



Open Enrollment 2017

The annual open enrollment period for City of Charleston health, dental/vision and healthcare reimbursement plans (C-LECT) is being held from November 15, 2016 to December 15, 2016. During this period, eligible employees and retirees may enroll in, add or delete eligible family members to, and/or change health and dental insurance plans and enroll in or re-enroll in C-LECT (Healthcare reimbursement plan).

WHAT IS CHANGING FOR 2017?

Dental

Effective January 1 2017, dental benefits will be administered by Delta Dental. Eligible employees and retirees will have the option of two (2) dental plan coverage types, Standard, which mimics our current plan, and an Enhanced Plan option, which provides additional coverage and an increased annual maximum. A summary comparison chart of the two dental plans is attached. If you wish to remain in the standard dental plan, you will automatically be enrolled in the standard plan offered by Delta Dental. **IF YOU WISH TO ENROLL IN THE ENHANCED PLAN, YOU MUST COMPLETE A NEW ENROLLMENT FORM.**

Dental Rates (per month)

Coverage Type	Standard	Enhanced
Single	\$3.40	\$6.75
Family	\$7.71	\$16.08

*Please note vision benefits will remain the same for both the standard and enhanced plans.

Information Sessions

Delta Dental informational sessions are scheduled for November 15, 2016 at the Charleston Civic Center at the following times: 6:30AM, 7:00 AM, 9:00AM, 2:00PM, AND 4:00PM. Spouses and retirees are welcome to attend.

OTHER IMPORTANT INFORMATION

Healthcare Reimbursement Plan

If you are currently enrolled or would like to re-enroll in the health care reimbursement account, you must do so during Open Enrollment if you wish to participate in the tax-saving program in 2017. The IRS has increased the allowed annual contribution to \$2600 for the 2017 plan year.

Health Risk Assessments (HRA)

As previously communicated, all active employees and applicable spouses enrolled in the Health Risk Management (HRM) discounted medical plan must complete their HRA no later than December 15, 2016 to remain eligible for the 2017 discounted plan. Please contact CareHere at (877)423-1330 or visit www.carehere.com to schedule your appointment, if you haven't done so already.

If you are not making changes to your current plan medical, dental or vision plan, you are not required to complete new enrollment forms. If you wish to enroll in C-Lect or opt. in to the Enhanced dental plan, you **MUST** complete new enrollment forms.

If you have any questions regarding open enrollment or benefits please contact Human Resources at (304)348-8015).

Plan Benefit Highlights for: City of Charleston

Group No: 18635

Effective Date: 01/01/2017

DELTA DENTAL PPOSM

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 19 or to the end of the month dependent turns age 26 if dependent is full-time student			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Standard Plan: \$25 per person / \$75 per family each calendar year Enhanced Plan: \$50 per person / \$150 per family each calendar year			
	Yes			
Maximums D & P counts toward maximum?	Standard Plan: \$1,200 per person each calendar year Enhanced Plan: \$2,000 per person each calendar year			
	No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services**	Standard Plan		Enhanced Plan	
	Delta Dental PPO dentists†	Non-Delta Dental PPO dentists†	Delta Dental PPO dentists†	Non-Delta Dental PPO dentists†
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %	100 %	100 %
Basic Services Fillings	80 %	80 %	90 %	90 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %	90 %	90 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %	90 %	90 %
Oral Surgery Covered Under Basic Services	80 %	80 %	90 %	90 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %	60 %	60 %
Prosthodontics Bridges, dentures and implants	50 %	50 %	60 %	60 %
Orthodontic Benefits Dependent children	50 %	50 %	50 %	50 %
Orthodontic Maximums	\$1,200 Lifetime	\$1,200 Lifetime	\$2,000 Lifetime	\$2,000 Lifetime

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

† Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of West Virginia One Delta Drive Mechanicsburg, PA 17055	Customer Service 800-932-0783	Claims Address P.O. Box 2105 Mechanicsburg, PA 17055-6999
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deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

5721

Group

CITY OF CHARLESTON
BENEFIT PLAN ENROLLMENT CARD

Effective Date of Coverage ____/____/____
Hire Date ____/____/____

Location	XXXXXXXX	Department
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O-Active O-Retiree O-Widow

Employee Information

Name _____
 (First) (Middle) (Last)

Social Security Number/Put Above

 Department/Put In Box

Address _____
 Street City State Zip Code

Sex _____
 O-Male Date of Birth ____/____/____ Marital Status: O-Single
 O-Female Telephone# _____ O-Married O-Widowed
 O-Divorced O-Separated

MEDICAL

- elect single
- elect employee + one child
- elect employee + spouse
- elect employee + children
- elect family
- do no elect coverage

DENTAL/VISION

- elect single
- elect employee + one child
- elect employee + spouse
- elect employee + children
- elect family
- do no elect coverage

DENTAL PLAN OPTION

- Standard
- Enhanced

Names of Dependents To Be Covered:

Name	Social Security Number	Relationship	Sex M/F	Birthdate	Full Time Student Y/N	Handicapped Y/N

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Have you or any of your dependents had previous health coverage? Yes No If "YES", complete the following boxes, including the effective and cancel dates.

