	Jefferson County Policies & Procedures		
Policy Name:	Open Enrollment Booklet	Approved:	FY2015
Policy Number:	206	Author:	Keyser
Associated:			

It's Time for Open Enrollment!

May 12 – June 12, 2014

Benefit Changes are Effective July 1, 2014

Open Enrollment Meetings if you wish to attend:

Monday, May 12th – 10:00 a.m. and 2:00 p.m. – Library Conference Room

Wednesday, May 14th, 8:00 a.m., 2:00 p.m. and 4:30 p.m. – Maintenance Conference Room

If you choose not to attend a meeting, you are REQUIRED to return a signed Open Enrollment form at the end of this packet.

Jefferson County Employees

Charles Town, WV

Jefferson County's Open Enrollment:

Jefferson County's Open Enrollment will take place from May 12, 2013 to June 12, 2014. **You will be required to complete the enrollment form (last page of your packet) and return by the deadline.** While the deadline is June 12, we hope everyone can return their form prior to departing for the Memorial Day Week-end. Failure to complete by the deadline by June 12th will prohibit you from making changes until the earlier of a family status change or next year's open enrollment.

The month of June will allow for processing of your paperwork internally for payroll and also at BCBS. It is our intent to have the changes made timely to Blue Cross, Delta Dental and Guardian so you will have your new membership cards, (if you make changes), by July 1, 2014.

The new payroll deductions will begin with the July 3rd paycheck. You should verify your new deductions are correct. Questions with your payroll deductions should be addressed to Sally Gran.

Effective June 1, 2012 you were required to provide documentation of a birth, death, divorce or marriage for changes in enrollment for health care, vision, dental and life insurance. You will continue to be required to provide proof when dependent names are different that your last name. You will also need to provide proof when you have a loss of insurance and want to be placed onto our plan. Proof must be provided within 30 days of the event.

You will have ONLY 30 days from the date of the event in order to make enrollment changes.

PPACA – Patient Protection Affordable Care Act

A key component of the Affordable Care Act (ACA), also known as health care reform, is the mandate that individuals be enrolled in health coverage. By 2014, U.S. citizens and legal residents are generally required to maintain minimum essential coverage for themselves and their dependents or pay a phased-in shared responsibility payment. The law refers to this as a penalty. Beginning last fall, individuals were able to shop for and purchase coverage that began Jan. 1, 2014, the date when the individual mandate became effective. Coverage can be bought directly through health insurers, like Highmark, and other BCBS plans, through private insurance brokers, your spouse's health care plan, or by enrolling in the Jefferson County employee health care plan. The implementation of the ACA does not constitute a family status change. If you haven't already done so, you and your family will need to enroll in our plan during this open enrollment period (May 12, 2014 – June 12, 2014) if there is a desire to have

coverage and avoid the penalty that could be assessed if you don't have essential minimum health care coverage. If you have questions, please see Sally Gran or Debbie Keyser.

Examples of a Family Status Change:

You get married October 1, 2014. You have until October 31, 2014 to add your spouse onto your health care plan. You must also provide proof by supplying a copy of your marriage certificate. If you fail to show proof or fail to complete an enrollment form to add your spouse, you will not be allowed to make changes until the following Open Enrollment period.

You have a baby November 25, 2014. You must complete an enrollment form no longer than December 25, 2014. You must make a copy of the birth certificate when it becomes available. If you fail to show proof or fail to complete an enrollment form to add your child, you will not be allowed to make changes until the following Open Enrollment period.

Your spouse is provided a different or significant monetary change to their health care plan. You wish to either enroll in our plan or remove yourself from our plan due to their coverage change. You have 30 days from the date your spouse's insurance changes in order to complete forms with the County for a family status change. Proof of change is required.

If you divorce and change from family to employee only coverage, you must complete a form as soon as possible to remove your spouse from the plan. If you fail to do so, you will NOT receive a refund for months you failed to notify the County. Also note you are required to provide a copy of your divorce court order and effective date for our record.

HRA's

Current HRA Account:

To avoid confusion, we will refer to the current HRA plan with Highmark BCBS as HRA Plan A. This plan will continue to remain with Highmark. On January 1, 2014 you were provided $1,000 into your HRA Plan A account. Due to budget constraints, you will not receive an HRA contribution into this account on 1/1/2015. Due to our plan not conforming to ACA standards:

You will no longer be able to utilize your HRA monies for your health care premium reduction effective 7/1/2014.

You will continue to have your debit card on the current HRA account and use it for dental, vision and medical expenses. A deadline for utilizing those monies has not been established.

However, keep in mind you will need to use those monies as soon as possible to avoid a forfeiture.

