2025

QUALIFYING LIFE EVENTS

EMPLOYEE BENEFITS GUIDE

ATLANTA PUBLIC SCHOOLS

Human Resources
Total Rewards + Workforce Planning

QUALIFYING LIFE EVENTS THAT ALLOW CHANGES IN COVERAGE

If you are an Active Employee and experience one of the qualifying events throughout the year, like changes in your family status or employment, you are allowed to adjust your coverage accordingly. It is important to note that the State Health Benefits Plan (SHBP) requires you to provide the Social Security Number for each dependent covered under your plan. If you don't provide this information, your coverage could be terminated.

When you report a qualifying event, be aware that the premiums for your benefits might change. You can find the updated rates on the attached rate sheet. Also, if you make any changes outside of the scheduled payroll dates for the current pay period, the missed premiums will be deducted from your pay in the next period to keep your payments up to date.

Step 1: Health Insurance:

- Employees must log on to the SHBP Enrollment Portal at www.mySHBPga.adp.com and declare a Qualifying Event.
- Members not able to access the website may call SHBP Members Services at (800) 610-1863, and a representative will assist you.
- Documentation must be sent directly to **the State Health Benefit Plan**. Members will receive a barcode coversheet within 7-10 business days of the Event Declaration, which they can use to either fax or email documentation.

Step 2: Qualifying Life Event Enrollment Election Form

- Complete the Qualifying Life Event Enrollment Election Form To:
  - Choose or change your Flexible Benefits (Dental, Vision, FSA, etc.)
  - Upload the SHBP Qualifying Event Confirmation
- Email the completed **Qualifying Life Event Enrollment Election Form** and your SHBP Qualifying Event Confirmation to employeebenefits@apsk12.org.

> ***NOTE: ALL QUALIFYING EVENTS MUST BE DECLARED WITHIN 31 DAYS OF THE LIFE EVENT.*** If you fail to make coverage changes due to qualifying events within the time allowed, your next opportunity to make coverage changes will be during the annual Open Enrollment period.

QUALIFYING EVENT CHART

The following chart shows qualifying events, and the corresponding changes that active Members can make. You must follow the steps listed for each qualifying event below.

QUALIFYING EVENT	PROVIDE THIS DOCUMENTATION	CHANGE OPTIONS
Birth	• Copy of certified birth certificate or birth card issued by the hospital listing parents by name. • Child's Social Security Number	• Enroll in coverage • Change coverage tier to include child(ren) • Enroll eligible Dependents • Change coverage option (optional)
Adoption	• Copy of Adoption certificate or court order establishing adoption with the date of adoption, or if adoption is not finalized, a certified court document establishing the date of placement for adoption. • Copy of certified birth certificate or birth card issued by the hospital listing parents by name. • Child's Social Security Number	• Enroll in coverage • Change coverage tier to include child(ren) • Enroll eligible Dependents • Change coverage option (optional)
Marriage	• Copy of certified marriage license or most recent jointly filed Federal Tax return, which includes legible signatures for both member and spouse • Spouse's Social Security Number • If applicable, the stepchild's Social Security Number and copy of certified birth certificate or birth card issued by the hospital listing Member's spouse by name	• Enroll spouse (and Dependent stepchild, if applicable) in coverage • Change coverage tier to include a spouse (and Dependents, if applicable). • **Discontinue coverage**: A letter from the other plan documenting you and your Covered Dependents are enrolled in your spouse's plan. The letter

QUALIFYING EVENT	PROVIDE THIS DOCUMENTATION	CHANGE OPTIONS
		should include the names of all Covered Dependents • Change coverage option (optional)
Child Due to Legal Guardianship	• Certified copy of court documents establishing guardianship with the date of placement, or, if guardianship is not finalized, a certified court document establishing the date of placement. • Copy of certified birth certificate or birth card issued by the hospital listing parents by name • Child's Social Security Number	• Enroll in coverage • Change coverage tier to include child(ren) • Enroll eligible Dependents • Change coverage option (optional)
Stepchild(ren)	• Copy of certified birth certificate or birth card issued by the hospital listing Member's spouse by name • Stepchild's Social Security Number • Copy of certified marriage license or most recent jointly filed Federal Tax return which includes legible signatures for both member and spouse	• Enroll in coverage • Change coverage tier to include child(ren) • Enroll eligible Dependents • Change coverage option (optional)
Divorce	• Adding coverage for yourself • Copy of divorce decree • Social Security Number for each Dependent you wish to cover • If you were covered by your former spouse's plan, letter from the other plan documenting name(s) of everyone who lost coverage, date, reason for loss and/or discontinuation of coverage required • Removing a former spouse from coverage	• Enroll in coverage, if losing coverage through spouse's plan • Enroll eligible Dependents, if losing coverage through spouse's plan • Remove spouse from coverage • Remove stepchild(ren) from coverage • Change coverage tier

