) receive my exam results?	Your primary care physician can receive your results only if you authorize it in writing.
With whom else will my exam results be shared?	Your results will not be shared with anyone. Under federal law, MultiCare can only share your exam results with your written consent.
Could follow-up testing or care occur based on the results of my exam?	While this would not be typical, in some instances your physician may recommend further testing or refer you to your primary care physician for additional follow up.

If you have any questions or concerns about the annual medical exam, please reach out to a Trustee or visit the Trust website at www.sffbt.com.

Current Medical Plan Summary

PREMERA BLUE CROSS

Medical Benefits	CLASSIC Plan Premera Blue Cross	
	BlueCard PPO Network Providers	All Other Providers
Deductible	$1,500 per Member / $3,000 per Family	
Coninsurance	Plan pays 80% / Member pays 20%	Plan pays 60% / Member pays 40%
Medical Out-of-Pocket Maximum	$2,250 per person / $4,500 per Family Deductible, all copays (except Rx copays), and coinsurance accrue to this maximum	
Office Visit Copay	$20 Copay	60% after Deductible
Outpatient Lab & Radiology Services	100%; Deductible Waived	60% after Deductible
Physical Inpatient (surgery, diagnostic procedures, etc.)	80% after Deductible	60% after Deductible
Preventive Care	100%; Deductible Waived	60% after Deductible
Spinal Manip./Chiropractic 24 visits PCY	$20 Copay	60% after Deductible
Emergency Room	$100 Copay, then 80% after Deductible (Copay is wavied if admitted to hospital)	
Ambulance Services	80% after Deductible	
Urgent Care	$20 Copay	60% after Deductible
Acupuncture 24 visits PCY	$20 Copay	60% after Deductible
Home Health Care 130 visits PCY	80% after Deductible	60% after Deductible
Hospice Care	80% after Deductible	60% after Deductible
Mental Health (Inpatient)	80% after Deductible	60% after Deductible
Mental Health (Outpatient)	$20 Copay	60% after Deductible
Chemical Dependency (Inpatient)	80% after Deductible	60% after Deductible
Chemical Dependency (Outpatient)	$20 Copay	60% after Deductible
Rehabilitation Services (Inpatient) 30 days PCY	80% after Deductible	60% after Deductible
Rehabilitation Services (Outpatient) 45 days PCY	$20 Copay	60% after Deductible
Transplants	80% after Deductible	Not Covered

This benefit comparison is only a summary of the benefits and not intended to replace the specifics of the Summary Plan Description. If there is a discrepancy, the Plan Contract will supersede this summary.

To find a participating provider, please visit www.premera.com/sharedadmin

Current Vision Plan Summary

Vision Plan Benefits

As of January 1st, 2020, your vision plan benefits include a benefit for elective refractive corrective surgery, not the result of cataracts (e.g. LASIK Surgery). There are two very important conditions with this change. First, there is a **lifetime maximum benefit of $2,400**. Second, when you use this benefit, it is in lieu of any future hardware benefit (frames, lenses, contacts) under the Plan. **You would remain eligible for an annual eye exam, however, you will no longer be eligible to receive benefits for lenses, frames, or contacts.** Please contact the Trust office for full details on how to use this benefit.

Vision Benefits	
Vision Exam	Covered in full
Vision Hardware	100% up to $600 every two calendar years
Corrective Elective Refractive Surgery (non-cataract)	Up to a $2,400 lifetime allowance for elective refractive surgery, in lieu of any future benefits for hardware (frames, lenses, or contacts)

Virtual Care through Teladoc

Virtual care gives you immediate and convenient access to care whenever and wherever you need it. Under your medical plan, you can receive care from a doctor through the national provider service, Teladoc. This care is provided via phone call, online video, email, or other online media.

Virtual care is not meant to replace your relationship with your primary care provider or to replace all in-person, face-to-face visits. It is simply another healthcare service option for you. In some cases, it can also help you and your family avoid a trip to the emergency room for non-emergency care.

Common conditions handled by virtual care providers include:

- Cold and flu symptoms
- Dermatology
- Nasal congestion and sinus problems
- Bronchitis
- Respiratory infections
- Allergies
- UTIs
- Ear infections

Additional Teladoc services – Adult Teladoc Behavior Health

The Teladoc behavioral health program is a comprehensive solution offering members ongoing access to diagnosis, talk therapy, and prescription/medication management when appropriate. Teladoc allows members to choose the type of behavioral health visit based on provider specialty.

Members may request a phone or video behavioral health visit with a provider seven days a week, from 7am to 9pm local time. Teladoc does not offer urgent/emergency behavioral health services and is not a crisis line. Members must request visits 72 hours in advance to allow time for the provider to review the request and then respond to the member to set up the behavioral visit with the right type of provider.

Common behavioral health conditions treated:

- Depressive disorders
- Anxiety disorders and phobias
- Bipolar and related disorders
- Schizophrenia and psychotic disorders
- Attention disorders
- Addiction and substance disorders
- Eating disorders
- Obsessive compulsive-related disorders
- Sleep/wake disorders
- Neurocognitive disorders and dementia

How Teladoc Works

1. Register

Create an account and fill out a health history. We highly recommend doing this before you need to use Teladoc for yourself or a family member. This can be done online or on the phone. You can also register your covered family members. To save time later, identify your primary care doctor and preferred pharmacy.

2. Consult a physician anytime

When you want to consult with a Teladoc physician, you can contact them by phone, online video, email, or other online media. You then provide your contact information and your current location. Virtual care services, such as consultations and prescriptions, may vary depending on your current location. A doctor will call back right away or at the time you request.

3. Continuity of care with your local doctor

If you have provided the name of your primary care doctor, Teladoc will send a record of the consult by fax or electronic medical record transfer.

