

# GUIDE TO FY 2014 OPEN ENROLLMENT PERIOD

This year's Open Enrollment period begins on May 9, 2013 and ends May 24, 2013. During this time, you may change your health, dental, long term disability plan coverage or enroll in the sick leave bank.



# Open Enrollment Guide

<p><b>What do I do if I'm satisfied with my current benefit plan choices?</b></p>	<p>If you are satisfied with your current plans, you need do nothing more!</p>
<p><b>If I want to make a change, what benefit plan choices can I make during Open Enrollment?</b></p>	<p><u>Health Insurance Plans:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Options to enroll, change, or drop your healthcare coverage.</li> <li><input type="checkbox"/> 3 Plans available in FY 2014 with individual, Employee + 1, and Family coverage options:             <ol style="list-style-type: none"> <li>1. Kaiser HMO</li> <li>2. United Healthcare Choice Plan (HMO)</li> <li>3. United Healthcare Choice Plus Plan (PPO)</li> </ol> <p>Note: Kaiser POS is no longer available.</p> </li> </ul> <p><u>Dominion Dental Insurance Plans:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Options to enroll, change, or drop your dental coverage.</li> <li><input type="checkbox"/> 2 Plans available in FY 2014 with individual, Employee + 1, and Family coverage options:             <ol style="list-style-type: none"> <li>1. DHMO Select Plan</li> <li>2. Access PPO Plan</li> </ol> </li> </ul> <p><u>The Standard Long Term Disability Plan:</u></p> <ol style="list-style-type: none"> <li>1. Upgrade from 120-day waiting period to 90-day waiting period</li> </ol> <p><u>The Sick Leave Bank:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> To enroll, employees must donate 8 hours of annual leave (prorated for regular part-time employees) to join.</li> <li><input type="checkbox"/> Employees may receive up to 160 hours (4 forty-hour weeks) from the Bank in the form of a grant for Family Medical Leave Act (FMLA) qualifying events in a rolling 12-month period.</li> </ul>
<p><b>What should I do if I'm considering a change to my benefits plan?</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review the packet you received by mail from HR that includes a personalized letter, the <i>Guide to FY 2014 Open Enrollment</i>, and benefit enrollment forms.</li> <li><input type="checkbox"/> Plan to visit one of the 11 on-site meetings scheduled to be held throughout the City during Open Enrollment so the health insurance carriers can answer your personal, unique questions/concerns. A schedule of dates/times is included on the next page.</li> <li><input type="checkbox"/> Visit the Open Enrollment and benefits information pages on <i>AlexNet</i>.</li> </ul>
<p><b>What is the deadline to make a change to my benefits plans?</b></p>	<p>The Open Enrollment period is Thursday, May 9 through Friday, May 24, 2013.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> If you decide to <u>enroll, change or drop</u> plan or tier, complete the appropriate enrollment form (included in this packet) and return it to Human Resources <b>no later than 4:30 pm on Friday, May 24<sup>th</sup> so it is processed timely.</b></li> </ul>
<p><b>Who can help me if I still have questions or need assistance with my choices?</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Visit one of the 11 on-site meetings scheduled to be held throughout the City during Open Enrollment (<i>see next page for schedule</i>) so the health insurance carriers can answer your personal, unique questions/concerns.</li> <li><input type="checkbox"/> Contact the HR Benefits Team Monday-Friday, 8:00AM – 5:00PM at (703) 746-3785.</li> </ul>

# Open Enrollment On-Site Meetings

## SCHEDULE OF OPEN ENROLLMENT ON-SITE MEETINGS

The FY 2014 Open Enrollment Period for the City's health and dental insurance plans, long term disability and sick leave bank will be held from **May 9 - May 24, 2013**. During this time, benefit eligible City employees and retirees will have the opportunity to review and discuss plan benefits with representatives from Dominion Dental, Kaiser Permanente and United HealthCare. Representatives will also be available to answer specific questions about the healthcare plan design changes and explain how the new deductibles will work.

Representatives from the City's health insurance carriers will be available at the scheduled "walk-in" enrollment meetings listed below. Please do not bring personal medical records or information to these sessions. Carriers will provide samples of the fees charged for many of the most common services provided to you.

<u>DATE</u>	<u>TIME</u>	<u>LOCATION</u>
Thursday, May 9	6:00 a.m. - 9:00 a.m.	T&ES 2900 B Business Center Drive Suite B
Friday, May 10	9:00 a.m. –11:00 a.m.	City Hall 301 King Street (Room 2000)
Monday, May 13	9:00 a.m. – 11:00 a.m.	Nanny Lee 1108 Jefferson Street (Gold Room)
Monday, May 13	1:00 p.m. – 3:00 p.m.	Beatley Central Library 5005 Duke Street
Tuesday, May 14	4:00 p.m. – 7:00 p.m.	Public Safety (Police) 3600 Wheeler Ave Suite 120A
Thursday, May 16	9:00 a.m. – 2:00 p.m.	Health, Wellness and Benefits Fair Charles Houston Recreation Center 901 Wythe Street
Friday, May17	1:00 p.m. – 3:00 p.m.	Dept. of Community & Human Services 2525 Mt. Vernon Avenue Atrium Conference Room
Monday, May 20	9:00 a.m. – 11:00 a.m.	DCHS (Joblink) 1900 N. Beauregard St.
Tuesday, May 21	1:00 p.m. – 3:00 p.m.	Dept. of Community & Human Services 720 N. St. Asaph Street 4 <sup>th</sup> Floor, Conference Room
Wednesday, May 22	6:00 a.m. – 9:00 a.m.	Public Safety (Fire) 900 Second Street (2 <sup>nd</sup> Floor)
Thursday, May 23	6:00 a.m. – 9:00 a.m.	Public Safety (Sheriff) 2003 Mill Road

# Common Health Insurance Terms

## COMMON HEALTH INSURANCE TERMS DEFINED

**Copayment (copay):** This is a specific amount you pay when you receive certain covered services or prescriptions. Copayments vary depending on the plan and the service.

- **In-Network copays** are fixed amounts you pay for covered services to providers who contract with your health insurance plan and are usually less than out-of-network copays.
- **Out-of-Network copays** are fixed amounts you pay for covered services from providers who do *not* contract with your health insurance plan and are usually more than in-network copays.

**Deductible:** A fixed amount you pay out of pocket before a health insurance plan begins to cover your health care costs.

**Emergency Room:** Typically, emergency room services include all services provided when a patient visits an emergency room for an emergency condition. An emergency condition is any medical condition of recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient's health in ***serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.***

**Out-Of-Pocket Maximum (Costs):** The most you pay in a plan year before your health insurance plan begins to pay 100% of the allowed amount. This limit never includes your premium and the design of a healthcare plan will determine if all, some, or none of your copays, deductibles, co-insurance, etc. count towards the limit.