New HRA Account:

This account will be referred to as HRA Plan B and is being established because the health care plan deductibles are increasing effective July 1, 2014. The Employee Only health care deductible is changing from $750 to $2,000. The Emp + 1 and Emp + Family deductible is changing from $2,000 to $4,000. There will be a new HRA account that will reimburse you for the difference between the current deductible and the new deductible beginning July 1, 2014.

For example: As of July 1, 2014, you have met your $750 for your deductible. You are hospitalized on or after July 1st and now have to meet your new deductible of $2,000. You will need to pay the difference between your old deductible of $750 and your new deductible of $2,000 which is $1,250. The new HRA Plan B will reimburse you for the difference. It is expected if you submit your EOB for reimbursement as soon as you receive it, it is likely you will have the funds prior to the medical provider billing you.

To best utilize your funds, you will want to use the old HRA Plan A for expenses such as prescription drugs, co-pays, glasses, etc., while the new HRA Plan B will only be for the reimbursement of your deductible costs.

As of this writing, we do not have a vendor for the HRA Plan B. It will be implemented and in place effective July 1st, 2014. Further documentation will be distributed as soon as possible.

Reminders:

How to File a Claim with your HRA Account:

Go to: www.mybenefitshome.com and select the "Members" tab. Enter Login ID & Password in the Log-in box (or new registrants click "register now"). Use your member ID number from your Highmark Insurance Card for new registrants. You will be assigned a pin number which you will use in the future. Be sure to write it down so you can obtain your PHI (personal health information) access to claims. Select "Your Spending" tab which will gain access to your claims history. This will also provide you with access to the BCBS provider network. If you have trouble accessing this website or seeing the information on a page, be sure to remove the pop-up blocker.

AFLAC Open Enrollment:

Aflac Open Enrollment will be in May and June. A representative will be present to assist you with your enrollment elections. A meeting notice will be sent to your manager.

Health Care Tiers:

You are now able to elect one of three options for Health Care, Dental and Vision. This selection will continue for this plan year as well. Since it is open enrollment time, you can move between tiers, if applicable, for you and your family:

Employee Only

Employee + One

Employee + Family (which is employee plus two or more)

Your Enrollment Form will provide you with the cost of those elections.

Health Care Plan Changes:

There are a significant number of changes to this year's health care plan as a result of our budget crunch and the ACA. Below is a brief chart of the changes. Please see the attachment for further information.

Employee Only Deductible	From: $750	To: $2,000
Employee + One; Emp + Family	From: $1,500	To: $4,000
Physician Visit Co-Pays	From: $20 each	To: $20 Reg. Office visit, $30 Specialist, $40 Urgent Care
Emergency Room Visit	From: $75	To: $125
Prescription Drug Co-Pays	Retail From: $10/$20/$40	Retail To: $10/$20/$40
	Mail Order From: $20/$40/$80	Mail Order To: $25/$50/$90

Deductibles: Your deductible will change effective 7/1/2014 and increase to the amount shown above. Your deductibles remain on a calendar year basis, so keep in mind your deductibles will begin again January 1, 2015.

If you've met your deductible as of June 30, 2014, those dollars will continue to count toward your deductible. You will not be starting over. However, you will need to meet the additional dollars between the current deductible and the increased deductible beginning July 1st.

Leave of Absence:

Now that all employees are required to pay for their health care, it will be necessary to pay for your elected benefit premiums while out on a leave of absence, at the rate you would pay as an employee. Please see Sally Gran with questions regarding how much you may owe.

EAP:

The County will continue to offer an Employee Assistance Program (EAP) for all full-time employees. This program is a free, confidential service to assist you and your family regarding personal matters such as family counseling, caregiving for a parent, alcohol and substance abuse, assistance as a supervisor or employee on how to handle work issues, and much more. You will be provided four free sessions with a local BCBS participating provider. If you need further assistance beyond your free visits, you can utilize your BCBS plan and pay the appropriate co-pay. The number to contact the EAP is:

1-800-865-1044

Delta Dental:

Delta Dental coverage began July 1, 2012. If you need to find a Delta Dental provider, here's the web address to find one in your area:

www.deltadentalins.com

There are two networks for Delta Dental. One is called a Premier Network. The other is a PPO Network. These networks work in the same manner as your BCBS network. If you visit a provider you are not balanced bill. If you visit a non-provider, you will be balanced bill. What you need to know is that Delta has two different networks, each with their own "Allowable Charge" which dictates how much you pay. Here are several examples:

You have a service completed for a crown from a Delta Premier Dentist:
Dentist's Charge: $1,000

Allowable Charge:	$ 800
Coinsurance	50%
Delta Payment	$400
You Owe:	$400

There's no balance billing for the difference between $800 and $1000 because you're visiting a Delta Dental Provider.