Premera now covers virtual care

Members can contact Teladoc at **(855) 332-4059** or by visiting the website at: www.teladoc.com/premera. When you call, tell the representative that you are a Premera member.

Current Prescription Drug Plan Summary

SFFBT prescription drug benefits are offered through Sav-Rx Prescription Services. The Sav-Rx Network consists of over 65,000 pharmacies nationwide and is accepted by all major chain pharmacies and most independent ones.

Your prescription drug benefit information can be found on your Premera ID Card. You should present this card at your pharmacy when having a prescription filled.

If you have any questions about your prescription drug benefits, including questions about mail order, formulary and prior authorizations, you can reach Sav-Rx 24 hours a day, 7 days a week at (800) 228-3108.

Note: Specialty medications must be filled at Sav-Rx Specialty Pharmacies.

SFFBT Prescription Drug Benefits	
Prescription Drug Out-of-Pocket Maximum (Includes all Mail Order and Retail Rx Copays)	$250 per Individual / $500 per Family
Preventive Medications	Covered at 100% *Per Affordable Care Act (ACA) Guidelines; contact Sav-Rx for more information*
Retail Prescription Drug Copays	
Generic Medications	$5 Copay
Formulary Brand Name Medications	$25 Copay
Non-Formulary Brand Name Medications	$50 Copay
Sav-Rx Mail Order Prescription Drug Copays - 90-day Supply	
Generic Medications	$10 Copay
Formulary Brand Name Medications	$50 Copay
Non-Formulary Brand Name Medications	$100 Copay
Specialty Medications	Applicable Copay applies; 30-day supply only **Must be filled via Sav-Rx Specialty Mail Order Pharmacy**

Non-Participating Pharmacies: You will need to pay the full price of the drug and submit a claim for reimbursement. After you've paid the applicable copay, you pay 40% of the allowable charge for the prescription and the difference between the pharmacy's billed charge and the allowable charge.

Dental Care

Delta Dental is your plan's dental provider. The Delta Dental website [www.deltadentalwa.com] is simple to navigate with helpful tools, such as a cost estimator. Login to your account to find a dentist, view and download your explanation of benefits, pay your bill, or see what is covered by your plan. You and your dependents each have your own page within your online account, which makes it easy to view everyone's benefits and care history all in one place.

Current Dental Plan - Delta Dental

- There are no changes to the Delta Dental Plan for this year.
- You (and any family members you've elected to receive medical coverage) will automatically be enrolled in the Delta Dental PPO dental plan.
- Delta offers the broadest PPO network with the best provider discounts through the national Delta Dental Network.

To find a Delta Dental participating dentist, please visit www.deltadentalwa.com

Benefits	Delta Dental Plan		
Network	**Delta Dental PPO Dentist**	**Delta Dental Premier Dentist**	**Non-Participating Dentist**
Class I - Diagnostic & Preventive Exams, Prophylaxis, Flouride, X-rays, Sealants**. Class I services do not reduce your annual maximum benefit.**	100%	100%	100%
Class II - Restorative - Diagnostic & Preventive Restorations, Endodontics, Periodontics, Oral Surgery	80%	70%	70%
Class III - Major Crowns, Dentures, Partials, Bridges, Implants	80%	70%	70%
Annual Maximum	$1,250	$1,250	$1,250
Annual Deductible - Waived on Class I benefits	$25 per Member $50 per Family	$25 per Member $50 per Family	$25 per Member $50 per Family
Orthodontia Benefits - Adults & Children Benefits paid accumulate against annual plan maximum	50%	50%	50%
Balance Billing - Can Dentist charge more than Delta Dental allowable amount?	No	No	Yes

This benefit comparison is only a summary of the benefits and not intended to replace the specifics of the Plan Contract. If there is a discrepancy, the Plan Contract will supersede this summary.

**Out-of-pocket costs will always be less when you see a Delta Dental PPO dentist. Delta Dental PPO and Premier dentists have negotiated contracts and cannot charge you more than the allowable amount. Non-Participating dentists may "balance bill" you for amounts in excess of what Washington Dental Service / Delta Dental allows.*

DENTAL

FAQs

QUESTION	ANSWER
How do I register for an account at Delta Dental?	It's easy. Go to www.deltadentalwa.com, click on 'Register' at the top and follow the prompts. Once you've registered, you'll have access to your benefits and eligibility information and claims status for yourself and, in most cases, any dependents on your plan.
How do I check to see if I have met my deductible and/or what is remaining on my annual maximum?	Sign in to your member account to access information about your plan. If you don't have an account, go to www.deltadentalwa.com to set one up.
How do I find a participating dentist in my area?	Under your plan, you can choose dentists from two networks: Delta Dental PPO™ or Delta Dental Premier®. You can find a participating, in-network, dentist in your area by visiting www.deltadentalwa.com and using our Find a Dentist tool. We recommend you select the Delta Dental PPO network to filter your search results.
What are the advantages of visiting an in-network dentist?	We encourage you to see a Delta Dental network dentist because they provide services at discounted rates and file all claims paperwork for you. We will pay our portion and you're only responsible for your stated deductibles, coinsurance and/or amounts in excess of the plan maximums. In most cases, you will experience the greatest out-of pocket savings if you choose a dentist from the Delta Dental PPO network.
What information do I provide when I visit participating, in-network dentist?	Be sure to tell your dentist you're covered by Delta Dental of Washington and give them your member identification number, plan name and group number. You can find all this information by logging in to your account at www.deltadentalwa.com.
What if I want to continue with my own dentist, but they are not in the Delta Dental network?	You are not limited to using a Delta Dental network dentist. You may use any licensed dentist. If you choose a non-participating dentist, you will be responsible to have the dentist complete your claim forms and to ensure that the claims are sent to us. Claim payments will be based on actual charges or our maximum allowable fees for non-participating dentists, whichever is less. You're then responsible for any balance remaining after we pay. Unlike our participating dentists, we have no control over non-participating dentists' charges or billing procedures.