**Premium:** The fixed amount that you will pay every month for health insurance coverage usually deducted from your biweekly paychecks.

**Preventive Care:** Medical care rendered not for a specific complaint, but focused on prevention and early-detection of disease. Specified by your plan, preventive care generally includes screening exams, routine preventive physical exams for adults and children, prenatal care, and vaccines (immunizations).

**Primary Care Physician (PCP):** A patient may be required to choose a primary care physician (PCP). A primary care physician usually serves as a patient's main healthcare provider. The PCP serves as a first point of contact for healthcare and may refer a patient to specialists for additional services.

**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.

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Sources:

- <http://www.ehealthinsurance.com/health-insurance-glossary/terms-e/>
- <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>
- [https://healthy.kaiserpermanente.org/static/health/en-us/landing\\_pages/continuingcoverage/glossary.htm](https://healthy.kaiserpermanente.org/static/health/en-us/landing_pages/continuingcoverage/glossary.htm)
- [http://www.uhc.com/source4women/understanding\\_health\\_coverage/common\\_terms\\_defined.htm](http://www.uhc.com/source4women/understanding_health_coverage/common_terms_defined.htm)

# Health Insurance

## CHANGES TO YOUR HEALTH INSURANCE BENEFITS IN FY 2014

The City will transition to a new consumer-driven health insurance model beginning July 1, 2013. This new model will not change your coverage. Your policy will cover the same services, procedures, tests, visits, and medications as before.

As you can see from the chart below, the plan design changes introduce a deductible that must be satisfied before health care benefits start. In addition, there is a new co-payment for in-network hospital visits and increased co-payments for Emergency Room and Urgent Care visits.

Plan Features	Current FY 2013 Plans		FY 2014 Plans
Deductibles	None		\$400/Individual \$800/Family (Includes Employee +1)
Annual Out-of-Pocket Maximum			Includes Deductible
<ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$2,200		\$2,200
	\$6,400		\$6,400
Preventive Care	Covered in Full		Covered in Full
PCP/Specialist Copay	\$15/\$25		Deductible + \$15/\$25
Emergency Room Copay	\$75		Deductible + \$150 copay
Inpatient Hospitalization Copay	Covered in Full		Deductible + \$500/admittance
Urgent Care Copay	\$15		Deductible + \$25 copay
Retail Prescription Drugs Copay	<u>Kaiser</u>	<u>UHC</u>	<u>All Plans</u>
<ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand Preferred</li> <li>• Brand Non-Preferred</li> </ul>	\$10	\$10	\$15
	\$20	\$25	\$30
	\$35	\$40	\$50
Mail Order	2xRetail	1xRetail	2.5xRetail
			After 3 <sup>rd</sup> refill, mail order is mandatory

# Health Insurance

## FY 2014 HEALTH INSURANCE PREMIUM RATES FOR **FULL-TIME EMPLOYEES**

As a result of the plan design changes, the FY 2014 premium rates will be **lower** than FY 2013 levels. On a total plan basis, the Kaiser rates will be 5.6% lower than FY 2013 levels and United Healthcare rates will be lower by 1.8%.

### REGULAR FULL-TIME EMPLOYEES

		Kaiser Permanente									
		HMO (In Plan Coverage Only)					POS (In Plan or out of Plan Coverage)				
		TOTAL COST	CITY COST	CITY % OF COST	EMPLOYEE COST	EMPLOYEE % OF COST	TOTAL COST	CITY COST	CITY % OF COST	EMPLOYEE COST	EMPLOYEE % OF COST
<b>Individual</b>	Monthly	\$479.89	\$383.91	80.00%	\$95.98	20.00%	Plan Will Not Be Offered in FY 2014**				
	Bi-Weekly*				\$47.99						
<b>Employee + One</b>	Monthly	\$959.77	\$767.82	80.00%	\$191.95	20.00%					
	Bi-Weekly*				\$95.98						
<b>Family</b>	Monthly	\$1,223.71	\$978.97	80.00%	\$244.74	20.00%					
	Bi-Weekly*				\$122.37						

		United Health Care									
		Choice (In Plan Coverage Only)					Choice Plus (In Plan or out of Plan Coverage)				
		TOTAL COST	CITY COST	CITY % OF COST	EMPLOYEE COST	EMPLOYEE % OF COST	TOTAL COST	CITY COST	CITY % OF COST	EMPLOYEE COST	EMPLOYEE % OF COST
<b>Individual</b>	Monthly	\$575.00	\$460.00	80.00%	\$115.00	20.00%	\$686.79	\$460.00	66.98%	\$226.78	33.02%
	Bi-Weekly*				\$57.50					\$113.39	
<b>Employee + One</b>	Monthly	\$1,150.01	\$920.01	80.00%	\$230.00	20.00%	\$1,452.11	\$920.01	63.36%	\$532.10	36.64%
	Bi-Weekly*				\$115.00					\$266.05	
<b>Family</b>	Monthly	\$1,477.77	\$1,182.21	80.00%	\$295.55	20.00%	\$1,866.16	\$1,182.21	63.35%	\$683.95	36.65%
	Bi-Weekly*				\$147.78					\$341.98	

\*Bi-Weekly payments are for 24 pay periods. Premium payments are not deducted for two pay periods per year.

\*\*Kaiser has informed the City that due to the plan design changes enacted in FY 2014 it will be unable to support the POS plan offered to employees and retirees in FY 2013. With the discontinuation of the POS plan, employees and retirees enrolled in the Kaiser POS plan in FY 2013 will be required to select a new City sponsored plan, or drop their coverage during the FY 2014 open enrollment period which will take place in May 2013.

# Health Insurance

## FY 2014 HEALTH INSURANCE PREMIUM RATES FOR **PART-TIME EMPLOYEES**

As a result of the plan design changes, the FY 2014 premium rates will be **lower** than FY 2013 levels. On a total plan basis, the Kaiser rates will be 5.6% lower than FY 2013 levels and United Healthcare rates will be lower by 1.8%.

### REGULAR PART-TIME EMPLOYEES

		Kaiser Permanente										
		HMO (In Plan Coverage Only)					POS (In Plan or out of Plan Coverage)					
		TOTAL COST	CITY COST	CITY % OF COST	EMPLOYEE COST	EMPLOYEE % OF COST	TOTAL COST	CITY COST	CITY % OF COST	EMPLOYEE COST	EMPLOYEE % OF COST	
<b>Individual</b>	Monthly	\$479.89	\$239.95	50.00%	\$239.95	50.00%	Plan Will Not Be Offered in FY 2014**					
	Bi-Weekly*	\$119.97										
<b>Employee + One</b>	Monthly	\$959.77	\$479.89	50.00%	\$479.89	50.00%						
	Bi-Weekly*	\$239.94										
<b>Family</b>	Monthly	\$1,223.71	\$611.86	50.00%	\$611.86	50.00%						
	Bi-Weekly*	\$305.93										

		United Health Care									
		Choice (In Plan Coverage Only)					Choice Plus (In Plan or out of Plan Coverage)				
		TOTAL COST	CITY COST	CITY % OF COST	EMPLOYEE COST	EMPLOYEE % OF COST	TOTAL COST	CITY COST	CITY % OF COST	EMPLOYEE COST	EMPLOYEE % OF COST
<b>Individual</b>	Monthly	\$575.00	\$287.50	50.00%	\$287.50	50.00%	\$686.79	\$287.50	41.86%	\$399.29	58.14%
	Bi-Weekly*	\$143.75					\$199.64				
<b>Employee + One</b>	Monthly	\$1,150.01	\$575.00	50.00%	\$575.00	50.00%	\$1,452.11	\$575.00	39.60%	\$877.11	60.40%
	Bi-Weekly*	\$287.50					\$438.55				
<b>Family</b>	Monthly	\$1,477.77	\$738.88	50.00%	\$738.88	50.00%	\$1,866.16	\$738.88	39.59%	\$1,127.28	60.41%
	Bi-Weekly*	\$369.44					\$563.64				

\*Bi-Weekly payments are for 24 pay periods. Premium payments are not deducted for two pay periods per year.

\*\*Kaiser has informed the City that due to the plan design changes enacted in FY 2014 it will be unable to support the POS plan offered to employees and retirees in FY 2013. With the discontinuation of the POS plan, employees and retirees enrolled in the Kaiser POS plan in FY 2013 will be required to select a new City sponsored plan, or drop their coverage during the FY 2014 open enrollment period which will take place in May 2013.

# Health Insurance

## FY 2014 COMPARISON OF HEALTH INSURANCE PLAN FEATURES

(For Period July 1, 2013 through June 30, 2014)

To help in your review of key benefits included in each of the plans, please see the comparison chart below:

Covered Benefits	Kaiser DHMO	United Healthcare Choice (HMO)	United Healthcare Choice Plus (PPO)	
			In-Network	Out-of-Network
<b>Deductible</b>	\$400 Individual \$800 Family*	\$400 Individual \$800 Family*	\$400 Individual \$800 Family*	\$800 Individual \$1600 Family
<b>Out-of-Pocket Maximum</b>	\$2200 Individual \$6400 Family	\$2200 Individual \$6400 Family	\$2800 Individual \$8600 Family	\$2800 Individual \$8600 family
<b>Primary Care Office Visit for Illness</b>	\$15 Copay \$0 Copay for Children under age 5	\$15 Copayment	\$15 Copayment	80% coinsurance
<b>Specialist Office Visit for Illness</b>	\$25 Copay	\$25 Copayment	\$25 Copayment	80% Coinsurance
<b>X-ray, Lab, and Diagnostics (Outpatient)</b>	\$0 Copay	100%	100%	80% Coinsurance
<b>X-ray, Lab, and Major Diagnostics (CT, PET, MRI, MRA and Nuclear Medicine (Outpatient))</b>	\$75 Copay	\$100 Copayment per service	\$100 Copayment per service	80% Coinsurance
<b>Inpatient Hospitalization</b>	\$500 Copay	\$500 Copayment per admit	\$500 Copayment per admit	80% Coinsurance
<b>Emergency Room Copay</b>	\$150 Copay**	\$150 Copayment per visit**	\$150 Copayment per visit**	\$150 Copayment per visit**
<b>Urgent Care Copay</b>	\$25 Copay	\$25 Copayment	\$25 Copayment	80% Coinsurance
<b>Mental Health and Substance Abuse Services-Inpatient/Intermediate</b>	\$500 Copay	\$500 Copayment per admit	\$500 Copayment per admit	\$500 Copayment per admit, 80% Coinsurance
<b>Mental Health and Substance Abuse Services-Outpatient</b>	\$15 Copay Individual \$7 Copay Group	\$15 Copayment	\$15 Copayment	80% Coinsurance
<b>Pregnancy/Maternity Services</b>	\$15 Initial visit, then \$0 copay	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category, 80% Coinsurance
<b>Preventive Care</b>				
<b>Well Child Care</b>	Covered in full	Covered in full	Covered in full	80% Coinsurance
<b>Adult Physical Exam</b>	Covered in full	Covered in full	Covered in full	80% Coinsurance
<b>Routine GYN Visit</b>	Covered in full	Covered in full	Covered in full	80% Coinsurance
<b>Mammogram</b>	Covered in full	Covered in full	Covered in full	80% Coinsurance
<b>Cancer Screening (Pap Test, Prostate)</b>	Covered in full	Covered in full	Covered in full	80% Coinsurance

# Health Insurance

## FY 2014 COMPARISON OF HEALTH INSURANCE PLAN FEATURES CONTINUED

(For Period July 1, 2013 through June 30, 2014)

Covered Benefits	Kaiser DHMO	United Healthcare Choice (HMO)	United Healthcare Choice Plus (PPO)	
			In-Network	Out-of-Network
<b>Prescription Drug Coverage<sup>1</sup></b>				
<b>Generic Brand<sup>2</sup> (Lowest-Cost)</b>	\$15 Medical Center, \$25 Participating Community Pharmacy	\$15 Copayment	\$15 Copayment	80% Coinsurance
<b>Preferred Brand (Mid-Range Cost)</b>	\$30 Medical Center \$40 Participating Community Pharmacy	\$30 Copayment	\$30 Copayment	80% Coinsurance
<b>Non-Preferred Brand (Highest Cost)</b>	\$50 Medical Center \$55 Participating Community Pharmacy	\$50 Copayment	\$50 Copayment	80% Coinsurance
<b>Mail Order</b>	Generic: \$13 Preferred: \$23 Non-Preferred: \$38	Mandatory mail order after 3 <sup>rd</sup> fill at retail	Mandatory mail order after 3 <sup>rd</sup> fill at retail	Mandatory mail order after 3 <sup>rd</sup> fill at retail

\* Includes Employee + 1

\*\*Waived if admitted

<sup>1</sup> If you choose a non-preferred brand name drug instead of the generic equivalent, you will pay the highest copay plus the difference in cost between the non-preferred brand name and the generic. If a generic version is not available, you will only pay the copay. Also, if your prescription is written for a brand name and DAW (dispense as written) is noted on the prescription, you will only pay the copay.

<sup>2</sup> Prescription Drug tiers are the different cost levels you pay for a medication. Each tier is assigned a cost, which is the amount you will pay when you fill a prescription. Generic medications are your lowest-cost options. If the brand of medication prescribed is Preferred or Non-Preferred, please check with your physician to see if there is a Generic alternative.

**NOTE:** While increasing use of generics is one way to lower pharmacy costs, not all generics represent the best value. In fact, there are many instances where a generic can be more expensive than a brand and/or other alternative.

When a new generic launches (just following the brand's patent expiration), the first generic manufacturer typically has six months of little to no competition from other generics in the marketplace, known as an exclusivity period. In some cases, pharmaceutical manufacturers will price the generic at a premium to the brand in order to take advantage of pharmacy dispensing practices that automatically favor generics, regardless of cost.

# Health Insurance

## OUT-OF-POCKET ASSISTANCE PROGRAMS

To assist employees with the transition to the new consumer-driven health insurance model, two one-time assistance programs have been created to help mitigate potential out-of-pocket healthcare costs in FY 2014.

**NOTE:** Rules and procedures for administering these programs are still under development, and the information above is subject to change. Once finalized, more detailed information about the programs noted below will be communicated to employees.

## LUMP SUM ASSISTANCE PROGRAM (AUTOMATIC)

All full- and part-time employees enrolled in a City-sponsored health care plan, as of the end of Open Enrollment (May 24, 2013), will automatically receive a one-time payment to assist with out-of-pocket healthcare expenses in FY 2014. Depending on the plan an employee is enrolled in, these payments will range from approximately \$196 - \$532. The payments listed in the table below reflect the net (after taxes) amount an employee will receive. Please note individual payments may vary depending on the federal and State tax withholdings an employee may be subject to. The lump-sum payments will be available in employees' July 26 paycheck.

Plan Type and Tier	Estimated Assistance Program Payout (Net "After Taxes" Amount)
<b><i>Kaiser &amp; UHC HMO Plans</i></b>	
Individual	\$196
EE+1	\$391
Family	\$501
<b><i>UHC PPO Plans</i></b>	
Individual	\$207
EE+1	\$414
Family	\$532

## ANNUAL /COMP TIME LEAVE CONVERSION PROGRAM (OPTIONAL)

Full and part-time employees enrolled in a City health plan will be able to convert available leave or comp time to a net \$200 cash payout. This is an optional program that will be available throughout FY 2014 (until June 30, 2014). Additional details about this program and a tool to assist employees with determining their net leave conversions will be available soon.

# Dental Insurance

## DOMINION DENTAL

Dominion Dental is the City's current provider of voluntary dental benefits. We are pleased to report there will be no increase in rates for the new plan year and they are reflected below:

DOMINION DENTAL PLANS (Bi-Weekly Employee Costs)		
Coverage Tier	DHMO Select Plan	Access PPO 100/75/50 Plan
Subscriber Only	\$ 9.76	\$18.18
Subscriber + One Dependent	\$16.28	\$33.98
Subscriber + Two or More Dependents	\$21.96	\$51.59

Enrollment forms and a benefits description are included in this packet. Additional information will be distributed at the informational meetings and will also be posted on AlexNet.

**NOTE:** Effective July 1, 2013, the benefit plan description will change from the Select Plan 607X to the Select Plan 707X which includes several new covered procedures (including discounts on all implant procedures and an extra cleaning for diabetics and expectant mothers). This change will occur automatically and does not require the employee to re-enroll.

# Flexible Spending Account (FSA)

## FLEXIBLE SPENDING ACCOUNT (FSA)

This fiscal year, we will align the start of the Flexible Spending Account (FSA) plan year (currently Jan.1) with the start of the City's health insurance plan year (July 1). In order to do this, there will be two open enrollment periods as shown on the chart below. The FSA open enrollment period will run concurrently with the healthcare open enrollment period beginning Spring 2014.

Open Enrollment Period	Plan Year Schedule*
November 2013	January 1 – June 30, 2014
Spring 2014	July 1, 2014 – June 30, 2015
<i>*Schedule for second open enrollment period not yet final</i>	

# *Long Term Disability*

## **LONG TERM DISABILITY (LTD) – The Standard Insurance Company:**

The City provides long-term disability insurance through the Standard Insurance Company. Each year during Open Enrollment, employees can make changes to the disability waiting period before LTD benefits begin. The basic benefit has a 120-day waiting period and is paid by the City. For an increased premium equal to .10% of insured earnings, employees can select a 90-day waiting period. For additional information and/or enrollment forms, please contact a member of the Benefits Team at (703) 746-3785.

# *Sick Leave Bank*

## **SICK LEAVE BANK**

The annual open enrollment period for the Sick Leave Bank runs concurrently with the healthcare open enrollment period (5/9 – 5/24). To enroll, regular employees must donate 8 hours of annual leave (prorated for regular, part-time employees) to join.

Employees may receive up to 160 hours (4 forty-hour weeks) from the Bank in the form of a grant for Family Medical Leave Act (FMLA) qualifying events in a rolling 12-month period. The 160 hours is prorated for regular, part-time employees. Please note once you have enrolled, you continue to participate until you notify Human Resources that you no longer wish to participate.

To learn more about the Sick Leave Bank, please read the Sick Leave Bank policy on the Human Resources home page on AlexNet (Sick Leave Bank Policy). For questions on the enrollment process or to obtain an enrollment form, please visit AlexNet [Sick Leave Bank FAQs](#) and [Sick Leave Bank Enrollment Form](#). An enrollment form is also included in this packet for your convenience.

# *Other Useful Open Enrollment Information*

## **HEALTH CARE REFORM**

As required under the Patient Protection and Affordable Care Act of 2010, the Summary of Benefits Coverage (SBC) for each of the 3 health plans must be made available to all benefitted employees through the City. These documents as well as updated FY 2014 Group Insurance Summary Descriptions will soon be posted on AlexNet for your review.

Also, this legislation mandates that dependents can continue health coverage on their parent's health plan up to age 26. Your dependent child must be less than 26 years of age and ineligible for health coverage through his/her employer. If you have questions or need additional information, please contact a member of the Benefits Team at (703) 746-3785.