QUALIFYING EVENT	PROVIDE THIS DOCUMENTATION	CHANGE OPTIONS
	• Copy of divorce decree	• Change coverage option (optional)
You or your spouse lose coverage through other employment.	• Letter from the other employer documenting name(s) of everyone who lost coverage, date, reason for loss and/or discontinuation of coverage required • Copy of certified marriage license, if applicable • Social Security Number(s) • Copy of Certified Birth Certificate for Dependent children, if applicable.	• Enroll in coverage • Enroll eligible Dependent(s) • Change coverage tier • Change coverage option (optional)
You, your spouse, or enrolled Dependent are covered under a qualified health plan and you lose eligibility, such as through Medicaid, State Children's Health Insurance Program (SCHIP) or Medicare.	• Letter from Medicaid, or Medicare documenting name(s) of everyone who lost coverage, date, reason for loss and/or discontinuation of coverage required • Copy of certified marriage license, if applicable • Social Security Number(s) • Copy of Certified Birth Certificate for Dependent children, if applicable	• Enroll in coverage • Enroll eligible Dependent(s) • Change coverage tier • Change coverage option (optional)
Your former spouse loses other qualified coverage, resulting in loss of your Dependent child(ren)'s coverage under former spouse's plan	• Letter from the other plan documenting name(s) of everyone who lost coverage, date, reason for loss and/or discontinuation of coverage required • Social Security Number(s) • Copy of certified marriage license, if applicable • Copy of Certified Birth Certificate for Dependent children, if applicable	• Enroll eligible Dependent(s) • Increase coverage tier • Change coverage option (optional)

QUALIFYING EVENT	PROVIDE THIS DOCUMENTATION	CHANGE OPTIONS
Your former spouse loses other qualified coverage, resulting in loss of your Dependent child(ren)'s coverage under former spouse's plan	• Letter from the other plan documenting name(s) of everyone who lost coverage, date, reason for loss and/or discontinuation of coverage required • Social Security Number(s) • Copy of certified marriage license, if applicable • Copy of Certified Birth Certificate for Dependent children, if applicable	• Enroll eligible Dependent(s) • Increase coverage tier • Change coverage option (optional)
Dependent Loss of Coverage due to reaching Age 26	• No documentation is required to change coverage tier when the last child turns twenty-six.	• Change coverage tier to remove Dependent(s) • Change coverage option (optional)
Gain of coverage due to other employer's open enrollment **NOTE:** Plan year can be the same, but Open Enrollment dates must be different	• Letter from the other employer documenting name(s) of everyone who gained coverage, date, reason for gain of coverage required	• Change coverage tier to remove spouse and/or Dependent(s) • Discontinue coverage • Change coverage option (optional)
Loss of coverage due to other employer's open enrollment **NOTE:** Plan Year can be the same, but Open Enrollment dates must be different	• Letter from the other employer documenting name(s) of everyone who lost coverage, date, and reason for loss of coverage and/or discontinuation of coverage required • Social Security Number(s)	• Enroll in coverage • Enroll eligible Dependent(s) • Change coverage tier • Change coverage option (optional)
You or your spouse acquire new coverage under spouse's employer's plan	• Letter from the other employer documenting name(s) of everyone who gained coverage, date, reason for gain of coverage required	• Change coverage tier to remove spouse and/or Dependent(s) • Discontinue coverage

QUALIFYING EVENT	PROVIDE THIS DOCUMENTATION	CHANGE OPTIONS
Your spouse or your only enrolled Dependent's employment status changes, resulting in a gain of coverage under a qualified plan other than from SHBP	• Letter from the other employer documenting name(s) of everyone who gained coverage, date, reason for gain of coverage required	• Change coverage tier to remove spouse and/or Dependent(s) • Discontinue coverage • Change coverage option (optional
You or your spouse is activated into military services	• Social Security Number(s) • Copy of orders required	• Enroll in coverage • Change coverage tier • Change coverage option (optional) • Discontinue coverage
Death of Dependent	• Death Certificate	• Remove dependent from plan • Enroll in coverage • Enroll eligible dependent(s)

OTHER QUALIFYING LIFE EVENTS

Name Change

- Contact the Records Management team at experienceverifications@atlanta.k12.ga.us.

