

**City of Memphis 2014 Special Enrollment
Active & Retired Employees**



MEDICAL BENEFIT CHANGES ONLY

“PREMIUM INCREASE”

Effective October 1, 2014

Please read this document carefully and completely!

You are receiving this notice because our records indicate you are currently enrolled in the City's medical benefits plan:

The City of Memphis will implement a 24% premium increase for all Active and Retired Employees effective October 1, 2014. Remember Premium deductions are made a month in advance meaning you will see the increased premium deduction the first pay period in September.

Please note, there are no changes to the medical benefits plan design. This is a premium increase only.

Due to the mid-year premium increase, the City is allowing all employees and retirees to participate in a Special Open Enrollment that will allow you to switch medical plans, add or delete dependents, terminate coverage, etc.

If you are keeping your same medical benefits plan and have no other dependent changes, **STOP! No action is required. Your premiums will automatically increase to the appropriate rate the first pay period in September.**

For anyone making a change, the Special Enrollment is Monday, July 21, 2014 through Friday, August 1, 2014. You may enroll online @ <http://openenrollment.memphistn.gov>; fax your enrollment changes to 901-636-8486; mail or bring forms to 2714 Union Avenue Ext., 5th Floor, Room 100, Memphis, TN 38112. All mail must be postmarked no later than August 1, 2014. If you need to speak with a member of the benefits team, please contact our office at 901-636-6800 (toll free 866-543-4367) Monday-Friday between 8:00 and 5:00 pm.

Remember you will not have an opportunity to make changes until the next Open Enrollment period unless there is a change in your family status (see page 3 for explanation of family status change).

RETIREES: IF YOU DROP YOUR MEDICAL COVERAGE ANYTIME BEFORE 12/31/2014, YOU WAIVE YOUR ENROLLMENT RIGHTS FOREVER. YOU WILL NOT HAVE THE OPPORTUNITY TO RE-ENROLL IN THE CITY'S MEDICAL PLAN.

NOTE: The online site will be available through midnight August 1, 2014. If you make changes on-line that require enrollment certification, such as affidavits, marriage licenses, birth certificates, divorce decrees and other pertinent documents, please fax to 901-636-8486 or send by US Mail. We must receive your supporting documentation by Friday, August 8, 2014 or your coverage elections from 1/1/2014 will continue. Also, please keep your on-line enrollment confirmation as well as your fax confirmation page(s) as verification.

WHAT'S IN THIS DOCUMENT?

- New Rates for Active Employees & Retirees
- Forms: Enrollment Change Form including the Tobacco/Spousal Insurance Affidavit

Active Participation in the Special Open Enrollment is not required and if you make no changes, your current plan will continue at the increased premium rate starting with your first paycheck in September.

What You Need To Know About the Special Enrollment 2014

Do I have to participate in the Special Enrollment? No, you only need to participate if you are making changes.

Who is Eligible to participate? If you are an active or retired employee currently enrolled in the City's medical benefits plan, you are eligible to participate in this special enrollment.

What documentation is needed?

- If enrolling a child, you must provide a birth certificate or proof of legal guardianship for all children. You must also provide a copy of each child's social security card.
- If you are enrolling a spouse, you must provide a marriage license, social security card and an affidavit. Additional documentation such as, but not limited to, a Certificate of Creditable Coverage (COC) may be required.
- If you are deleting a spouse due to change in marital status, you must provide a divorce decree or death certificate.

What is a change in family status/qualifying life event?

A change in family status can include marriage, divorce, birth of a child, adoption, and change in spouse's job status.

It is your responsibility to remove any dependents age 26, divorced spouse or otherwise ineligible dependent from your coverage. Failure to remove any ineligible dependents will result in you being responsible for any claims paid on their behalf after the termination date.

How can I remove the tobacco/nicotine Surcharge?

To have the tobacco/nicotine surcharge removed, you along with all family members age 16 and over must provide negative nicotine test results from a certified testing provider along with an updated affidavit. The surcharge will be removed when all required tests and documents have been received by the Benefits Office.

What must I do to remove the spousal surcharge?

A spousal surcharge is assessed if you choose to cover a spouse on your plan who has opted out of medical coverage through his/her employer. The spousal surcharge is waived during Open Enrollment only if the spouse has no access to medical care or if the spouse is enrolled in his/her employer's medical plan that pays as primary to the City of Memphis medical plan. To waive the surcharge, submit a signed affidavit along with documents to prove that your spouse has no access to coverage.

Can I switch to my spouse's employer sponsored plan during the City's Special Enrollment period?

You will need to check your spouse's employer eligibility guidelines but usually you can only join plans outside the regular open enrollment period if you have a qualifying life event (see above definition). Additionally, because the City's Special Enrollment period does not create a 'loss of coverage' situation, most likely you will have to wait until your spouse's employer open enrollment period in order to enroll in the plan.

Important Note: Signed affidavits waiving spouse and/or tobacco surcharges are subject to verification via random audits that may result in disciplinary action including termination of healthcare coverage.

**CITY OF MEMPHIS 2014 HEALTH PLAN PREMIUM RATES FOR
ACTIVE & RETIRED EMPLOYEES**

(PER PAY PERIOD)

Rates Effective September 2014 – November 2014

Active Employees	Single Coverage	Family Coverage
Basic Plan	\$100.45	\$213.25
Premier Plan	\$108.98	\$220.13
Value Plan	\$46.00	\$182.90

Non-Medicare Retirees	Single Coverage	Family Coverage
Basic Plan	102.64	\$215.76
Premier Plan	\$114.03	\$226.14

Medicare Retirees	Single Coverage	Family Coverage
Basic Plan	\$94.59	\$198.43
Premier Plan	\$104.52	\$207.28

CITY OF MEMPHIS INSURANCE AFFIDAVIT

If you or a member of your family age 16 or older uses tobacco or nicotine products, you will have to pay the tobacco surcharge.