You have a service completed for a crown from a Delta PPO Dentist:

Dentist's Charge:	$1,000
Allowable Charge:	$ 700
Coinsurance	50%
Delta Payment	$350
You Owe:	$350

There's no balance billing for the difference between $800 and $1000 because you're visiting a Delta Dental Provider.

If you visit a non-participating provider, you will pay the difference between the Premier Allowable Charge and the Dentist's Charge for services performed.

Beneficiaries:

This is a good time to review your beneficiaries for your life insurance, particularly you've have had a family status change within the past year (i.e., marriage or divorce). If you wish to review or make changes or review your current elections, you should visit Sally Gran for the proper paperwork.

Emergency Contact:

Attached is a blank copy of our Emergency Contact Form. If you have a medical condition which has changed since your last form was completed or you have a different emergency contact, please complete the form and return to Debbie Keyser.

Benefits and Covered Services
For detailed information per procedure code, select a link from the Treatment Type listed below.

Treatment Type	Description	Contract Benefit Level: Delta Dental PPO[SM] Dentist	Delta Dental Premier® Dentist	Non-Delta Dental Dentist
Diagnostic	Oral Exams and X-Rays	100%	100%	100%
Preventive	Routine Cleanings and Fluoride Treatment	100%	100%	100%
Restorative	Restorative Procedures	50% - 80%	50% - 80%	50% - 80%
Endodontics	Root Canals	80%	80%	80%
Periodontics	Gum Treatment	80%	80%	80%
Prosthodontics; Removable	Partial Dentures, Full Dentures	50% - 80%	50% - 80%	50% - 80%
Implant Services	Implant Related Services	50%	50%	50%
Prosthodontics; Fixed	Inlays, Onlays, Bridges	50%	50%	50%
Oral & Maxillofacial Surgery	Tooth Extraction	80%	80%	80%
Adjunctive General Services	Miscellaneous Services	50% - 100%	50% - 100%	50% - 100%

Maximums

Type	Program Maximum (Applies to the following services)	Network	Amount	Remaining
Calendar Individual Maximum	Implant Services Adjunctive General Services Restorative Oral & Maxillofacial Surgery Prosthodontics; Fixed Periodontics Prosthodontics; Removable Endodontics Other Restorative Services	Delta Dental PPO[SM] Dentist, Non-Delta Dental Dentist, Delta Dental Premier® Dentist	$1,000.00	N/A

Deductibles

Type	Program Deductible (Applies to the following services)	Network	Amount	Remaining
Calendar Family Deductible	Implant Services Adjunctive General Services Restorative Oral & Maxillofacial Surgery Prosthodontics; Fixed Periodontics Prosthodontics; Removable Endodontics Other Restorative Services	Delta Dental PPO[SM] Dentist, Non-Delta Dental Dentist, Delta Dental Premier® Dentist	$150.00	N/A
Calendar Individual Deductible	Implant Services Adjunctive General Services Restorative Oral & Maxillofacial Surgery Prosthodontics; Fixed Periodontics Prosthodontics; Removable Endodontics Other Restorative Services	Delta Dental PPO[SM] Dentist, Non-Delta Dental Dentist, Delta Dental Premier® Dentist	$50.00	N/A

Waiting Period Summary
Treatment Type Effective Date End Date
Some programs require patients to wait a certain length of time before they are eligible to receive certain types of services.

This coverage has no waiting period.

Other Provisions
Basis of Payment N/A
Child Covered to Age 26
Student Covered to Age 26
Missing Tooth Coverage N/A
Orthodontic Age Limit N/A
Pregnancy Benefits This program allows an additional cleaning benefit during pregnancy.

This information is based on our records and claims processed as of the day you accessed this system. This is not an authorization, nor a guarantee of eligibility, benefits, or payment.

Vision

HOW THIS PLAN WORKS

We pay benefits for the covered charges a Covered Person incurs as follows. What we pay is subject to all of the terms of this Plan. Read the entire Plan to find out what we limit or exclude.

Covered charges are the Usual and Customary charges for the services and supplies described below. We pay benefits only for covered charges incurred by a Covered Person while he or she is insured by this Plan. Charges in excess of any payment limits shown in this Plan are not covered charges.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive pre-authorization from VSP prior to providing the Covered Person with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this Plan for specific requirements.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 90 days of the date services are completed or supplies are received.

Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include the necessary tests to ensure visual wellness and detect potential eye-related medical problems, such as glaucoma.

We cover no more than one vision examination for each covered person in any 12 month period.

From a Preferred Provider — We pay benefits in full for the covered charges a Covered Person incurs.

From a Non-Preferred Provider — We pay benefits for the covered charges a Covered Person incurs up to a maximum of $46.00 for each examination.

Vision Materials

Glasses (Lenses and Frames) or Contact Lenses — We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We pay benefits for frames. We pay benefits for prescription contact lenses and a contact lens exam needed to check for eye health risks associated with improper wearing or fitting of contact lenses.