DENTAL

FAQs *continued*

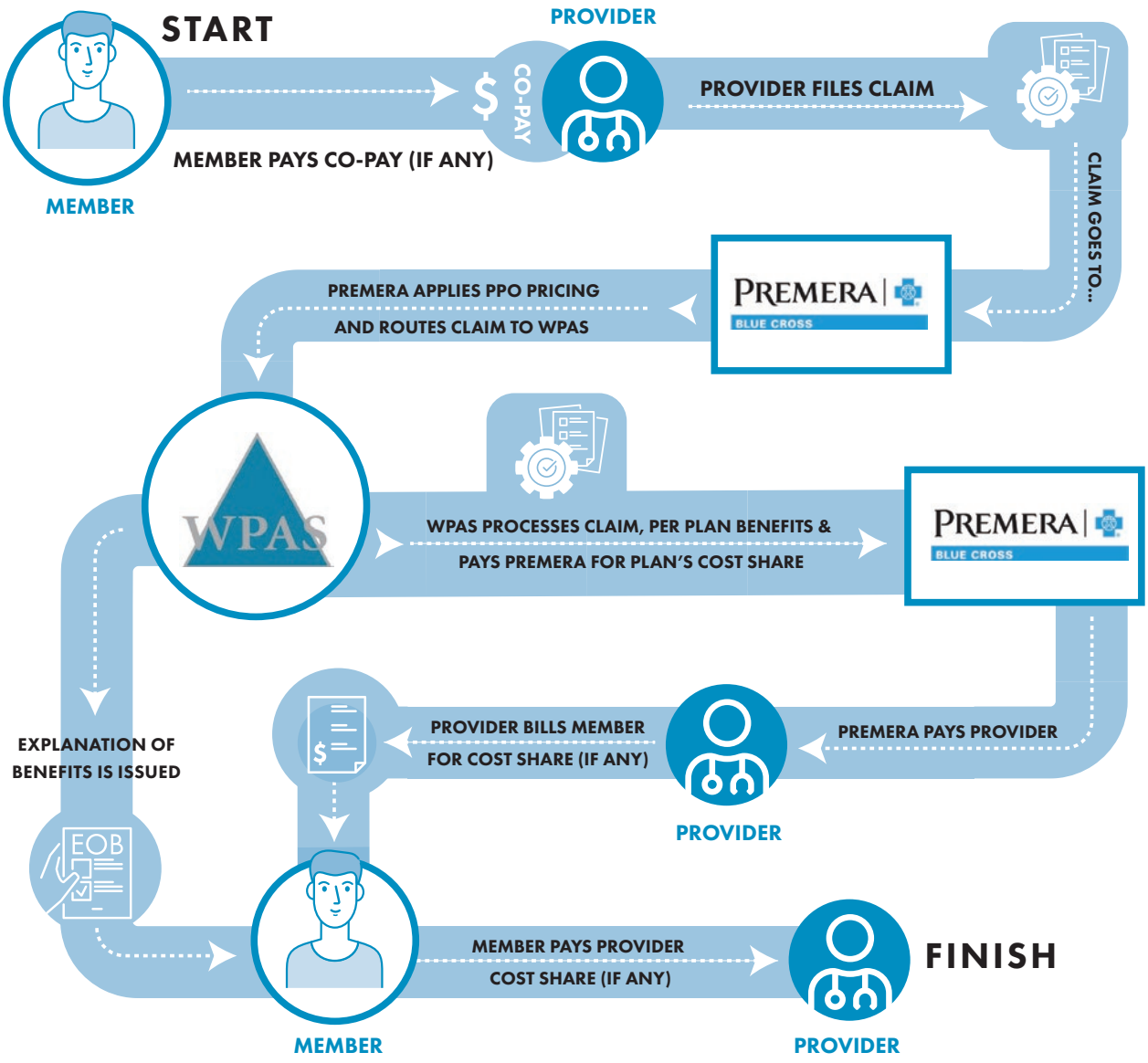
QUESTION	ANSWER
What happens when my dentist refers me to a specialist?	If you are considering extensive treatments such as crowns, oral surgery, periodontics or prosthodontics, we recommend you ask your dentist to request a predetermination from Delta Dental. They will process the request and provide you and your dentist with a Confirmation of Treatment and Cost (Confirmation). The Confirmation will show you what procedures will be covered, an estimate of what Delta Dental of Washington will pay and your expected financial responsibility. Confirmations are based on the treatment plan submitted by your dentist and the covered dental benefits available to you at the time the Confirmation is issued. Confirmations are estimates, not guarantees of payment.
Can I receive dental treatment when I am out of the country?	Delta Dental's networks are nationwide and most dental plans allow you to visit a dentist anywhere within the 50 states, Washington, D.C. and Puerto Rico and receive the same benefits you would receive at home. Yes, you can receive dental treatment when you are out of the country. Simply submit an out of country claim form available at www.deltadentalwa.com.
Does Delta Dental require claim forms? Where should claims be sent?	Most dentists will submit claim forms on your behalf. If you do need to submit a claim yourself, we have forms available for download. Sign in to your member account to access claim forms.
Other questions?	Call Delta Dental of Washington at (800) 554-1907, Monday–Friday from 7 am to 5 pm, Pacific Time. Our mailing address is Delta Dental of Washington, PO Box 75983, Seattle, WA 98175-0983.

Overview

As a Local 29 member, you have comprehensive health plans that cover you for medical, vision, and dental care. The cost of this care is covered primarily by your employer, and a portion also comes out of your paycheck every month. Your VEBA HRA is also there to cover any medical expenses you have until you reach your deductible. Between your health plans and health reimbursement account, we've got you covered.