If your spouse has access to medical insurance through his/her employer but has declined coverage, you will pay the spouse surcharge if you choose to enroll him/her in the City of Memphis medical plan.

To determine if you will be subject to either or both surcharges per pay period, you must answer all of the following questions. Any questions left blank could result in the assessment of the surcharge(s):

- yes or no 1) Do you or your family members age 16 or over who are enrolled/enrolling in the medical plan use nicotine products including, but not limited to cigarettes, snuff, chewing tobacco, etc.?

If so, please list all family members who use tobacco/nicotine: _____, _____
 _____, _____

- yes or no 2) Are you enrolling your spouse in medical? (If no, skip to signature section)

- yes or no a) Is your spouse employed?

- yes or no b) Does your spouse have medical insurance through his/her employer or is he/she enrolled in Medicare? (If your spouse has other insurance that is primary, the surcharge will not apply).

- yes or no c) Does your spouse have access to other medical insurance but chooses not to enroll? (If so, a spouse surcharge will be added to your medical premium.)

Please provide your spouse's name, spouse's employer name and telephone number:

Spouse Name: _____ Employer Name: _____

Employer Telephone Number: _____ Insurance Company Name: _____

Group Number: _____ Subscriber ID #: _____

By signing this affidavit, I am certifying that I have answered the questions regarding tobacco/nicotine usage and my spouse's access to medical coverage honestly and completely under the penalties of perjury. If I am found guilty of perjury, I will be held liable to repay all claims and the City of Memphis has the right to terminate my benefits as well as my employment.

Employee Signature:	Employee Oracle ID #:
Employee Printed Name:	Date:

ACKNOWLEDGEMENT AND AUTHORIZATION:

I, _____, hereby certify under penalty of perjury that the information provided in this application for employee benefits, including social security numbers, addresses, spouse and or dependent child(ren) information, is true and correct. I further acknowledge that I understand that providing false information may subject me to a denial of employee benefits, disciplinary action including termination of employment from City of Memphis. I authorize the release of this information to my employer, the City of Memphis, and insurance carriers.

In addition:

- I authorize my employer to reduce my salary by pre-tax or after-tax deductions, either prospectively or retroactively, for my elected benefits.
- I agree it is my responsibility to check my earnings statement each month to verify my current benefits enrollments and deductions and to alert Health Wellness and Benefits immediately of any errors. Further, I understand that the City of Memphis may not be able to remedy problems identified beyond 30 days.
- I understand that my benefits can only be changed during the designated annual Open Enrollment period or by written notification to Health Wellness and Benefits within 60 days of a qualified life event.
- I understand it is my responsibility to contact Health Wellness and Benefits within 60 days to remove my ex-spouse from all benefits plans if I divorce or become legally separated.
- I understand that while on an unpaid leave of absence or any unpaid status, I am responsible for paying my benefits premiums. Failure to pay premiums timely may result in cancellation of my benefits and reimbursement of any claims paid to my provider(s) for healthcare, etc.
- As a retiree, I understand if I drop my medical coverage anytime before 12/31/2014, I waive enrollment rights forever.

My signature below indicates I have read and understand the above:

Print Name:	Signature:	Date:	Oracle Employee ID #(Required):

EMPLOYER USE ONLY:

Employee Enrollment Date:	Termination Date:	Employment Status: _Active _COBRA _ NEMP
		Received By/Date:
Received By/Date:	Entered By/Date:	



City of Memphis

2014 SPECIAL OPEN ENROLLMENT CHANGE FORM AND INSURANCE AFFIDAVIT

NOTE: Complete ONLY if you elect to enroll in or change existing medical coverage.

BENEFITS ACTION (please select one):

Cancel All Benefits Make Changes Add/Delete Dependents

A. EMPLOYEE INFORMATION

Social Security Number - -	City Oracle ID Number	Last Name M.I.	First Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Street Address	Apt.#	Effective Date of Enrollment/Change: 10/01/2014	Division Name	
City, State, Zip	Date of Birth:	Hire Date:		
Email Address:	Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -			

B. BENEFIT ELECTION (CHECK ONE PER BENEFIT)

Medical Plan	ENROLL: <input type="checkbox"/> BASIC <input type="checkbox"/> PREMIER <input type="checkbox"/> VALUE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE <input type="checkbox"/> WAIVE COVERAGE If waived, are you are covered by another plan. Yes or No If yes, please list name of insurance carrier	<input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE + FAMILY
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C. FAMILY MEMBERS TO BE COVERED - List all dependents to be covered. If you do not list a dependent, they will not be covered

LAST NAME	FIRST	M.I.	Social Security Number (Required)	Date Of Birth	Check desired Action			Employer Use Only:
					Medical	Dental	Vision	
Spouse:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:

D. OTHER INSURANCE COVERAGE INFORMATION (PLEASE COMPLETE THE SECTION BELOW)

Do you or any of your covered dependents have other Medical/Medicare coverage that is primary to the City's Medical Plan? *Yes or *No Entitlement: If Yes, Name of Insured: Place of Employment: Insurance Company: _____ Policy #: _____ Insurance Company Phone #: _____ Insurance Company Address:	If covered by Medicare, please check what type(s): <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Both A&B Reason for Medicare <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease Medicare HIC #: Medicare Part A Effective Date: Medicare Part B Effective Date:
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Address

City of Memphis Active & Retired Employees

Special Enrollment 2014

July 21, 2014 – August 1, 2014

Time Sensitive:

Please open immediately! Important benefit information enclosed regarding 2014 premium increases.