In any 12 month period we pay benefits for either glasses or contact lenses, but not both.

Materials Payment Limit — We limit what we pay for covered materials in any 12 month period to an allowance of $100.00. The discounts shown below are applied before the charges are applied to the allowance.

- Materials purchased from either a Preferred Provider or a Non-Preferred Provider are covered by this Plan, and can be used toward the $100.00 allowance.

Special Limitations

If This VSP Plan Replaces Another VSP Plan

If, prior to being covered under this *plan*, a *covered person* was covered by another vision care plan with VSP under which he or she received a covered service within 6 months prior to the effective date of this *plan*, the date he or she received such a covered service will be used as the last date of service when applying the *benefit period* limitations under this *plan*. We apply this provision only if the *covered person* was enrolled in another VSP plan immediately before enrolling in this *plan*.

CGP-3-VSN-96-SL1 B505.0031

Exclusions

We won't pay for:

- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.
- Plano lenses.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at normal intervals when services are otherwise available.
- Expenses associated with securing materials such as lenses and frames.
- Blended lenses, oversized lenses, or progressive multifocal lenses.
- Coating of lenses, laminating of lenses, cosmetic lenses.
- UV(ultraviolet) protected lenses.
- Photochromatic lenses and tinted lenses, except for Pink #1 and Pink #2.
- Refitting of contact lenses after the initial 90-day fitting period.
- Routine maintenance of contact lenses such as polishing or cleaning.
- Corneal Refractive Therapy(CRT) or Orthokeratology(a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Optional cosmetic processes.

CGP-3-VSN-96-XCL1 B505.0373

Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments* or *deductibles*, if any.

CGP-3-VSN-96-EXC17 B505.0037

Jefferson County Benefits Reference Sheet		
Benefits	**Phone Number**	**Other**
AFLAC	304-676-7547	James_Zombro@us.aflac.com
BCBS App for your phone	n/a	Type: MyBenefitsHome.com in your mobile browser
BCBS Customer Service	1-888-809-9121	www.highmarkbcbswv.com
BCBS Prescription Service (MEDCO)	1-800-820-9730	Customer Service Agent
BCBS Benefits Booklet	n/a	www.mybenefitshome.com
Health Care Case Management	n/a	www.highmarkbcbswv.com
COBRA	1-315-671-9820	JoAnne.Reith@ebsrmsco.com
Delta Dental	1-800-932-0783	Customer Service 8:00am - 8:00pm
Delta Dental - Claims Address	n/a	PO Box 2105 Mechanicsburg, PA 17055
Delta Dental - Provider Finder	n/a	www.deltadentalins.com
DSRS - Deputy Retirement	1-800-654-4406	www.wvretirement.com
EAP - Unicare	1-800-865-1044	www.unicare.com
Guardian Life Insurance	1-800-627-4200	www.guardiananytime.com
Guardian Vision Insurance	1-877-814-8970	www.guardiananytime.com
Highmark Member Website	n/a	www.mybenefitshome.com
HRA Account	1-800-391-4441	Customer Service Agent
ING Retirement Services - 457 Plan	304-641-0773	Bob Aman
MyCareNavigator	1-888-BLUE-428	Assists with your h.c. needs
PERS - Retirement Plan	1-800-654-4406	www.wvretirement.com
Pharmacy Services for BCBS	n/a	www.highmarkbcbswv.com
Teladoc	1-800-835-2362	www.mybenefitshome.com/teleadoc
Last Revision: May, 2014		

My Other Important Phone Numbers		

If you have benefit issues, your first recourse should be to contact the provider. If you are unable to resolve your benefit issues you should contact Sally Gran for assistance.

Emergency Contact Information

Your Personal Information

Name:

Address:

Address:

Home Phone: Cell:

Emergency Contact Information #1

Name:

Address:

Address:

Day Phone: Cell:

Emergency Contact Information #2

Name:

Address:

Address:

Day Phone: Cell:

Physician's Information

Name:

City/State:

Phone Number:

Medical Information

If you wish to share this information, list here any medical condition that may require assistance from your co-workers or information needed by Emergency Services. You can also choose to leave your MedicAlert informationbelow, if applicable.

Example: Carry EpiPen; Medical Allergies, Pace Maker, etc.

I understand providing this information is completely optional, and will be shared with my Department Manager & HR to assist my employer and Emergency Services in the event of an emergency.

Signature

Date

HIGHMARK. West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

Jefferson County Commission 2014-2015

SuperBlue Plus 2010

SUMMARY OF BENEFITS

IMPORTANT: PLEASE READ THE SUMMARY OF BENEFITS SECTION. THIS IS PART OF YOUR BENEFIT BOOKLET AND SUBJECT TO CHANGE. FOR FURTHER EXPLANATION REFER TO YOUR BENEFIT BOOKLET.