But how are the costs sorted out behind the scenes? What happens between leaving your doctor's office and receiving an Explanation of Benefits — and maybe a bill — in the mail?

The Claims Process



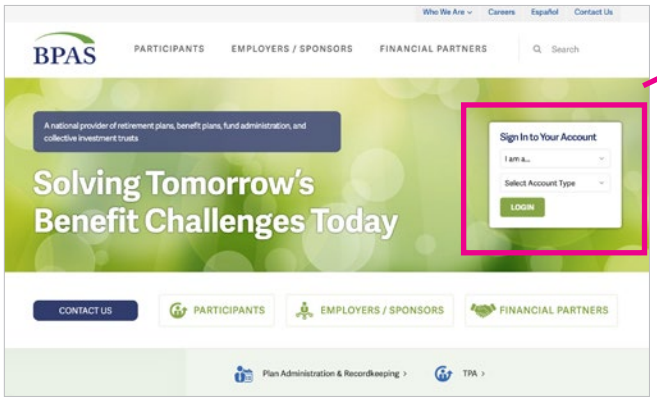
Get Reimbursed for Your Expenses through BPAS

From time to time you will have out-of-pocket medical expenses, like antibiotics for your kid or fuel to drive to their doctor's appointment. You will also typically pay your co-pay any time you have an office visit.

To get reimbursed for these and other medical-related expenses, you will need to submit a claim to BPAS, which handles all our claims and makes sure you get paid back out of your VEBA HRA account.

This is how to file a claim with BPAS:

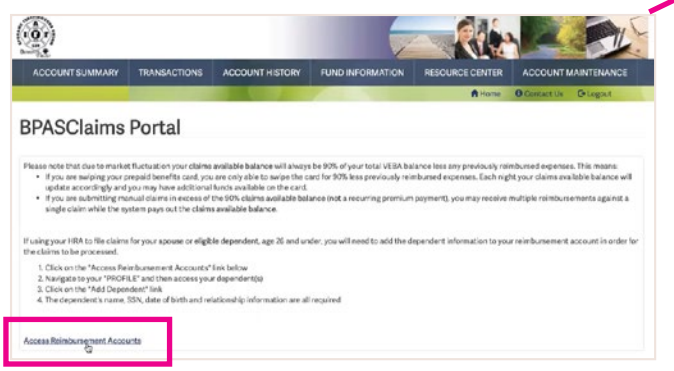
BPAS Home Page



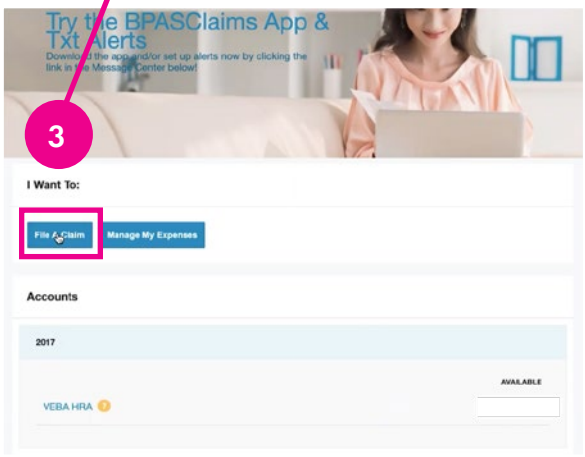
1 *Login to your BPAS account.*

Then click on "BPASClaimsPortal" on the left side of the screen.

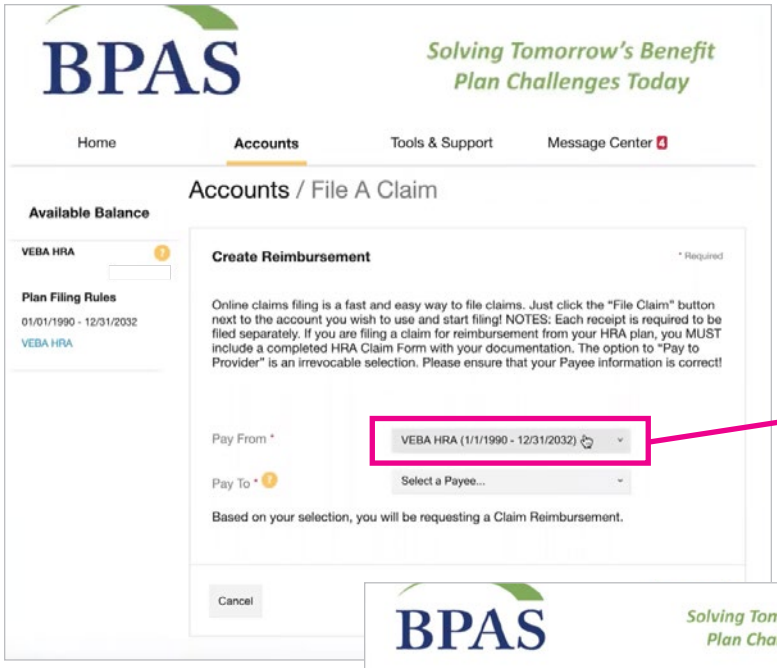
BPAS Claims Portal



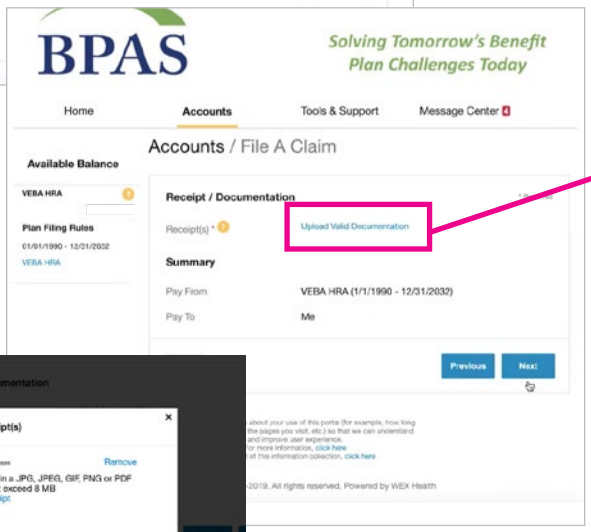
2 *Read the instructions, and when you're ready to start filing your claim, click on* **Access Reimbursement Accounts**.



