DEPARTMENT OF HUMAN RESOURCES

Alyssa Williamson
Chief Human Resources Officer

2331 Mill Road, Room 301
Alexandria, VA 22314

Phone: 703.746.3777
Alexandriava.gov/HR

Benefit and Rate Changes effective July 1, 2026

Dear City of Alexandria Retiree,

Welcome to Open Enrollment! Carefully review the materials in this packet as they contain important information about your benefit options, including rate changes effective July 1, 2026. We have highlighted some key changes below, but we encourage you to read through the enclosed Benefit Guide as well. **If you want to make changes to your benefits, please do so by May 29 using the enclosed forms**. Please also note that our offices have moved!

Medical Plans

- The deductible for a Consumer-Driven Health Plan (CDHP) is now $1,700 single/$3,400 family per IRS regulations. This applies to both Kaiser Permanente and United Healthcare CDHP plan options.
- United Healthcare (UHC) will offer the same plan options, but starting July 1, pharmacy benefits will also be through UHC/Optum. Members will have one card to use for both medical and pharmacy benefits and one customer service number. Overall rates for UHC plan options are increasing by 12.7%. Refer to page 10 of your Guide for specific rates.
- Kaiser Permanente will offer the same plan options. Overall rates for Kaiser plan options are increasing by 5.7%. Refer to page 11 of your Guide for specific rates.

Note: if you and/or your spouse will turn age 65 during the next benefit year (July 1, 2026 to June 30, 2027) you will need to apply for and enroll in both Medicare Parts A and B to get coverage through one of the City's approved plans for Medicare-eligible retirees. Contact the DHR Benefits Team for assistance with this transition.

Dental Plans

- The Aetna PPO dental plan now includes coverage of orthodontia for children up to age 19. Rates are increasing by 4.8%. Refer to page 14 of your Guide for more information.

Vision Plan

- There are no changes to benefits or rates for the Aetna vision plan.

Supplemental Life Insurance

- This benefit is only available to you if you were enrolled prior to retiring.
- Premiums will increase from $0.56 to $0.82 per $1,000 of coverage.
- You may choose to discontinue your supplemental life insurance coverage at any time using the enclosed form, but note that this change is final and you will not be able to reinstate this coverage.

How to Contact Us

By email: DHR.Benefits@alexandriava.gov

By mail: 2331 Mill Road, Room 301, Alexandria, VA 22314

By phone: 703.746.3777

Visit us online at https://www.alexandriava.gov/human-resources/retirees-corner

We invite and encourage you and your dependents to attend any of our Benefits Open House Sessions. Page 5 of your Guide has more information about our Open House Sessions.

We hope this information is helpful.

Early- Retiree Open Enrollment FY 2027

Forms Kit

For Early Retiree Participants

In this Kit

- **City of Alexandria Early Retiree Plan Change Form**
  - You **DO NOT NEED TO RETURN ANY FORMS** if you are not making any changes!
  - Note, there are some rate changes per the Memo

- **City of Alexandria Retiree Information Form**
  - Return this form only you are changing your demographic information

- **City of Alexandria Retiree Medical Insurance Reimbursement Statement**
  - Return this form only if you require reimbursements for the cost of your Retiree Medical premium payments

- **City of Alexandria Retiree EFT Authorization Agreement**
  - Return this form if you are changing your bank account information or are requesting Electronic Funds Transfer (EFT) for the first time

- **The Standard Retiree Benefit Change Form**
  - Return this form if you are changing your beneficiary or demographic information for your retiree life insurance coverage with The Standard

Forms are due by May 29, 2026!

You have several options to submit your change forms:

- **REGULAR MAIL:** Must be postmarked by May 29, 2026 (note new address below!)
- **DROP-OFF TO HR DEPARTMENT:** Must be returned by 5 PM ET on May 29, 2026 (note new address!)
- **E-MAIL:** Must be timestamped by 5 PM ET on May 29, 2026

Address: 2331 Mill Road, Room 301, Alexandria, VA 22314
Email: DHR.Benefits@alexandriava.gov

Department of Human Resources

FY2027 EARLY RETIREE PLAN CHANGE FORM

RETIREES WHO **DO NOT** WISH TO MAKE ANY CHANGES FOR FY 2027 **DO NOT** NEED TO COMPLETE THIS FORM. THIS FORM IS TO BE COMPLETED AND RETURNED/POSTMARKED BY **MAY 29, 2026,** ONLY BY THOSE RETIREES WHO WISH TO MAKE A CHANGE TO THEIR PLAN AND/OR COVERAGE LEVEL**.** CHANGES WILL BE EFFECTIVE JULY 1, 2026.

Directions: Place an "X" on the lines below for the medical, dental, and vision plan(s) and the coverage level you would like for **FY 2027**. Then complete page 2 and sign. This form can be submitted by email or mailed to the address listed below.