Effective Date	July 1, 2014	
Benefit Period (used for Deductible and Coinsurances limits; and certain benefit frequencies)	January 1 through December 31 (Calendar Year)	
Deductible (Network and Non-Network Deductibles do not cross apply) Individual Family (may be met collectively)	NETWORK[2] $2,000 $4,000	NON-NETWORK[2] $6,000 $12,000
Carry-Over Deductible Period	None	
Coinsurance Limit (Network and Non-Network Coinsurance dollars do not cross apply) Individual Family (may be met collectively)	NETWORK[2] $1,000 $2,000	NON-NETWORK[2] $3,000 $6,000
Total Maximum Out-of-Pocket[5] (Includes Medical Deductible, Copays, and Coinsurance per Benefit Period, Network only.): Individual Family (may be met collectively)	NETWORK[2] $6,350 $12,700	NON-NETWORK[2] Not Applicable Not Applicable
Non-Network Liability	Unlimited	
Lifetime Maximum Benefit for all Covered Services	Unlimited	

BENEFIT HIGHLIGHTS

	NETWORK[2]	NON-NETWORK[2]
Primary Care Medical Office Visit/Office Consultation - (Applies to Charges for Visit only. Does not apply to other services received during Visit.	$20 per Office Visit, 100% thereafter, No Deductible	$20 per Office Visit, 80% thereafter, No Deductible
Specialist Care Medical Office Visit / Office Consultation - Specialist - (Includes Specialist Virtual Visit). Applies to Charges for Visit only. Does not apply to other services received during Visit.	$30 per Office Visit, 100% thereafter, No Deductible	$30 per Office Visit, 80% thereafter, No Deductible
Urgent Care Center Visit Applies to Charges for Visit only. Does not apply to other services received during Visit.	$40 per Office Visit, 100% thereafter, No Deductible	$40 per Office Visit, 80% thereafter, No Deductible
Virtual Visit Originating Site	100%	80%
Telemedicine Service[3]	$10 per Visit, 100% thereafter, No Deductible	
Prescription Drugs are provided through a Retail Pharmacy Network If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. Maximum 34 day supply. **Note:** Prescription Deductibles, Copayments and/or Coinsurance amounts do not apply toward the Total Maximum Out-of-Pocket	$10 Generic / $20 Formulary Brand / $40 Non-Formulary Brand	NO BENEFITS
Mail Order Drugs - If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. Maximum 90 day supply. **Note:** Prescription Deductibles, Copayments and/or Coinsurance amounts do not apply toward the Total Maximum Out-of-Pocket	$25 Generic / $50 Formulary Brand / $90 Non-Formulary Brand	NO BENEFITS
Additional Preventive Prescription Benefits[4] (Retail or Mail Order) - (Guidelines as determined by certain Governmental Agencies) -- You may access this information at www.healthcare.gov. You may also contact Member Services.	100%, No Deductible	NO BENEFITS

PREVENTIVE CARE SERVICES		
	NETWORK[2]	NON-NETWORK[2]
Annual Gynecological Exam – up to two per benefit period.	100%, No Deductible	$20 per Office Visit, 80% thereafter, No Deductible
Routine Pap Smear – up to two per benefit period	100%, No Deductible	80%
Well Woman Physical Exam and Services – up to two per benefit period	100%, No Deductible	No Benefits
Routine HPV Testing - one every 3 years age 30 and older	100%, No Deductible	80%
Routine Mammogram - per schedule age 35 and older	100%, No Deductible	80%
Prostate Exam - one per benefit period for males over age 50.	100%, No Deductible	$20 per Office Visit, 80% thereafter, No Deductible
Prostate Specific Antigen (PSA) Test - one per benefit period	100%, No Deductible	80%
Colorectal Cancer Exam - for individual's age 50 and older (one per benefit period) or a person under age 50 with high risk factors (e.g. family history). See Section V for additional information.	100%, No Deductible	$20 per Office Visit, 80% thereafter, No Deductible
Fecal occult blood test - one per benefit period	100%, No Deductible	80%
Flexible Sigmoidoscopy - one every 5 years	100%, No Deductible	80%
Colonoscopy - one every 10 years	100%, No Deductible	80%
Double Contrast Barium Enema - one every 5 years	100%, No Deductible	80%
Routine Physical Exam - one per benefit period	100% , No Deductible	$20 per Office Visit, 80% thereafter, No Deductible
Routine Screening, Immunization and Diagnostic Services[4] *(guidelines as determined by certain governmental agencies)* – You may access this information at www.healthcare.gov. You may also contact Member Services.	100%, No Deductible	No Benefits
Routine Immunization Services: MMR, Pneumococcal Polysaccaride, Influenza, Varicella, Hepatitis A & B Series and Meningococcal vaccinations	100%, No Deductible	80%
Routine Diagnostic Services Lipid panel, urinalysis, complete blood count, blood glucose screening and rubella titer test.	100%	80%
Routine Immunization Services (in addition to the above)	No Benefits	No Benefits
Routine Diagnostic Services (in addition to the above)	100%, No Deductible	No Benefits
Diabetes Education & Control - Copay applies to Office Visit only. All other services will fall under medical benefits.	$20 per Office Visit, 100% thereafter, No Deductible 100% other services, Subject to deductible	$20 per Office Visit, 80% thereafter, No Deductible 80% other services, Subject to deductible
WELL BABY / CHILD CARE SERVICES[4]		
Well Baby Care - Routine Office Visits, lab tests and immunizations to age 6.	100%, No Deductible	100%, No Deductible
Well Child Care – Routine Office Visits and immunizations age 6 through 17.	100%, No Deductible	100%, No Deductible
AUTISM SPECTRUM DISORDER		
Services for diagnosis and treatment of Autism Spectrum Disorder (See Section V for additional information). Note: Covered Services will be paid according to the benefit category (e.g. Speech Therapy, Office Visit, etc.)	100%	80%
PHYSICIAN SERVICES		
In-Hospital Medical Visit	100%	80%
Surgery, Assistant to Surgery, Anesthesia	100%	80%
Second Surgical Opinion, Consultations (Outpatient)	100%, No Deductible	100%, No Deductible
Maternity Care - Dependent daughters are covered.	100%	80%
Newborn Care including circumcision.	100%	80%
Occupational Therapy (Rehabilitative and Habilitative)- **Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Physical Therapy (Rehabilitative and Habilitative)- **Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Chiropractic Manipulations (Rehabilitative and Habilitative)- **Maximum 30 visits per Benefit Period.** Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Respiratory, Hyperbaric and Pulmonary Therapy	100%	80%

PHYSICIAN SERVICES (Continued)		
Cardiac Rehabilitation Therapy	100%	80%
Dialysis	100%	80%
Chemotherapy	100%	80%
Radiation Therapy	100%	80%
Infusion Therapy	100%	80%
Speech Therapy when necessary due to a medical condition.	100%	80%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	100%	80%
Diagnostic, X-ray, Lab and Testing	100%	80%
Allergy Testing and Treatment	100%	80%
INPATIENT HOSPITAL / FACILITY SERVICES		
	NETWORK[2]	NON-NETWORK[2]
Unlimited Days Semi-Private Room and Board Note: If an admission is not Precertified, you will pay a $500 Precertification review penalty.	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
Ancillaries, Drugs, Therapy Services, X-ray and Lab	100%	80%
General Nursing Care	100%	80%
Surgical Services	100%	80%
*Birthing Center Care/Maternity Services - Dependent daughters are covered.	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
OUTPATIENT HOSPITAL / FACILITY SERVICES		
Pre-Admission Testing	100%	80%
Diagnostic, X-ray, Lab and Testing	100%	80%
Surgery, Operating Room	100%	80%
Radiation and Chemotherapy	100%	80%
Occupational Therapy (Rehabilitative and Habilitative)- Maximum 30 visits per Benefit Period. Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Physical Therapy (Rehabilitative and Habilitative)- Maximum 30 visits per Benefit Period. Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	80%	80%
Respiratory, Hyperbaric and Pulmonary Therapy	100%	80%
Speech Therapy when necessary due to a medical condition.	100%	80%
Cardiac Rehabilitation Therapy	100%	80%
Dialysis	100%	80%
Chemotherapy	100%	80%
Radiation Therapy	100%	80%
Infusion Therapy	100%	80%
BEHAVIORAL HEALTH SERVICES		
Outpatient Mental Health Services	100%	80%
Outpatient Substance Abuse Services	100%	80%
Inpatient Mental Health Care Services - Note: If an admission is not Precertified, you will pay a $500 Precertification review penalty.	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
Inpatient Substance Abuse Care Services - Note: If admission is not Precertified, you pay a $500 Precertification review penalty.	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
EMERGENCY CARE SERVICES		
Emergency Accident Care and / or Emergency Medical Care provided in the ER	$125 ER Co-Pay, 100% thereafter (Co-pay waived if admitted)	$125 ER Co-Pay, 100% thereafter (Co-pay waived if admitted)
Emergency Ambulance	100%, No Deductible	100%, No Deductible
NON-EMERGENCY CARE SERVICES		
Non-Emergency Medical Care provided in the ER	$125 ER Co-Pay, 100% thereafter	$125 ER Co-Pay, 80% thereafter
Non-Emergency Ambulance Services	100%	80%