Once the name change is processed, the update is sent to the State Health Benefit Plan and all other vendors.

Address Change

- Contact the Records Management team at experienceverifications@atlanta.k12.ga.us

Once the address change is processed, the update is sent to the State Health Benefit Plan and all other vendors.

GROUP HEALTH INSURANCE - STATE HEALTH BENEFIT PLAN

Active Employee, *Early Retiree, & Employees on FMLA/Disability/Military Leave w/o Pay	Single	Employee & Child(ren)	Employee & Spouse	Family
ANTHEM - GOLD	194.67	355.26	482.76	643.35
ANTHEM - GOLD - TOBACCO	274.67	435.26	562.76	723.35
ANTHEM - SILVER	131.17	247.31	349.41	465.55
ANTHEM - SILVER - TOBACCO	211.17	327.31	429.41	545.55
ANTHEM - BRONZE	82.67	164.86	247.56	329.75
ANTHEM - BRONZE - TOBACCO	162.67	244.86	327.56	409.75
ANTHEM HMO	157.53	292.12	404.77	539.36
ANTHEM HMO TOBACCO	237.53	372.12	484.77	619.36
UHC HMO	196.58	358.50	486.77	648.69
UHC HMO - TOBACCO	276.58	438.50	566.77	728.69
UHC HDHP	72.69	147.89	226.60	301.80
UHC HDHP - TOBACCO	152.69	227.89	306.60	381.80
KAISER HMO	157.53	292.12	404.77	539.36
KAISER HMO - TOBACCO	237.53	372.12	484.77	619.36
TRICARE - SUPPLEMENT	60.50	119.50	119.50	160.50

	Single	Family
GROUP DENTAL INSURANCE - METLIFE PPO - HIGH PLAN 800-942-0854	15.44	81.70
GROUP VISION CARE - VISION SERVICE PLAN 800-877-7195 6.28	6.28	12.16
IDENTITY THEFT PROTECTION PLAN 888-494-8519	8.95	16.95
MEDICAL SPENDING & DEPENDENT DAYCARE FEE 800-422-4661	2.10	(SEE BROCHURE)
CRITICAL ILLNESS WELLNESS FEE 800-433-3036	1.52	(SEE BROCHURE)

Benefit elections are binding through DECEMBER 31, 2025, except under qualifying life events as outlined by the Internal Revenue Service Section 125.

QUALIFYING LIFE EVENT ENROLLMENT ELECTION FORM

Personal Information

Employee's Name

Employee ID (Lawson Number)

Add Dependent(S)

Using Internet Explorer or Google Chrome, access the Lawson Employee Self-Service Portal using the following web address: **https://www.atlantapublicschools.us/**

Click here to access instructions: Accessing Employee Self-Service, or copy and paste this link into your browser: http://tinyAPS.com/?ESSHelp

Qualifying Life Event

Due to a qualifying life event, I wish to update the following benefit plans.	**Enroll** ☐	**Cancel** ☐
DENTAL	Employee ☐	Family ☐
VISION	Employee ☐	Family ☐
LIFE INSURANCE (Employee must be enrolled in supplemental life insurance to select below life benefits)		
Spousal Life		($10,000 - $250,000) Cannot exceed half of the employee's life
AD&D Family Life		($10,000 - $100,000)
Child Life		$5,000, $10,000 OR $15,000 EACH CHILD
FLEXIBLE SPENDING ACCOUNTS		
Medical		$3,050 MAXIMUM
Dependent Day Care		$5,000 MAXIMUM
CRITICAL ILLNESS		
The employee must be currently enrolled in the plan.	Employee ☐	Spouse ☐
IDENTITY THEFT PROTECTION		
	Employee ☐	Family ☐

Signature: Date: