CITY of HOLLYWOOD, FLORIDA

Office of Human Resources and Risk Management
2600 Hollywood Blvd. • Room 206 • P.O. Box 229045 • Hollywood, Florida 33022-9045
Phone (954) 921-3218 • www.hollywoodfl.org

November 4, 2011

To All Healthcare Plan Participants:

Our open enrollment period will be from November 14, 2011 to December 13, 2011. To make changes to your dependent coverage, please complete a new enrollment form and return it to Human Resources by December 13, 2011 for the effective date of January 1, 2012. **Please note:** If you intend to add dependents, documentation proving a legal relationship/dependency must be provided. Proper documentation includes birth certificates, marriage certificates, court orders, social security numbers, and dates of birth.

If you do not wish to make any changes – NO ACTION IS NECESSARY.

As a part of Healthcare Reform, the City will be eligible to participate in the "Early Retiree Reinsurance Program." In order for the City to receive reimbursement under this program, a notice must be provided to all members of the City's health plan. This informational notice is included in this packet. Please share the notice with those family members who are covered in this plan.

Blue Cross and Blue Shield will remain the administrator of the City's Health Plan and Florida Combined Life for the City's Dental Plans. Specific medical payroll deductions are outlined in the applicable union contract or other policy.

Davis Vision will be offering a voluntary vision product for a January 1, 2012 effective date. For more information regarding this product, please attend one of the informational sessions (schedule attached). Mutual of Omaha is our life insurance carrier and both Colonial Life and AFLAC provide other voluntary benefits. This is the time to apply for or make changes to your life or dependent life insurance or other voluntary benefits. Once again, we like to take this time to mention that all employees should review their life insurance beneficiary(ies) and make changes, if need be. However, this can be done at any time during the year.

The City's Flexible Spending Accounts (FSA) will be administered by Ceridian. As always, the FSA enrollment form must be completed each year. It is important to note, there will be no reimbursements for over-the-counter drugs that are not prescribed. An enrollment form, titled "Section 125 – Flexible Benefit Plan," is attached for your convenience. As with all other enrollment forms, this form must be submitted to Human Resources by December 13, 2011.

The Office of Human Resources and Risk Management is available to answer your insurance questions. Please attend one of the informational meetings or contact me or Bridget Bravo, Human Resources Analyst, at 954-921-3505 if you have any questions.

Sincerely,

Lisa Powell
Assistant Director of Human Resources and Risk Management

Attachments:

- Schedule of Information and Enrollment Sessions
- Early Retiree Reinsurance Program Notice
- Women's Health and Cancer Rights Notice
- Health and Dental Enrollment Form
- Designation of Beneficiary Form
- Section 125 – Flexible Benefit Plan Enrollment Form
- Voluntary Vision Information and Enrollment Form

2011 Open Enrollment
Information and Enrollment Sessions

DATE	LOCATION	TIME
Tuesday November 15, 2011	City Hall 2600 Hollywood Boulevard, Room 219 Fire Station # 74 2741 Stirling Road	9:00am – 11:00am 2:00 pm – 4:00 pm
Wednesday, November 16, 2011	Fire Station # 74 2741 Stirling Road Waste Water Treatment Plant 1621 N. 14th Avenue, 2nd Floor	9:00am – 11:00am 2:00 pm – 4:00 pm
Thursday, November 17, 2011	Fire Station # 74 2741 Stirling Road Hollywood Police Department 3750 Hollywood Boulevard, Line up Room	10:00am – 12:00am 1:45 pm – 3:45 pm
Wednesday, November 30, 2011	Hollywood Police Department 3750 Hollywood Boulevard, Line up Room Parks/Public Works 1405 S. 28th Avenue	7:15 am – 9:15 am 1:00 pm – 3:00 pm
Thursday, December 1, 2011	Underground Utilities/Streets 1600 S Park Road (past fuel station in break-room) City Hall 2600 Hollywood Boulevard, Room 219	7:30am – 10:30am 1:00 pm – 3:00 pm

Enrollment sessions will be held in the Conference Room of the Office of Human Resources and Risk Management (City Hall, Room 206) during the following dates and times:

DATE	TIMES
Tuesday, November 29, 2011	1:30pm – 3:30 pm
Friday, December 9, 2011	8:30am – 11:30am
Tuesday, December 13, 2011	8:30am – 11:30 am

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

4800 Deerwood Campus Parkway
Jacksonville, Florida 32246
www.bcbsfl.com

September 21, 2011

Important Notice for Covered Employees and their Dependents

Health Plan Participant
Hollywood Florida, 33020

Dear Health Plan Participant:

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protection to patients who choose to have breast reconstruction in connection with a mastectomy. Your plan covers breast reconstruction surgery for covered employees and their covered dependents, as described below. In order to comply with the annual WHCRA benefit notification, and encourage mammogram screenings, please share the information below with your employees.

Coverage for breast reconstruction surgery

Breast reconstruction surgery can be performed at the same time as the mastectomy or later. You are covered for both the reconstruction of the breast on which the mastectomy is performed, as well as the other breast to produce a symmetrical appearance. In addition, your health plan covers prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema. The type of procedure is determined in consultation between you and your attending physician. Coverage is subject to the terms of your contract.

Spread the word ...

Mammograms help detect breast cancer early, when it's much easier to treat. If you or a family member is due for a mammogram, schedule this important screening today. Visit the U.S. Preventive Services Task Force (USPSTF) at **www.uspreventiveservicestaskforce.org** for breast cancer screening recommendations.

For breast cancer facts, information about treatments, patient forums and more, visit the American Cancer Society at **www.cancer.org**, Komen for the Cure® at **www.komen.org** or the National Breast Cancer Foundation at **www.nationalbreastcancer.org**.

Thank you. If you have questions about your coverage, please call your agent or sales representative.

Sincerely,

Jannifer Drake Harper MD
Vice President of Medical Operations

70732 0811

City of Hollywood, Florida
Employee Group Medical and Dental Plan

__New Enrollment __Reinstate
__Open Enrollment __Change

OFFICE USE ONLY
Effective Date of Coverage: ___/___/___ Medical Code:_____ Dental Code:_____ Classification:_______

Subscriber Information

Employee Last Name	First Name	M.I.	Social Security Number*	Date of Birth	Gender __M __F
Mailing Address Apt.	City State Zip			County	
Department/Division	Job Title	Date of Hire	Work Phone (if any) and Home Phone ( )___-_____, ( )___-_____		

If this is a Change, Indicate Type: __Add Dependent(s) __Drop Dependent(s) __Drop Employee and Dependent(s), if any
(attach document for proof)
__New address(as above), __New Name: From_____________________ to _____________________
This Change is due to:___Marriage ___Birth ___Separation of Employment ___Other:__________ Date of Event: ________

Additional Information

Have you had continuous health care coverage for the past 12 months?__Yes __No
If yes, please attach a copy of your certificate of coverage as evidence of prior coverage.

Other than this Health Plan, will you and/or your family have other Health Insurance Coverage as of this date?Yes __No Dental? __Yes __No
If yes, list Covered Person(s):_______________________ **Attach copy of ID Card(s)**
Insurance Company Name:_____________________ Do you or your spouse have Medicare?__Yes __No

Covered Individuals	Medical		Comprehensive Dental		Premium Dental	
Indicate your medical and/or dental coverage options by placing an X in the appropriate ( )	Indicate Option	OFFICE USE ONLY	Indicate Option	OFFICE USE ONLY	Indicate Option	OFFICE USE ONLY
Employee Only	( )		( )	111	( )	114
Employee and One Dependent*	( )		( )	112	( )	115
Employee and Two or More Dependents*	( )		( )	113	( )	116

*Eligible dependents are: spouse or domestic partner and/or natural, adopted or awarded child as defined in the plan document.

List below **all** eligible dependents you wish to cover on your medical or dental plan. This enrollment form will replace all previously completed forms. Only those listed below will have coverage on the effective date of this enrollment or chan[g]

Last Name First M.I.	Date of Birth	Gender	Social Security Number*	Coverage Selection
(2) ___Spouse or ___Domestic Partner	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental
(3) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental
(4) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental
(5) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental
(6) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental

Proper documents required: marriage/domestic partner certificate, birth certificate, hospital birth record, adoption award, medical child support order.

Authorization

I hereby (1) **REQUEST** coverage for the Group Medical and/or Dental Plan for which I am, or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the Health Plan. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to any illness, injury, or medical history to the claims payor, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made directly to the hospital or physician for services rendered unless paid receipts are presented. *Your social security number is requested for the purpose of payroll eligibility verification, processing employment benefits, applicant and employee background checks, and income reporting. In addition, the social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHI

Employee Signature ______________________ **Date**______________

Declination

I hereby **DECLINE** ___Medical and/or___Dental coverage at this time. I realize that I cannot elect coverage until the next enrollment period unless I have a qualifying event as allowed in the Plan Document.

Employee Signature ______________________ **Date**______________

Distribution: Human Resources Payroll

Rev: 6/2009

Brought to you by:

Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk (*).)

*Employer/Group Name:	Group ID:

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:	MI:

*Social Security Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:

*Street Address:	E-mail Address:

*City:	*State:	*Zip Code:	Telephone: ( ) -

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
				Percentage Total:	100%

Agreement and Signature

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

SIGNATURE OF EMPLOYEE/MEMBER ______________________ DATE ____/____/____

SECTION 125- FLEXIBLE BENEFIT PLAN
ELECTION / CHANGE FORM
CITY OF HOLLYWOOD, FLORIDA

EFFECTIVE DATE: ________________

PLAN YEAR: ______________________ INITIAL ENROLLMENT _____ CHANGE _____

EMPLOYEE INFORMATION

Social Security No.	Employee I.D. No.	Last Name	First	M.I.
	/			

Complete Mailing Address

Sex	Marital Status	Marriage or Divorce Date	Birth Date	Date of Hire
Male ☐ Female ☐	☐ Single ☐ Divorced ☐ Married ☐ Other	/ /	/ /	/ /

Type of Election: ☐ Annual Election ☐ Update Personal Information ☐ Change in Family Status ☐ Elect COBRA ☐ Terminate All Coverage

Reason for Status Change: ______________________________ **Date of Change:** ____________

Must Supply Proper Documentation and comply with IRS Rules and Regulations ~ Submit within 30 days of Status Change

LIST ALL DEPENDENTS

Relationship	Name	Sex	Birth Date	Social Security No.
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

BENEFIT(S) DESIRED

Accept Coverage	Decline Coverage	Payroll Code	Yearly Deductions	Bi-Weekly (Yrly/# pays)
☐ 1. Medical Premium	☐	(HWM025)	$ ________	$ ________
☐ 2. Dental Premium	☐	(HWD025)	$ ________	$ ________
☐ 3. Flexible Spending Reimbursement - Limit $2,000/yr. (Unreimbursables: Co-pays, Deductibles & Co-insurance)	☐	(HWF025)	$ ________	$ ________
☐ 4. Dependent Care Reimbursement – Limit $5,000/yr. (Monthly Reimbursement)	☐	(HWC025)	$ ________	$ ________
			$ ________ Yearly Total	$ ________ Bi-Weekly Total

WAIVER

I have been given the opportunity to participate in the CITY OF HOLLYWOOD SECTION 125 - FLEXIBLE BENEFIT PLAN and choose **not** to do so for the current plan year as "checked" above.

Employee Signature ______________________________ **DATE** ______________

I have read and understand the explanation I have received regarding my options under the City's Flexible Benefits Plan. I understand my election of the pre-tax options are irrevocable for the plan year to which it applies unless I have a change in family status or otherwise qualify to make a change under regulations or rulings of the Internal Revenue Service (IRS). I further understand that amounts allocated to each Option above may be used only to pay the expenses under that Option. I hereby apply for the options listed above, and I authorize the City to redirect my salary during the plan year as indicated under Yearly/Bi-Weekly Deductions. I understand that any amounts not used for qualified expenses by the end of the plan year will be forfeited to my employer.

Employee Signature ______________________________ **Date** ______________

DISTRIBUTION: White = Human Resources Yellow = Plan Administrator Pink = Payroll Office Goldenrod = Employee

IN-NETWORK BENEFITS ONE-YEAR EYEGLASS BREAKAGE WARRANTY INCLUDED	Davis Option I: Fashion Value	Option II: Designer	Option III: Premier Platinum
Frequency – Once Every:			
Eye Health Examination inclusive of Dilation (when professionally indicated)	12 Months	12 Months	12 Months
Spectacle Lenses	12 Months	12 Months	12 Months
Frame	24 Months	24 Months	24 Months
Contact Lens Evaluation, Fitting & Follow-Up Care	12 Months	12 Months	12 Months
Contact Lenses (in lieu of eyeglasses)	12 Months	12 Months	12 Months
Copayments			
Eye Health Examination	$10	$10	$10
Spectacle Lenses	$25	$20	$10
Contact Lens Evaluation, Fitting & Follow-Up Care	N/A	$20/1	$10
Eyeglasses - Frame Benefit		Average Retail Value	
Non-Collection Frame Allowance (Retail):	Up to $100	Up to $130	Up to $150
	Plus a 20% discount on any overage/2		
Davis Vision Frame Collection/3 (in lieu of Allowance):			
Fashion level	Included	Included	Included
Designer level	$15 copayment	Included	Included
Premier level	$40 copayment	$25 copayment	Included
Eyeglasses - Spectacle Lenses Benefit		Member Charges	
All ranges of prescriptions & sizes	Included	Included	Included
Choice of Glass or Plastic Lenses	Included	Included	Included
Oversize Lenses	Included	Included	Included
Tinting of Plastic Lenses	$15	Included	Included
Scratch-Resistant Coating	Included	Included	Included
Polycarbonate Lenses	$0 or $35/4	Included	Included
Ultraviolet Coating	$15	$12	Included
Standard Anti-Reflective (AR) Coating	$40	$35	$35
Premium AR Coating	$55	$48	$48
Ultra AR Coating	$69	$60	$60
Standard Progressive Lenses	$65	$50	Included
Premium Progressives (Varilux®, etc.)	$105	$90	$40
Intermediate-Vision Lenses	$30	$30	Included
Blended-Segment Lenses	$20	$20	Included
High-Index Lenses	$60	$55	$55
Polarized Lenses	$75	$75	$75
Photochromic Glass Lenses	$20	$20	Included
Plastic Photosensitive Lenses	$70	$65	$65
Scratch Protection Plan: Single Vision Lenses | Multifocal	$20|$40	$20|$40	$20|$40
Contact Lens Benefit (In lieu of eyeglasses)			
Non-Collection Contact Lenses: Materials Allowance	Up to $100	Up to $130	Up to $150
	Plus a 15% discount on any overage/2		
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types	15% Discount	15% Discount	Included
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types	15% Discount	15% Discount	Up to $60 Allowance plus a 15% discount on any overage
Collection Contact Lenses/3 (in lieu of Allowance): - Materials, Evaluation, Fitting & Follow-up Care	N/A	Included (up to 4 boxes)	Included (up to 8 boxes)
Medically Necessary Contact Lenses (with prior approval)- Materials, Evaluation, Fitting & Follow-Up Care	Included	Included	Included
OUT-OF-NETWORK REIMBURSEMENT SCHEDULE			
Eye Examination: up to $30	Trifocal Lenses: up to $45	Elective Contact Lenses: up to $75	
Frame: up to $30	Lenticular Lenses: up to $60	Medically Necessary CL: up to $225	
Employee Bi-Weekly Rates	**Option I: Fashion Value**	**Option II: Designer**	**Option III: Premier Platinum**
Employee	$2.23	$2.69	$3.76
Employee + Spouse	$4.02	$4.84	$6.78
Employee + Child(ren)	$4.24	$5.12	$7.15
Employee + Family	$6.69	$8.09	$11.29

1/ Copayment applies to Collection Contact Lenses only.

2/ Additional discounts not applicable at Walmart or Sam's Club locations.

3/ Collection is available at most participating independent provider offices.
Collection is subject to change. All contact lenses in Collection are single vision spherical

4/ Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

Vision Benefits
Employee Enrollment Form

☐ New Enrollee ☐ Termination ☐ Change of Status ☐ Change of Address

SECTION I: XB7 GROUP INFORMATION

Group Name	Group Number	Effective Date

SECTION II: EMPLOYEE INFORMATION

Last Name:	First Name:		Middle Initial
Social Security Number	Date of Birth mm/dd/yyyy		Gender ☐ Male ☐ Female
Address	City	State	ZIP Code

SECTION III: DEPENDENT INFORMATION

Spouse Name (Last, First, M.I.) *(if applying for spousal coverage)*	Date of Birth	Gender ☐ Male ☐ Female

Other Eligible Dependent Information *(if additional space is needed, please attached a separate sheet of paper)*

Name	Date of Birth	Gender	Relationship
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

SECTION IV: VISION COVERAGE SELECTIONS

Coverage Choice: *(check one coverage only)*

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Plan Choice: *(Fill in plan name in space below)*

I represent that the information provided above is true and correct to the best of my knowledge and belief. For those coverages I have declined, I understand that I can terminate or change previously elected coverage only during an employer-sponsored open enrollment period or on a qualifying event. If the plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee Signature **Date**

TERMINATION OF COVERAGE:

I wish to terminate my Vision coverage. I understand that I can terminate or change previously elected coverage only during an employer-sponsored open enrollment period or on a qualifying event.

Employee Signature **Date**

Please return completed form via secure email to: FloridaVision@davisvision.com or Fax: 1-800-783-9046 or mail to: Davis Vision Manual Enrollment, Attention: Florida Vision, P.O. Box 1501 Latham, NY 12110

Underwritten by HM Life Insurance Company