OTHER COVERED SERVICES		
	NETWORK[2]	NON-NETWORK[2]
Private Duty Nursing - Maximum 35 visits per benefit period Note: Maximum is Network and Non-Network combined.	100%	80%
Skilled Nursing Facility Note: If admission is not Precertified, you pay a $500 Precertification review penalty.	$100 per admission Co-Pay, 100% thereafter	$100 per admission Co-Pay, 80% thereafter
Durable Medical Equipment and Oxygen at home	100%	80%
Orthotic Devices and Prosthetic Appliances	100%	80%
Home Health Care - Maximum 100 visits per benefit period Note: Maximums are Network and Non-Network combined.	100%	80%
Hospice Care	$100 per admission Co-Pay, 100% thereafter	Inpatient:$100 per admission Co-Pay, 80% thereafter Outpatient: 80%
HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES		
Human Organ Transplant • Includes transportation, meals and lodging	100%	Inpatient: $100 per admission Co-Pay, 80% thereafter Outpatient: 80%
Bone Marrow Procedures • Includes transportation, meals and lodging	100%	Inpatient: $100 per admission Co-Pay, 80% thereafter Outpatient: 80%

Eligible Dependent Age Limitation	Coverage stops at the end of the month of the 26th birthday for an adult Dependent who qualifies as an Eligible Dependent.
Precertification Requirement	Penalty for no Precertification is a $500 reduction of benefits per Inpatient admission.

[1]ALL SERVICES ARE SUBJECT TO A DETERMINATION OF MEDICAL NECESSITY BY HIGHMARK WV.

[2]PAYMENT IS BASED ON THE PLAN ALLOWANCE. THE PLAN ALLOWANCE WILL GENERALLY BE LESS FOR SERVICES RECEIVED FROM A NON-NETWORK PROVIDER. IN ADDITION, YOU WILL BE RESPONSIBLE FOR THE NON-NETWORK LIABILITY.

[3]SERVICES MUST BE PERFORMED BY A HIGHMARK APPROVED TELEMEDICINE PROVIDER.

[4]THE SCHEDULE OF COVERED SERVICES IS BASED UPON RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS; THE AMERICAN COLLEGE OF PHYSICIANS; THE U.S. PREVENTIVE SERVICES TASK FORCE; THE AMERICAN CANCER SOCIETY; THE INSTITUTE OF MEDICINE AND THE BLUE CROSS BLUE SHIELD ASSOCIATION. THEREFORE, THE FREQUENCY AND ELIGIBILITY OF SERVICES IS SUBJECT TO CHANGE.

[5] EFFECTIVE WITH PLAN YEARS BEGINNING ON OR AFTER JANUARY 1, 2014, THE NETWORK TOTAL MAXIMUM OUT-OF-POCKET AS MANDATED BY THE FEDERAL GOVERNMENT MUST INCLUDE DEDUCTIBLE, COINSURANCE, COPAYS, AND ANY QUALIFIED MEDICAL EXPENSES. THE TOTAL MAXIMUM OUT-OF-POCKET CANNNOT BE MORE THAN $6,350 FOR INDIVIDUAL AND $12,700 FOR TWO OR MORE PERSONS.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.highmarkbcbswv.com or by calling 1-888-809-9121.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** individual/**$4,000** family network, **$6,000** individual/**$12,000** family out-of-network. **Network deductible** does not apply to primary care visits, specialist visits, preventive care services, emergency medical transportation, urgent care and prescription drug benefits. Copayments, coinsurance amounts don't count toward the **network deductible.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Network: **$1,000** individual/**$2,000** family out of pocket limit up to a total maximum out-of-pocket of **$6,350** individual /**$12,700** family. Out-of-Network: **$3,000** individual/**$6,000** family out-of-network.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out–of–pocket limit?	Network: Precertification penalties, prescription drug expenses, premiums, balance-billed charges and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-Network: Copayments, prescription drug expenses, deductibles, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.highmarkbcbswv.com or call 1-888-809-9121.	If you use a **network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **network** doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	20% coinsurance after $20 copay/visit	——————none——————
	Specialist visit	$30 copay/visit	20% coinsurance after $30 copay/visit	——————none——————
	Other practitioner office visit	20% coinsurance for chiropractor	20% coinsurance for chiropractor	Combined network and out-of-network limits: 30 visits per benefit period. Combined network and out-of-network: habilitation and rehabilitation services.
	Preventive care Screening Immunization	No charge for preventive care services	20% coinsurance after $20 copay/visit for preventive care visits 20% coinsurance for screening and immunizations	Please refer to your preventive schedule for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-888-809-9121.	Generic drugs	$10 copay (retail) $25 copay (mail order)	Not covered	Up to 34-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Formulary Brand drugs	$20 copay (retail) $50 copay (mail order)	Not covered	Up to 34-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Non-Formulary Brand drugs	$40 copay (retail) $90 copay (mail order)	Not covered	Up to 34-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	——————none——————
	Physician/surgeon fees	No charge	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$125 copay/visit	$125 copay/visit	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$40 copay/visit	20% coinsurance after $40 copay/visit	——————none——————

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after $100 copay per admission	20% coinsurance after $100 copay per admission	Precertification may be required.
	Physician/surgeon fee	No charge	20% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	20% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	No charge after $100 copay per admission	20% coinsurance after $100 copay per admission	Precertification may be required.
	Substance use disorder outpatient services	No charge	20% coinsurance	——————none——————
	Substance use disorder inpatient services	No charge after $100 copay per admission	20% coinsurance after $100 copay per admission	Precertification may be required.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	——————none——————
	Delivery and all inpatient services	No charge after $100 copay per admission	20% coinsurance after $100 copay per admission	——————none——————

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Combined network and out-of-network: 100 visits per benefit period.
	Rehabilitation services	20% coinsurance	20% coinsurance	Combined network and out-of-network limits: 30 visits for occupational therapy, 30 visits for physical therapy per benefit period. Combined network and out-of-network: habilitation and rehabilitation services.
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No charge after $100 copay per admission	20% coinsurance after $100 copay per admission	Precertification may be required.
	Durable medical equipment	No charge	20% coinsurance	——————none——————
	Hospice service	No charge after $100 copay per admission	20% coinsurance after $100 copay per admission, 20% coinsurance for outpatient	——————none——————
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.bcbsa.com
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-809-9121. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Highmark West Virginia, Inc. at 1-888-809-9121.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform .
- Additionally, a consumer assistance program can help you file your appeal. Contact: West Virginia Offices of the Insurance Commissioner, Consumer Service Division 1124 Smith St, Room 309 Charleston, WV 25301 **(888) 879-9842** http://www.wvinsurance.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To obtain language assistance, call 1-888-809-9121.
SPANISH (Español): Para obtener asistencia en Español, llame al **1-888-809-9121.**
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-809-9121.**
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 **1-888-809-9121.**
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-809-9121.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,440
- **Patient pays** $2,100

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$100
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,100**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,100
- **Patient pays** $2,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,700
Copays	$600
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,300**

You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from **network providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Jefferson County Commission
Open Enrollment Election Form

Open Enrollment May 12, 2014 - June 12, 2014 - Benefits Effective 7/1/2014

☐ No Change - Keep all elections the same.

Due to the Affordable Care Act, all employees must submit this form to Payroll along with your signature.

Employees working 30 or more hours a week on average may be eligible for health care. See Payroll if you think you qualify.

☐ Waive Coverage - I understand if I waive medical coverage for me/family I am not eligible to enroll until the next open enrollment and may be subject to a gov't penalty if I don't have insurance on or after 1/1/2014 due to the ACA.
If understand if I waive medical, I also waive dental.

Employee Name: _____ DOB: _____

Address: _____ Dept: _____

Work Email Address: _____

		Total Cost	Per Pay	List Dependents to be covered/dob
HighMark BCBS - Plan 1				**Health Care and Dental must be elected together.**
☐	No coverage	$ -	$ -	____/____/____ Spouse
☐	Employee Only	$ 786.19	$ 19.00	____/____/____ Child
☐	Employee + One	$ 1,572.38	$ 142.50	____/____/____ Child
☐	Employee + Family	$ 1,965.48	$ 212.50	____/____/____ Child
Delta Dental			Per Pay	**Health Care and Dental must be elected together.**
☐	No coverage	$ -	$ -	____/____/____ Spouse
☐	Employee Only	$ 22.56	$ -	____/____/____ Child
☐	Employee + One	$ 44.91	$ 11.18	____/____/____ Child
☐	Employee + Family	$ 67.35	$ 22.40	____/____/____ Child
Guardian Vision			Per Pay	____/____/____ Spouse
☐	Employee Only	$ 7.53	$ -	____/____/____ Child
☐	Employee + One	$ 12.89	$ 2.68	____/____/____ Child
☐	Employee + Family	$ 20.60	$ 6.54	____/____/____ Child

I authorize Jefferson County Payroll to take payroll deductions for my elected benefits as needed in order to remain current with all monies due to the County. I understand I cannot make an election change unless it is within 30 days of a family status change or at the next Open Enrollment Period. My signature below indicates I agree to the terms shown on this form and am in receipt of Highmark SBC (Summary of Benefits Coverage) attached to the Open Enrollment package.

_____ _____

Employee Signature Date:

_____ _____

Payroll Processed/Date HR Processed/Date

Please list additional dependents on the back of the form if necessary.

PLEASE RETURN THIS FORM TO PAYROLL AS SOON AS POSSIBLE SIGNED AND CHECKED.