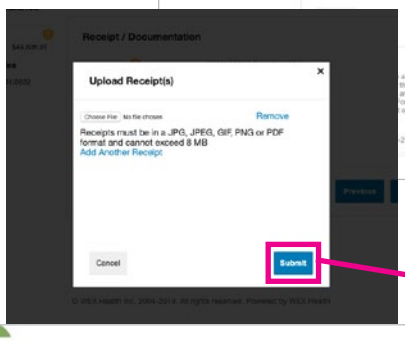
3 *Click on* **File A Claim**.



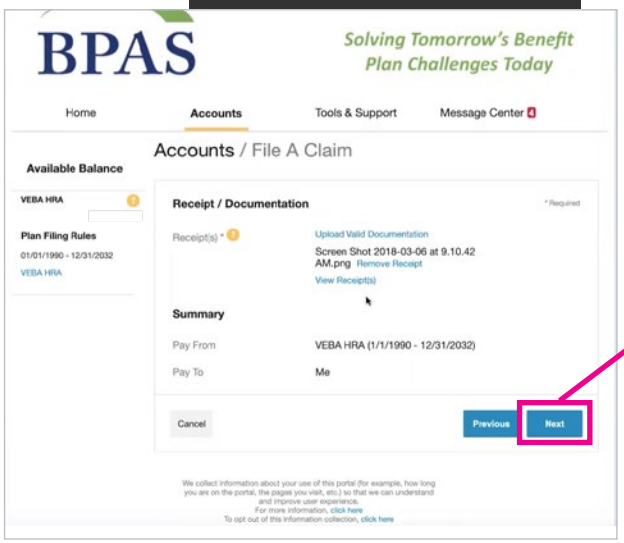
If you want to be reimbursed from your VEBA account, select **VEBA HRA** and your name from the dropdown lists. Click Next.



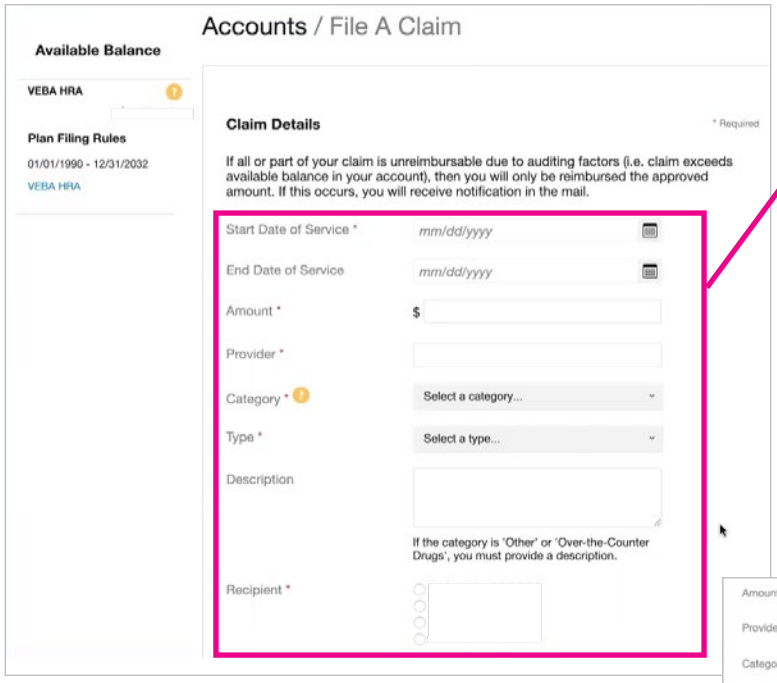
Now you will upload an image of your receipt.



Your image can be uploaded in several formats. If you have more receipts to add to your claim, click **Add Another Receipt**.



Confirm that all your receipts were uploaded and everything looks ok. You can remove a receipt if necessary.



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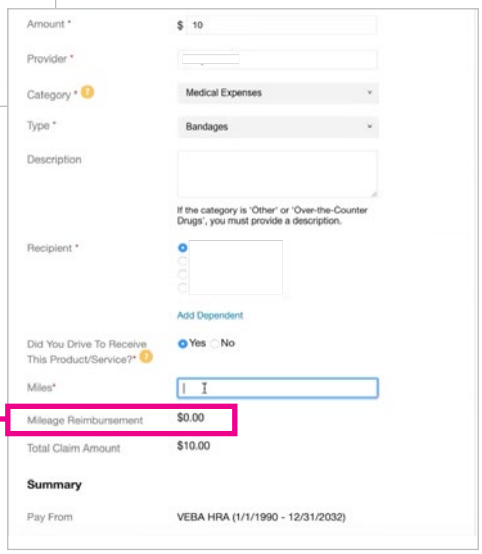
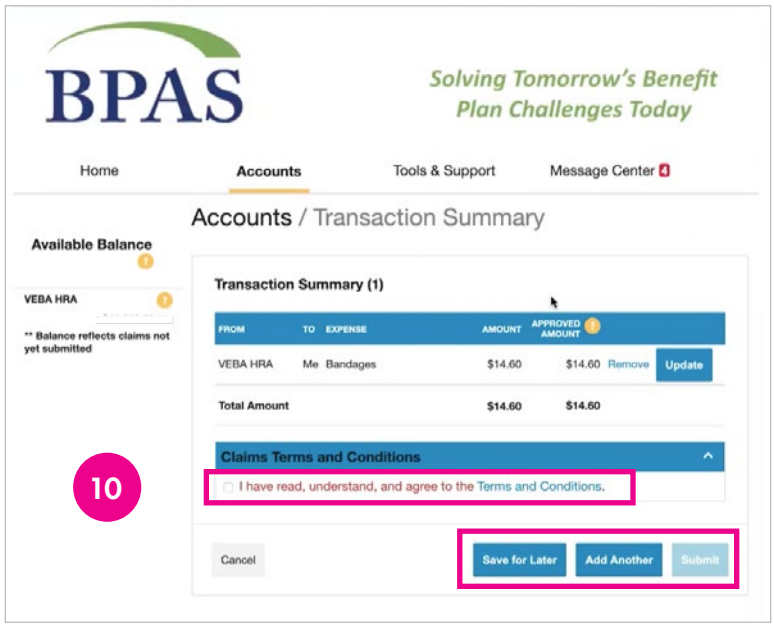
Now you can enter the details of your claim: the service dates, amount, provider, category (e.g. drugs and medicine) and type of service, and any notes that should be added. Remember to select the name of the person on your plan who received the service.