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## **QUALIFYING EVENTS**

Employees are responsible for notifying the Benefits Team of any changes in their dependents' status (Divorce, Birth, Legal Adoption, Legal Guardianship, Death, Eligible Dependent's loss of health coverage). This qualifying event allows employees to change tiers, but not plans, even after open enrollment has ended. If you have any questions or concerns regarding your dependent enrollments and eligibility requirements, please contact the Benefits Division at (703) 746-3785 for assistance.

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## **REMOTELY ACCESSING INFORMATION AND FORMS FROM HOME**

AlexNet is available from outside the City's institutional network (I-Net). While you are logged into AlexNet remotely, your session will be encrypted in the same manner as an online store or your bank's Web site. This means that you can access your confidential pay and benefits information in the privacy of your home. In order to protect the security of the City's network, you must meet certain anti-virus and system requirements. You may view or print out the list of requirements and a step-by-step guide by visiting the following web address on AlexNet:

<https://alexnet.alexandriava.gov/Technology/content.aspx?id=4222>

Otherwise, you may access the AlexNet Remote Access gateway from the following web address:

<https://alexnet.alexandriava.gov>

Note: Employees with newer Windows 8 computers at home will not be able to access AlexNet remotely. ITS will be scheduling an update to allow Windows 8 authentication in the near future.

# *Forms*

- Kaiser Permanente Enrollment Form
  - United Healthcare HMO Enrollment Form
  - United Healthcare PPO Enrollment Form
  - Dominion Dental Choice Plan Comparison, Enrollment and Change Form
  - Long-Term Disability Enrollment Form
  - Sick Leave Bank Enrollment Form
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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)
2101 East Jefferson Street, Rockville, Maryland 20852

KAISER PERMANENTE ENROLLMENT & CHANGE FORM
HMO PLAN OFFERINGS
INSTRUCTIONS

Table with 2 columns and multiple rows containing enrollment instructions, section headers (Section B, C, D, E), and detailed instructions for each section.

	<b>Section G: Subscriber Sign-off</b>
<b>Section F: Other Coverage Information</b>	Review and sign this form. Before you sign this form, please make certain you have read all coverage materials and have selected a primary care provider. Failure to complete all relevant parts of this form may delay or prevent enrollment and the issuance of a member ID card.
<p>Tell us if you, your spouse, or other family dependents are covered by other group health insurance plans. This may occur when both spouses are employed and have health care benefits from one or more health plan(s). If you or your family are covered by more than one health plan, you may be able to save money while improving your coverage. If you are covered by two plans that include a Coordination of Benefit (COB) provision, you may be able to eliminate some of your out-of-pocket expenses for approved services now only partially covered by those plans.</p> <p>If the Coordination of Benefits provisions apply to you, your signature on this form will permit KFHP-MAS to bill any other health care policy that is determined to be the primary carrier in accordance with the National Association of Insurance Commissioners (NAIC) guidelines including , but not limited to; Medicare, Motor Vehicle Insurance (Except Virginia residents and Virginia group employees. Virginia residents and Virginia group employees are not subject to subrogation of a recovery for personal injuries from a third person.), Workers' Compensation, Tricare, Veterans Administration, so long as you are enrolled in the primary plan and such plan remains primary to KFHP – MAS plan. Your signature authorizes KFHP-MAS and its employees to release any records or information with respect to any claim for covered services that may be requested by your other carrier. Such authorization shall be valid for the duration of coverage. For more information on Coordination of Benefits, please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380.</p>	<p style="text-align: center;"><b>MISREPRESENTATION</b></p> <p>If you knowingly or intentionally file an enrollment form or statement of claim containing any materially false or deceptive statements, or you knowingly or intentionally fail to provide requested information, you may have violated state law which could subject you to civil and/or criminal penalties. <b>You may also be liable to KFHP-MAS for the cost of health care services provided because of the false or misleading information or omission.</b></p>

REMOVE THIS INSTRUCTION SHEET PRIOR TO SUBMITTING FORM

\*Additional documentation will be required.

\*\* May require additional information

**Kaiser Foundation Health Plan of the  
Mid-Atlantic States, Inc. (KFHP-MAS)**  
2101 East Jefferson Street, Rockville, Maryland 20852

**KAISER PERMANENTE ENROLLMENT & CHANGE FORM  
HMO PLAN OFFERINGS**

If you have any questions concerning the benefits and services that are provided by or excluded under your plan offering, please contact a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 before signing this form.

Please see instructions located at the back of this booklet for directions on how to complete this form. After you have completed this form, please sign and return all pages, including the instructions, to your employer's benefits office. **DO NOT SEND THIS FORM TO KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.**

If you are enrolling in our Medicare product, there is a separate enrollment process. Please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 for more information.

**TO BE COMPLETED BY EMPLOYER Please print or type in black ink only.**

**ENROLLMENT TYPE**

NEW     CHANGE

**EMPLOYMENT STATUS**

Active     Retired

**GROUP NO.**

**SUBGROUP NO.**

**THE INFORMATION BELOW IS REQUIRED BY LAW. FAILURE TO COMPLETE WILL RESULT IN A DELAY OF APPLICATION PROCESSING.**

CHECK IF NEW HIRE      IF NEW HIRE, INDICATE NEW HIRE DATE (MM/DD/YYYY)

**EMPLOYEE LAST NAME**

**FIRST NAME**

**MI**

**SUFFIX**

*Check One and indicate date of event:*

New enrollment      New enrollment Effective Date (MM/DD/YYYY)

Open enrollment (complete sections A, C, F, G)      Open enrollment Effective Date (MM/DD/YYYY)

COBRA (complete sections A, B, E, G)      COBRA Effective Date (MM/DD/YYYY)

Loss of other coverage (complete sections A, C, F, G)

Cancel all coverage (empl. and family) (complete sections A, G) Effective Date of Cancellation (MM/DD/YYYY)

**EMPLOYER AUTHORIZED REPRESENTATIVE SIGNATURE**

*I hereby certify that this(these) enrollment(s) has been reviewed and meet(s) all eligibility requirements*

Printed or Typed Name/Title		
Employer Signature		
Date	Telephone	Fax

\*Additional documentation will be required.

\*\* May require additional information

A. EMPLOYEE INFORMATION

ENROLLMENT TYPE  SELF ONLY  SELF & DEPENDENTS complete sections A, C, F, G)

PLAN Check one:

HMO Signature   
 Select

Added Choice Signature   
 Select

<input type="checkbox"/> Deductible HMO (DHM) Signature <input type="checkbox"/> Select <input type="checkbox"/>	<input type="checkbox"/> Deductible HMO w/HRA (DHR) Signature <input type="checkbox"/> Select <input type="checkbox"/>
<input type="checkbox"/> HSA-Qualified HMO (HHM) Signature <input type="checkbox"/> Select <input type="checkbox"/>	<input type="checkbox"/> HSA-Qualified HMO w/HRA (HHR) Signature <input type="checkbox"/> Select <input type="checkbox"/>

COMPANY NAME

LAST NAME

FIRST NAME

MI

SUFFIX

SOCIAL SECURITY NUMBER

MEDICAL RECORD NO.

DATE OF BIRTH (MM/DD/YYYY)

MALE

FEMALE

ADDRESS

APARTMENT NUMBER CITY

STATE

ZIP CODE

HOME PHONE

WORK PHONE

Email address (Optional)

Primary Care Provider (PCP) Name \_\_\_\_\_

PCP ID#

\*Additional documentation will be required.  
\*\* May require additional information

**B. Waiver of Coverage**

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer. I refuse the following:

- All Coverage     Coverage for my Spouse
- Coverage for my Children

*I understand that if I or my Dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit documentation to support enrollment outside the Open Enrollment period and coverage may be subject to late enrollment provisions, as allowed by law and as directed by my employer.*

Reason for refusal: (Please check all appropriate boxes)

- other group coverage sponsored by my employer\*
- other group coverage sponsored by my Spouse's employer\*
- other group coverage sponsored by another organization\*
- other reasons (please explain)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IF MAKING A CHANGE, COMPLETE THE FOLLOWING:**

ADD DEPENDENTS (Complete sections A, C, F, G)

	Date of Event (MMDDYYYY)		Date of Event (MMDDYYYY)
<input type="checkbox"/> Birth**	□□□□□□□□	<input type="checkbox"/> Loss of other Coverage*	□□□□□□□□
<input type="checkbox"/> Adoption*	□□□□□□□□	<input type="checkbox"/> Marriage*	□□□□□□□□
<input type="checkbox"/> Address (complete sections A, G)	<input type="checkbox"/> Telephone (complete sections A, G)		
<input type="checkbox"/> Name Change* _____ Previous Name _____	<input type="checkbox"/> Other (please specify; Complete sections A, C, G)*		

**C. FAMILY INFORMATION** (If additional space is needed please use another form and attach it to this form)

<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> DOMESTIC PARTNER (If eligible under your plan)
LAST NAME	FIRST NAME	MI	SUFFIX
□□□□□□□□□□□□□□□□	□□□□□□□□□□□□□□	□	□□□□
SOCIAL SECURITY NUMBER	MEDICAL RECORD NO.	DATE OF BIRTH (MM/DD/YYYY)	MALE    FEMALE
□□□□□□□□□□	□□□□□□□□□□	□□□□□□□□	□    □
Primary Care Provider (PCP) Name _____		PCP ID # □□□□□□□□	

<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER _____
LAST NAME	FIRST NAME	MI	SUFFIX
□□□□□□□□□□□□□□□□	□□□□□□□□□□□□□□	□	□□□□
SOCIAL SECURITY NUMBER	MEDICAL RECORD NO.	DATE OF BIRTH (MM/DD/YYYY)	MALE    FEMALE
□□□□□□□□□□	□□□□□□□□□□	□□□□□□□□	□    □
Primary Care Provider (PCP) Name _____		PCP ID # □□□□□□□□	

\*Additional documentation will be required.  
\*\* May require additional information



**F. OTHER COVERAGE INFORMATION**

Including yourself, do any of the persons listed above have other coverage?  YES  NO

Name \_\_\_\_\_ Insurance Carrier Name \_\_\_\_\_ Policy Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

Are you or any of your dependents eligible for Medicare?  YES  NO

If Yes, please complete the following:

**MEDICAID NUMBER**

**MEDICARE (HIC) NUMBER**

**MEDICARE Part A** Effective Date (MM/DD/YYYY)

**MEDICARE Part B** Effective Date (MM/DD/YYYY)

**MEDICARE Part D** Effective Date (MM/DD/YYYY)

**G. Important:** I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this form is accepted, coverage will be provided according to the terms and conditions of my employer's contract with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

I authorize KFHP-MAs and its employees to release any records or information with respect to any claim for covered services that may be requested by another insurance carrier. Such authorization shall be valid for the duration of coverage.

I understand that I or any person authorized to act on my behalf is entitled to receive a copy of this form.

**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties may include imprisonment and/or fines. In addition, KFHP-MAS may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your form and/or claims payment.

\_\_\_\_\_  \_\_\_\_\_  
Employee/Applicant Signature Date Employer Signature Date

\*Additional documentation will be required.

†† May require additional information

1 EMPLOYEE INFORMATION									
Last Name	First Name	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married			
Home Address			City		State	Zip Code	Home Phone Number (    ) (    )		
Employer Name		Division/Location		<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> Union <input type="checkbox"/> Nonunion	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary	<input type="checkbox"/> Active <input type="checkbox"/> Retired (Date    )	Work Phone Number (    ) (    )	

2 WHO SHOULD BE COVERED
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse <input type="checkbox"/> Employee Plus One Dependent <input type="checkbox"/> Employee Plus Child(ren) <input type="checkbox"/> Employee Plus Family

3 WAIVER OF COVERAGE
<input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents  <i>Reason:</i> <input type="checkbox"/> covered under another plan <input type="checkbox"/> Other: _____ (see sections 6&7)  <i>*Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.</i>

4 TYPE OF CHANGE
<input type="checkbox"/> Add Spouse/Child (complete Sec. 5) <input type="checkbox"/> Terminate Spouse/Child (complete Sec. 5) <input type="checkbox"/> Address (enter above) <input type="checkbox"/> Name Change (complete Sec. 5) <input type="checkbox"/> Terminate All Coverage - Reason _____  <input type="checkbox"/> Reinstatement - Reason _____ <input type="checkbox"/> <b>Surviving Spouse - Former Employee SSN</b> _____ <input type="checkbox"/> <b>COBRA Continuee - Former Employee SSN</b> _____ <input type="checkbox"/> Other _____

5 COVERAGE INFORMATION									
(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Zip Code	Date of Birth (MM/DD/YY)	Sex	Other Insurance	Disabled	Full-Time Student Over 19?
	Employee								
	Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		
	Child 1					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child 2					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child 3					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

6 OTHER INSURANCE
On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another United HealthCare plan, Medicare or Medicaid? ..... <input type="checkbox"/> Y <input type="checkbox"/> N Is another person legally responsible for coverage for your children? ..... <input type="checkbox"/> Y <input type="checkbox"/> N If you answered yes to either of the questions above, please complete the following:
Person's Name with Other Health Plan _____ Social Security Number _____ Date of Birth _____ Sex _____ Other Company's Name and Phone Number _____ Other Company's Policy Number and Effective Date _____ Medicare Number _____ Part A Effective Date _____ Part B Effective Date _____