Retiree name (please print)_____

MEDICAL PLAN SELECTION

Kaiser Permanente: _____DHMO _____HMO* _____CDHP

*HMO plan is open to current enrollees only—new enrollments not permitted

United Healthcare: _____Choice _____Choice Plus _____CDHP

City of Alexandria: _____Insurance Reimbursement Plan*

*Must also complete and return the Retiree Medical Insurance Reimbursement Plan form

COVERAGE LEVEL SELECTION

_____Individual _____Retiree + Spouse _____Retiree + Child(ren) _____Family

DENTAL PLAN SELECTION

Aetna: _____DMO _____PPO

COVERAGE LEVEL SELECTION

_____Individual _____Retiree + Spouse _____Retiree + Child(ren) _____Family

_____None--I do not want dental coverage.

VISION PLAN SELECTION

Aetna: _____Vision Plan

COVERAGE LEVEL SELECTION

_____Individual _____Retiree + Spouse _____Retiree + Child(ren) _____Family

_____None--I do not want vision coverage. **(OVER)**

Family members to be added or removed from health, dental, or vision insurance coverage:

Add/Remove (Circle one)	Name	Date of Birth (MM/DD/YYYY)	Relationship
Add/Remove			
Add/Remove			
Add/Remove			

SUPPLEMENTAL LIFE INSURANCE

Place an "X" on the line below ONLY if you want to terminate your supplemental life insurance coverage. **If you want to keep your current coverage, no action is necessary.**

_____ I hereby terminate my supplemental life insurance. I understand that this decision is final and I will not be able to re-enroll in supplemental life insurance coverage. I also understand that Basic (City-paid) life insurance I have will remain in force, subject to applicable age reductions.

COMPLETE AND SIGN

_____ _____
Print Name Date

_____ _____
Signature Phone

_____
Email address

RETURN TO:

Department of Human Resources, ATTN: Benefits
By mail: 2331 Mill Road, Room 301, Alexandria, VA 22314
By email: DHR.Benefits@alexandriava.gov

City of Alexandria
Retiree Information Form

Retiree Name		
Retirement Date	Department Retired from	Sworn staff? Yes ☐ No ☐
SSN	Email Address:	

Retiree Information

Current Address: Street			Home Phone
City	State	Zip code	Cell Phone
Date of Birth	Gender	Marital Status	Email

Spouse Information (if Applicable)

Spouse Name			
Current Address: Street		Same as above ☐	Home Phone
City	State	Zip code	Work/Cell Phone
Date of Birth	Gender	SSN	

Emergency Contact Information

Contact Name			
Address: Street			Phone
City	State	Zip code	Relation

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DEPARTMENT OF HUMAN RESOURCES

2331 Mill Road, Room 301
Alexandria, Virginia 22314
Phone: 703.746.3777

RETIREE MEDICAL INSURANCE REIMBURSEMENT PLAN

NAME OF RETIREE _____
(PLEASE PRINT)

DATE OF BIRTH _____

ADDRESS _____

TELEPHONE Home: _____ **Cell:** _____

EMAIL ADDRESS _____

Insurance Plan Name: _____ **Spouse Plan? Yes** ___ **No** ___

Plan Year (Month/Year): _____

If the coverage is in your spouse's name, please be sure to provide the rate for both individual and family premiums. This information is required to determine the cost of adding you to your spouse's plan only.

Monthly premiums: Individual $_____ **Family: $**_____ **Other:** _____

Proof of coverage attached (please check all that apply):

_____**Statement of monthly premiums from plan carrier or employer.**

_____**Copies of payment coupons and cancelled checks.**

_____**Copies of payroll check stubs reflecting payroll deductions for health insurance coverage.**

I request to be reimbursed for the cost of healthcare premiums I have paid as shown above. I understand that I must notify the Department of Human Resources immediately if my premiums change or if I am no longer qualified for this program.

Date _____ **Signature** _____

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CITY OF ALEXANDRIA
DEPARTMENT OF HUMAN RESOURCES

2331 Mill Road, Room 301
Alexandria, VA 22314

Phone: 703-746-3777
www.alexandriava.gov

Authorization Agreement for Electronic Funds Transfer for Retiree Health and/or Life Insurance Premium Payments

I authorize the City of Alexandria, through Truist, to automatically debit/credit my bank account for health and/or life insurance payments/reimbursements as specified below. I understand that transactions will be processed on the 15th of each month. If the 15th falls on a holiday or weekend, transactions will be processed the next business day. I understand that funds will not be transferred to the City if there are insufficient funds in my account and that I will be subject to a $35 returned check fee.

Complete this agreement and attach a voided check from your checking account. A deposit slip may be used for a savings account only. Mail the completed agreement and your voided check to: Department of Human Resources, ATTN: Benefits, 2331 Mill Road, Room 301, Alexandria, VA 22314.

Applicant's Name:

Last Name:_____ First Name:_____ Middle Initial ____ SSN: _____

Mailing Address:

Street:_____ City: _____ State: _____ Zip: _____

Email: _____

Telephone Number: Home: _____ Cell: _____

Bank Name: _____ ☐ Checking ☐ Savings

Name of Account Holder: _____

Bank Routing Number (nine digits): _____ **Bank Account Number**: _____

By signing this agreement I understand I am authorizing the City to automatically debit/credit my bank account for health, dental, vision and/or life insurance payments/reimbursements and to stop health and/or life insurance deductions from my monthly VRS and/or Empower retirement payments, if applicable. I also understand that this electronic funds transfer authorization remains in effect until the City of Alexandria receives written notification of its termination. Written cancellation must be received by the City at least 15 days before the next scheduled deduction.

I have read and agree to the terms and conditions contained in this Authorization Agreement.

Print Name: _____

Signature: _____ **Date:** _____

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Standard Insurance Company

Change Form - Retirees

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT

Your Name (Last, First, Middle)		Group Name **City of Alexandria**	Group Number(s) **645212**	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Date Retired	

LIFE

Life Insurance

☒ Amount in effect as of your date of retirement.

BENEFICIARY

This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	**Address**	**Soc. Sec. No.**	**Relationship**	**% of Benefit**

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Name Change ☐ Beneficiary Change

Former name _____

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required	Date (Mo/Day/Yr)

Human Resources Department - Complete this section. Retain form for your records.

Received by	Date

Beneficiary Information

- Your designation revokes all prior designations.

- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).

- If you name two or more Beneficiaries in a class:

    1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

    2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

    3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____ ."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.