Mileage is also a covered expense that you can be reimbursed for, so remember to enter the number of miles you traveled to get to your appointment or receive a health product/service.

9





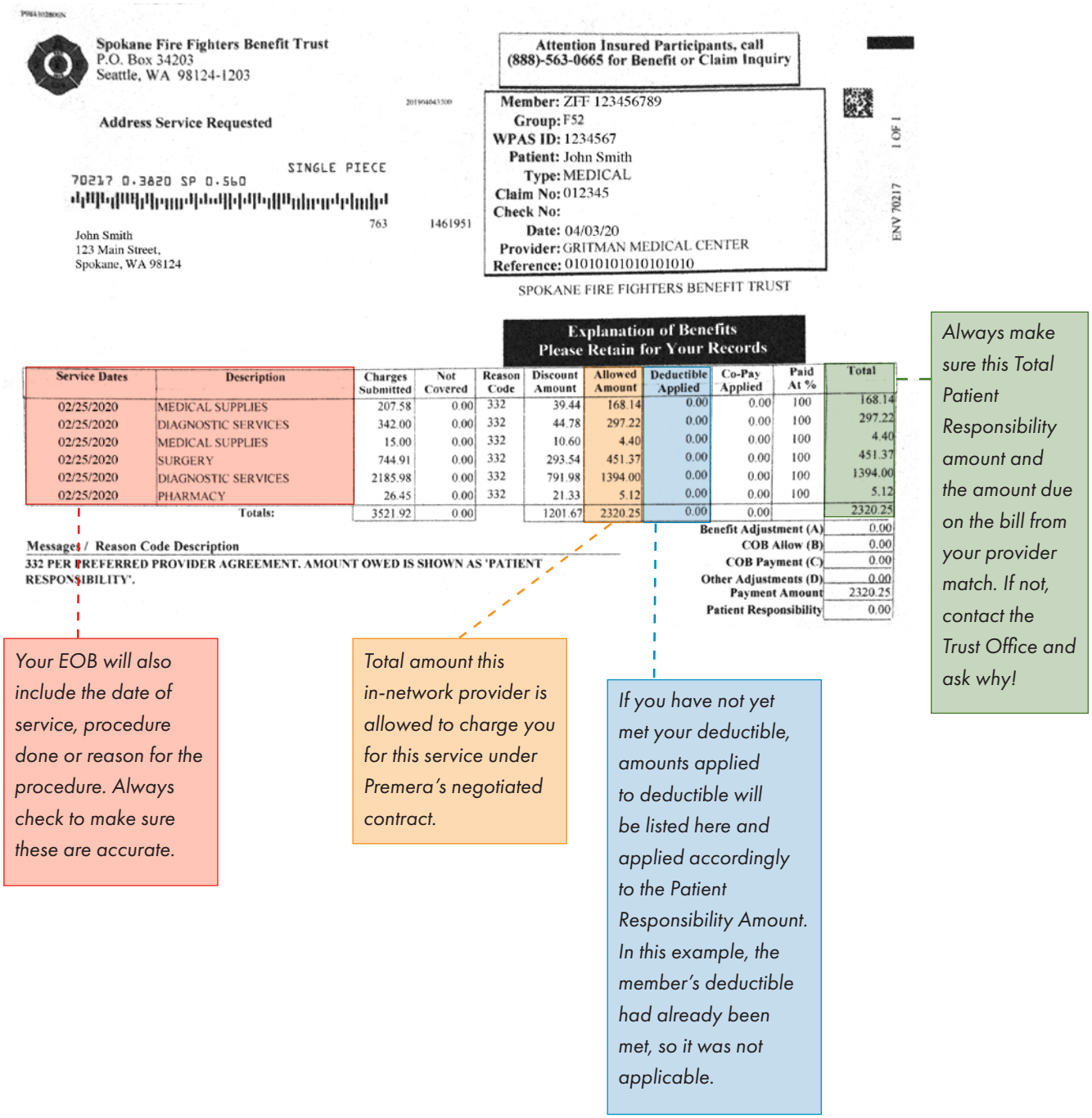
10

Finally, you will see a summary of your transaction. If everything looks ok, check the box to agree to the Terms and Conditions.

When you are finished, click **Submit**. If you want to add more claims later, click **Save for Later**, or to file another claim, click **Add Another**. You can also delete the entire transaction by clicking on **Cancel** on the left.

How to Read an EOB

*EOB = Explanation of Benefits. Always make sure you receive an EOB for any medical service you receive.