7 AUTHORIZATION
On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give United HealthCare and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.  If my employees plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.
<b>NOTICE OF ENROLLMENT RIGHTS</b> I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.
Health Insurance or medical services benefits provided or administered by United HealthCare Insurance Company of New York, Hauppauge, NY. X Signature _____ Date _____

8 TO BE COMPLETED BY EMPLOYER							
Date of Hire	Date Submitted	Health/Change Eff. Date	Policy Number	GRP/SUBGRP/BNFT GRP	Plan Variation/Sub	Reporting Code/Branch	Employer Signature

1 EMPLOYEE INFORMATION									
Last Name	First Name	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married			
Home Address			City		State	Zip Code	Home Phone Number (    ) (    )		
Employer Name		Division/Location		<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> Union <input type="checkbox"/> Nonunion	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary	<input type="checkbox"/> Active <input type="checkbox"/> Retired (Date    )	Work Phone Number (    ) (    )	

2 WHO SHOULD BE COVERED
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse <input type="checkbox"/> Employee Plus One Dependent <input type="checkbox"/> Employee Plus Child(ren) <input type="checkbox"/> Employee Plus Family

3 WAIVER OF COVERAGE
<input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents  <i>Reason:</i> <input type="checkbox"/> covered under another plan <input type="checkbox"/> Other: _____ (see sections 6&7)  <i>*Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.</i>

4 TYPE OF CHANGE
<input type="checkbox"/> Add Spouse/Child (complete Sec. 5) <input type="checkbox"/> Terminate Spouse/Child (complete Sec. 5) <input type="checkbox"/> Address (enter above) <input type="checkbox"/> Name Change (complete Sec. 5) <input type="checkbox"/> Terminate All Coverage - Reason _____  <input type="checkbox"/> Reinstatement - Reason _____ <input type="checkbox"/> <b>Surviving Spouse - Former Employee SSN</b> _____ <input type="checkbox"/> <b>COBRA Continuee - Former Employee SSN</b> _____ <input type="checkbox"/> Other _____

5 COVERAGE INFORMATION									
(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Zip Code	Date of Birth (MM/DD/YY)	Sex	Other Insurance	Disabled	Full-Time Student Over 19?
	Employee								
	Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		
	Child 1					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child 2					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child 3					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

6 OTHER INSURANCE
On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another United HealthCare plan, Medicare or Medicaid? ..... <input type="checkbox"/> Y <input type="checkbox"/> N Is another person legally responsible for coverage for your children? ..... <input type="checkbox"/> Y <input type="checkbox"/> N If you answered yes to either of the questions above, please complete the following:
Person's Name with Other Health Plan _____ Social Security Number _____  Date of Birth _____ Sex _____ Other Company's Name and Phone Number _____  Other Company's Policy Number and Effective Date _____ Medicare Number _____ Part A Effective Date _____ Part B Effective Date _____

7 AUTHORIZATION
On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give United HealthCare and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.  If my employees plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.
<b>NOTICE OF ENROLLMENT RIGHTS</b>  I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.  Health Insurance or medical services benefits provided or administered by United HealthCare Insurance Company of New York, Hauppauge, NY.
X Signature _____ Date _____

8 TO BE COMPLETED BY EMPLOYER							
Date of Hire	Date Submitted	Health/Change Eff. Date	Policy Number	GRP/SUBGRP/BNFT GRP	Plan Variation/Sub	Reporting Code/Branch	Employer Signature

# Enrollment Application and Change Form

## INSTRUCTIONS

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1 .....Complete all information.

SECTION 2 .....Select who should be covered on the plans.

SECTION 3 .....Complete this section if you choose to decline coverage for yourself or any of your dependents.

SECTION 4 .....Complete this section if you are making a change. Select the box which indicates the type of change you are making.

SECTION 5 .....Fill in the appropriate action code for completing this form:

- A = To add a dependent to your benefit plan
- T = To terminate your or a dependent's coverage
- C = To change information about yourself or a dependent

Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, check the box marked Other Insurance and complete Section 6. Provide the zip code, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is disabled or a full-time student. (If you have more than 4 dependents, please attach an additional enrollment form.)

SECTION 6 .....This section must be completed for all new enrollments or coverage changes.

SECTION 7 .....The employee must sign and date this form in order for it to be processed.

SECTION 8 .....This section is to be completed by the employer's benefit representative.



# Choice Plan Comparison

## Select Plan 707X (Same as a DHMO)<sup>1</sup>

Summary of Benefits	Your Coverage <sup>2</sup>
<b>Diagnostic &amp; Preventive Care</b> <ul style="list-style-type: none"> <li>• Oral exams</li> <li>• Bitewing X-rays</li> <li>• Topical fluoride for children</li> <li>• Semiannual (2) teeth cleanings</li> <li>• Sealants</li> </ul>	100%
<b>Basic Care</b> <ul style="list-style-type: none"> <li>• Fillings               <ul style="list-style-type: none"> <li>◦ Amalgam (silver)</li> <li>◦ Composite (white)</li> </ul> </li> <li>• Full and panoramic X-rays</li> <li>• Extraction, erupted tooth</li> </ul>	70-85%
<b>Major Restorative Care<sup>3</sup></b> <b>Prosthetics</b> <ul style="list-style-type: none"> <li>• Crowns and bridges</li> <li>• Dentures</li> <li>• Relining of dentures</li> </ul> <b>Periodontics</b> <ul style="list-style-type: none"> <li>• Root planing and therapy</li> </ul> <b>Endodontics</b> <ul style="list-style-type: none"> <li>• Root canals</li> </ul> <b>Oral Surgery</b> <ul style="list-style-type: none"> <li>• Extraction of impacted teeth</li> </ul>	60-75%
<b>Orthodontics</b> <ul style="list-style-type: none"> <li>• Children</li> <li>• Adults</li> </ul>	45%
Benefit Features	Your Coverage
Office Visit	\$10 Copayment
Deductibles	None
Annual Maximum	None
Waiting Periods	None
Claim Forms	None <sup>4</sup>
Receive Care From	Select Plan Dentist

1. Same as a DHMO with fixed member copayments, no annual maximum dollar limits, no waiting periods, no deductibles, no pre-authorization paperwork or pre-treatment estimates and no claim forms (except in the case of out-of-area emergencies).
2. Approximate percentage of coverage based on the Captiva Context Fee Schedule's 80th percentile. A specific copayment schedule is enclosed.
3. As performed by a General Practitioner.
4. Out-of-area emergency care reimbursement requires a receipt or other proof of loss.

## Access PPO 100/75/50

Summary of Benefits	Your Coverage
<b>Diagnostic &amp; Preventive Care</b> <ul style="list-style-type: none"> <li>• Oral exams</li> <li>• Bitewing X-rays</li> <li>• Topical fluoride for children</li> <li>• Semiannual (2) teeth cleanings</li> </ul>	100%
<b>Basic Care<sup>1</sup></b> <ul style="list-style-type: none"> <li>• Fillings               <ul style="list-style-type: none"> <li>◦ Amalgam (silver)</li> <li>◦ Composite (white)</li> </ul> </li> <li>• Full and panoramic X-rays</li> <li>• Extraction, erupted tooth</li> </ul>	75%
<b>Major Restorative Care<sup>2</sup></b> <b>Prosthetics</b> <ul style="list-style-type: none"> <li>• Crowns and bridges</li> <li>• Dentures</li> <li>• Relining of dentures</li> </ul> <b>Periodontics</b> <ul style="list-style-type: none"> <li>• Root planing and therapy</li> </ul> <b>Endodontics</b> <ul style="list-style-type: none"> <li>• Root canals</li> </ul> <b>Oral Surgery</b> <ul style="list-style-type: none"> <li>• Extraction of impacted teeth</li> </ul>	50%
<b>Orthodontics</b>	0%
Benefit Features	Your Coverage
Office Visit	No Charge
Deductibles <sup>3</sup>	\$50 (\$150)
Annual Maximum <sup>3</sup>	\$1,000
Waiting Periods	Yes
Claim Forms	Yes
Receive Care From	Any Dentist or Access PPO Dentist

1. New applicants must first complete 3 months of continuous coverage.
2. New applicants must first complete 12 months of continuous coverage.
3. Deductibles and annual maximums are per insured person. Deductibles apply to basic care and major restorative care.

**Dominion Dental Services, Inc.  
Alexandria, VA**

**Enrollment Card**

**SELECT ONE:**  Select Plan  
 Access PPO

**Enrollment Information**

Last Name		First Name		M.I.
Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (MM/DD/YY)	
Home Address			Home Phone	
City	State	ZIP	Work Phone	
Email Address			Hire Date	

**List All Your Eligible Dependents Below**

Last Name (if different)	First Name	M.I.	Social Security Number	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse					
Child					

**SELECT PLAN**

Provider Selection

Dental Office Name & Code #  
(As Indicated on Your Dentist Directory)

If I am enrolling in the Select Plan and I am voluntarily paying 100% of the cost of this Plan, without employer contribution, I agree to remain in Plan a minimum of twelve (12) months. If I cancel before the end of the 12 month period, I may be responsible for the usual, customary and reasonable charges for services received, reduced by the sum of the subscription dues and copayments paid.

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by dentists and other providers of dental services. Information will be released to Dominion Dental Services, Inc., for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent/Broker #	Group #	Group Name	City of Alexandria	Coverage Eff. Date
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**Dominion Dental Services, P.O. Box 75314 Charlotte, NC 28275-5314**

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Virginia - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

# CHANGE IN COVERAGE FORM

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Change Plans:   | <input type="checkbox"/> Address/Name Change  | <input type="checkbox"/> Add Dependents                          |
| <input type="checkbox"/> Select Plan     | <input type="checkbox"/> Terminate Subscriber | <input type="checkbox"/> Delete Dependents                       |
| <input type="checkbox"/> Access PPO Plan | <input type="checkbox"/> Split Dental Centers | <input type="checkbox"/> Change Dental Office (SELECT PLAN ONLY) |

### Changes to Subscriber Information

Social Security Number: _ _ - _ - _		Plan Number:	Sex (circle one): <b>MALE</b> <b>FEMALE</b>	
Last Name:		First Name:	MI:	Birthdate (mm/dd/yy): / /
Home Address:			Telephone (Home):	
City:	State:	Zip Code:	Telephone (Work):	

### Changes to Selected Dental Office (SELECT PLAN ONLY)

Dental Office Code:	Dental Office Name:
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### Changes to Spouse Information

	Sex (M/F)	Last Name (If different)	First Name	MI	DOB	SELECT PLAN ONLY: Dental Office (if different)
<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /	

### Changes to Dependent Information

	Sex (M/F)	Last Name (If different)	First Name	MI	DOB	SELECT PLAN ONLY: Dental Office (if different)
<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /	
<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /	
<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /	
<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /	

### Authorization

_____ Subscriber's Signature	_____ Date
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### To Be Completed By Benefits Administrator

Group Number:	Group Name:	Effective Date of Change	Mo. / Day / Yr.
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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 <b>City of Alexandria</b>		Group Number(s) <b>645212</b>	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Hire Date	
DISABILITY	<p><i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements</i></p> <p><b>Long Term Disability</b></p> <p><input type="checkbox"/> Employer Paid LTD – 120-day Benefit Waiting Period</p> <p><input type="checkbox"/> Enhanced LTD (Buy-up) – 90-day Benefit Waiting Period</p>					
	SIGNATURE	<p>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.</p>				
Member/Employee Signature Required				Date (Mo/Day/Yr)		
<p><b>Human Resources Department - Complete this section. Retain form for your records.</b></p>						
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.



## SICK LEAVE BANK DONATION

DONOR'S NAME \_\_\_\_\_ City ID# \_\_\_\_\_  
PLEASE PRINT

DEPARTMENT \_\_\_\_\_ Mail Box # \_\_\_\_\_ PHONE \_\_\_\_\_

### ENROLLMENT / DONATION

I wish to donate \_\_\_\_\_ hours of annual leave from my annual leave balance to the Sick Leave Bank (the Bank). I understand this donation makes me eligible to request hours from the Bank. I further understand that I have no further claim on my donated hours and that they will not be restored to me.

\_\_\_\_\_  
Date Employee Signature

- I am eligible, but do not wish to join the Sick Leave Bank at this time (check this box sign above). Annual leave availability verification is not required.

### **Annual Leave Availability Verification**

I verify that this donor holds an eligible position that accrues annual leave and, as of today, he or she has sufficient hours of earned annual leave to cover this donation. The budgeted FTE percentage for his or her position is \_\_\_\_\_%.

\_\_\_\_\_  
Date Signature for department HR/Payroll

Donors will receive written confirmation of the elected donation, the eligibility period covered, and future notices when additional leave donations will be required to maintain Sick Leave Bank membership.

Complete and forward this form to the HUMAN RESOURCES DEPARTMENT, Room 2500, City Hall, BOX 52 by the close of business on Friday, May 24, 2013