Spokane Fire Fighters Benefit Trust
P.O. Box 34203
Seattle, WA 98124-1203

Address Service Requested

SINGLE PIECE
70217 0.3820 SP 0.560

John Smith
123 Main Street,
Spokane, WA 98124

Attention Insured Participants, call
(888)-563-0665 for Benefit or Claim Inquiry

Member: ZFF 123456789
Group: F52
WPAS ID: 1234567
Patient: John Smith
Type: MEDICAL
Claim No: 012345
Check No:
Date: 04/03/20
Provider: GRITMAN MEDICAL CENTER
Reference: 01010101010101010

SPOKANE FIRE FIGHTERS BENEFIT TRUST

ENV 70217 1 OF 1

Explanation of Benefits
Please Retain for Your Records

Service Dates	Description	Charges Submitted	Not Covered	Reason Code	Discount Amount	Allowed Amount	Deductible Applied	Co-Pay Applied	Paid At %	Total
02/25/2020	MEDICAL SUPPLIES	207.58	0.00	332	39.44	168.14	0.00	0.00	100	168.14
02/25/2020	DIAGNOSTIC SERVICES	342.00	0.00	332	44.78	297.22	0.00	0.00	100	297.22
02/25/2020	MEDICAL SUPPLIES	15.00	0.00	332	10.60	4.40	0.00	0.00	100	4.40
02/25/2020	SURGERY	744.91	0.00	332	293.54	451.37	0.00	0.00	100	451.37
02/25/2020	DIAGNOSTIC SERVICES	2185.98	0.00	332	791.98	1394.00	0.00	0.00	100	1394.00
02/25/2020	PHARMACY	26.45	0.00	332	21.33	5.12	0.00	0.00	100	5.12
	Totals:	3521.92	0.00		1201.67	2320.25	0.00	0.00		2320.25

Messages / Reason Code Description
332 PER PREFERRED PROVIDER AGREEMENT. AMOUNT OWED IS SHOWN AS 'PATIENT RESPONSIBILITY'.

Benefit Adjustment (A)	0.00
COB Allow (B)	0.00
COB Payment (C)	0.00
Other Adjustments (D)	0.00
Payment Amount	2320.25
Patient Responsibility	0.00

Always make sure this Total Patient Responsibility amount and the amount due on the bill from your provider match. If not, contact the Trust Office and ask why!

Your EOB will also include the date of service, procedure done or reason for the procedure. Always check to make sure these are accurate.

Total amount this in-network provider is allowed to charge you for this service under Premera's negotiated contract.

If you have not yet met your deductible, amounts applied to deductible will be listed here and applied accordingly to the Patient Responsibility Amount. In this example, the member's deductible had already been met, so it was not applicable.

View Your EOB Online

This is how your EOB statement looks online.

02/25/2019	MEDICAL CENTER	$3,521.92	036855	04/03/2019	$2,320.25

Date of Service	Description	Charges Submitted	Not Covered	Reason Code	Discount Amount	Allowed Amount	Deductible Applied	Co-pay Applied	Paid At %	Total
02/25/2019	MEDICAL SUPPLIES	$207.58	$0.00	332	$39.44	$168.14	$0.00	$0.00	100%	$168.14
02/25/2019	DIAGNOSTIC XRAY	$342.00	$0.00	332	$44.78	$297.22	$0.00	$0.00	100%	$297.22
02/25/2019	DIAGNOSTIC XRAY	$15.00	$0.00	332	$10.60	$4.40	$0.00	$0.00	100%	$4.40
02/25/2019	SURGERY	$744.91	$0.00	332	$293.54	$451.37	$0.00	$0.00	100%	$451.37
02/25/2019	DIAGNOSTIC XRAY	$2,185.98	$0.00	332	$791.98	$1,394.00	$0.00	$0.00	100%	$1,394.00
02/25/2019	MEDICAL SUPPLIES	$26.45	$0.00	332	$21.33	$5.12	$0.00	$0.00	100%	$5.12
	Totals:	**$3,521.92**	**$0.00**		**$1,201.67**	**$2,320.25**	**$0.00**	**$0.00**		**$2,320.25**
									Benefit Adjustment (A):	**$0.00**
									COB Allow (B):	**$0.00**
									COB Payment (C):	**$0.00**
									Other Adjustments (D):	**$0.00**
									Payment Amount:	**$2,320.25**
									Patient Responsibility:	**$0.00**

Reason Codes:
332 - PER PREFERRED PROVIDER AGREEMENT, THE AMOUNT OWED THE PROVIDER IS SHOWN AS "PATIENT RESPONSIBILITY".

2023 VEBA HRA Contributions

HRA contributions from your employer go to your individual VEBA account at BPAS. In 2023, a $500 bonus contribution was earned by members who completed their fire fighter exam at MultiCare Rockwood Spokane Valley Primary Care prior to the September 30, 2022 deadline.

In the table below, 2023 VEBA contribution amounts are listed, with and without exam completion. Remember, the amount of your VEBA contribution also depends on the bargaining unit in which you participate, which is summarized below.

	2023 VEBA contribution		2023 VEBA contribution with completed exam	
	Individual	Family	Individual	Family
City of Spokane Fire Fighters	$3,500	$7,000	$4,000	$7,500
SAFO	$3,500	$7,000	$4,000	$7,500
SIA Fire Fighters	$3,500 + $900	$7,000 + $900	$4,000 + $900	$7,500 + $900

Please note, the 2024 $500 VEBA bonus contribution will be tied to members receiving their Annual Fire Fighter Exam between October 1, 2022 and September 30, 2023.

Things to remember about your VEBA HRA account:

- This is your individual account that remains with you for life. You determine if and when you want to access your account for reimbursable expenses.
- You'll need to submit an insurance Explanation of Benefits (EOB) or itemized statement with a claim form to get reimbursed for eligible expenses.
- You can submit your claims 4 ways: Online, Mobile App, Fax, or US Mail.
- If you use your "benny" debit card, KEEP YOUR RECEIPT AND EOB as BPAS will request a copy to substantiate your claim. This is an IRS requirement.
- Use the BPAS online tools. If you haven't already done, obtain online account access by calling BPAS at: 1-855-404-8322 5:30am to 5:30pm PST.

Overview

The following pages provide some helpful explanations, definitions of acronyms, and contact information. Remember to check the SFFBT website for regularly updated information.

www.sffbt.com

Acronym Cheat Sheet

BPAS	Benefit Plans Administrative Services
EOB	Explanation of Benefits
HRA	Health Reimbursement Arrangement
LEOFF	Law Enforcement Officers and Firefighters
LTD	Long-Term Disability
OOP	Out of Pocket
PCY	Per Calendar Year
SBC	Summary of Benefits and Coverage
SFFBT	Spokane Fire Fighters Benefit Trust
VEBA	Voluntary Employees' Beneficiary Association
WPAS	Welfare and Pension Administration Service

Glossary of Health Coverage and Medical Terms

This glossary has many commonly used terms, but isn't a full list. These terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also may not have exactly the same meaning when used in your policy or plan, and in this case, the policy or plan governs. (See the *Understanding and Managing Your Benefits* section for information on how to get a copy of your policy or plan document.)

- **Bold blue** text indicates a term defined in this glossary.

Glossary of Health Coverage and Medical Terms

Allowed Amount

Maximum amount on which payment is based for covered healthcare services. This may be called an "eligible expense," "payment allowance", or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible

The amount you owe for healthcare services that your health insurance or plan covers before your **health insurance** or **plan** begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a healthcare **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Healthcare services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your healthcare costs in exchange for a **premium**.

Home Healthcare

Healthcare services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percentage (for example, 20%) you pay of the **allowed amount** for covered healthcare services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

A fixed amount (for example, $15) you pay for covered healthcare services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary

Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, **providers**, and suppliers your health insurer or **plan** has contracted with to provide healthcare services.

Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-Network Co-insurance

The percentage (for example, 40%) you pay of the **allowed amount** for covered healthcare services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-Network Co-payment

A fixed amount (for example, $30) you pay for covered healthcare services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or healthcare your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union, or other group sponsor provides to you to pay for your healthcare services.

Preauthorization

A decision by your health insurer or **plan** that a healthcare service, treatment plan, **prescription drug**, or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval, or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly, or yearly.

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of healthcare services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional or healthcare facility licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Rehabilitation Services

Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

Information Sources	Contact
Trust Office For questions regarding general Trust benefits, claims, EOBs, open enrollment, eligibility and Trust business, and to request benefit/enrollment forms	**Welfare & Pension Administration Service, Inc. (WPAS)** P.O. Box 34203 Seattle, Washington 98124-1203 Phone: (888) 563-0665, Ext. 3320 Fax: (206) 505-9727 Email: gdimof@wpas-inc.com **www.sffbt.com**
Trust Consultants For questions regarding Trust operations	**DiMartino Associates** (800) 488-8277 **www.dimarinc.com**
Sav-Rx Prescription Drugs For questions regarding benefits, pharmacy claims, finding participating pharmacies, mail order and specialty pharmacy	**Customer Service** 24 hours a day, 7 days a week (800) 228-3108 **www.SavRx.com**
Teladoc For virtual care by phone or online video with a doctor 24 hours a day, 7 days a week, 365 days a year	**Free Medical Consultations** 24 hours a day, 7 days a week (855) 332-4059 **www.Teladoc.com/Premera**
Delta Dental of Washington For questions regarding claims, requesting new ID cards, and finding a dentist	**Customer Service** Monday-Friday 8:00am-5:00pm (800) 554-1907 **www.deltadentalwa.com**
BPAS VEBA HRA benefits/claims and help with your online account	**Customer Service** Monday-Friday: 5:30am - 5:30pm PST (855) 404-VEBA (8322) **www.bpas.com**
Premera Blue Cross For help finding participating providers	**Customer Service** Monday-Friday 8:00am - 5:00pm (800) 810-BLUE (2583) **www.premera.com/sharedadmin**
MultiCare Rockwood Spokane Valley Primary Care Formerly known as Spokane Internal Medicine (SIM). This is where you should schedule your firefighter exam.	**Patient Scheduling** (509) 598-7749 Exams will be done at: 1215 N McDonald Rd #101

The information in this Guide is presented for illustrative purposes. The text in this Guide was taken from various summary plan descriptions and benefits guides. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of any discrepancy between this Guide and the formal plan documents, the Benefit Booklet will always prevail on issues concerning benefits available, and the Summary Plan Description shall prevail on issues concerning eligibility and enrollment. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

BPAS Information Sources

BPAS Financial Calculators
Want to see how increasing your contributions to your 401(k) or HSA impact your future savings? You can use the BPAS calculators to model scenarios related to retirement planning, health savings accounts, social security benefits, and more. Note: they're intended for illustrative purposes only and do not serve as advice.
https://pec.bpas.com/financial-calculators/

Risk Tolerance
When it comes to investing your retirement plan balance, it's important to think about your investment objectives and tolerance for risk. use the BPAS questionnaire to help you determine your investment objectives and risk tolerance. Based on your responses, you'll see sample asset allocation portfolios that may be suitable for you.
https://pec.bpas.com/test/determine-your-risk-tolerance/

Investment Basics
Learn about stocks, bonds, mutual funds, and more from BPAS's series of videos
https://pec.bpas.com/investment-basics/

Investment Glossary
It never hurts to understand the terms and acronymns found in the investment world.
https://www.investmentterms.com/

Retirement Planning
Learn more about the topics that impact your as you plan and save for your journey to retirement.
https://pec.bpas.com/retirement-planning/