Name(s) of Covered Persons	Name of Other Insurance Co.	Policy Number	Effective Date/Cancel Date	Coverage Type(s)
				O Medical O Prescription Drug O Dental O Vision
				O Medical O Prescription Drug O Dental O Vision

REASON FOR CANCELING

*Check box below for each individual receiving treatment for end-stage renal disease.

Medicare Information - Check the appropriate boxes and fill in all information for you and dependents who are covered by Medicare.

O-You	Medicare#	Eff. Date - Part A:	Part B:	Renal Disease
O-Spouse	Medicare#	Eff. Date - Part A:	Part B:	Renal Disease
O-Dependent	Medicare#	Eff. Date - Part A:	Part B:	Renal Disease

Do any of the dependents listed above live in a different city? Y or N -- If Yes list below the dependent(s) and the city and state in which they live.

1. Dependent _____ City & State 2. Dependent _____ City & State

Employee Signature

Date

(check other side of this form)

Healthcare Premium Discount Enrollment Verification

Overview & Instructions: The City of Charleston offers eligible full-time employees a Health Risk Management (HRM) or Non-Tobacco User (NTU) healthcare premium discount. In order to receive the HRM or NTU discount eligible employees must enroll and comply with the HRM or NTU program discount requirements. A complete description of each discount can be found in Section I. Please review each description and select the box adjacent to the premium for which you would like to enroll. If you enroll in the City's healthcare plan, **you must select one (1) box in Section I.** Complete Section II in its entirety, and sign and date the enrollment form in Section III.

Section I. Healthcare Premium Selection (Please Select only 1 Box)

Standard Rate: Select this option if you do not want to enroll in the Health Risk Management (HRM) Program or receive the Non-Tobacco User discount.

Health Risk Management (HRM) Discount: The City has partnered with CareHere, the operator the City of Charleston Employee Wellness Center and the Pharm UC Patient Care Clinic at the University of Charleston to offer an HRM Program to eligible employees. To participate in the HRM Program and be eligible to receive a discounted healthcare premium, you must certify and agree that you and your covered spouse, if applicable, will adhere to the program requirements including, but not limited to keeping appointments with Wellness Center and/or Pharm UC staff, complying with any program(s) prescribed by Wellness Center and/or Pharm UC medical professionals and agree to participate in random nicotine screenings.

Non-Tobacco User (NTU) Discount: Select this option if you do not want to participate in the HRM Program, but would like to receive a reduced discounted rate for being a non-tobacco user. To participate and be eligible to receive a reduced discounted healthcare premium, you must certify that you and your covered spouse, if applicable, do not use tobacco products, and that you agree to participate in random nicotine screenings.

Section II. Employee Information (Please Print)

Name: _____ Department: _____

Address: _____ City: _____

_____ State: _____ Zip: _____ **Section III.**

Certification

By signing below, I do hereby certify, acknowledge and agree the information provided herein is true, accurate and complete to the best of my knowledge. I further understand that by enrolling in the HRM Program or electing to receive the NTU discount, by checking the designated box in Section I herein, that I agree to the applicable requirements in order to receive the associated discount. I also acknowledge and understand the City or its authorized agent may access my medical records for purposes of verifying my status as a tobacco user.

Employee Signature

Date

2017



C-Lect - Flexible Spending Account (FSA)

Annual Minimum \$130.00 to Annual Maximum \$2,600.00
Bi-weekly per pay deduction \$5.00 to \$100.00

Employee's Name (Last, First, Middle)	Social Security Number	Date of Birth	
Employee's Address	City	State	ZIP
Employee Number	Department	Date Employed	

Dependent Information

Spouse's Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth

I request that my salary be reduced per pay period as follows: \$ _____

Authorization for Flexible Spending Account

Authorization: I certify the above information to be correct and true to the best of knowledge and that the children based under "Dependent Coverage" either reside with me in a parent-child relationship or are legally dependent on me for support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment.

Signature _____ Date _____

C-Lect is administered by:
HealthSmart Benefit Solutions: P.O. Box 3262 Charleston, WV 25332 Toll Free 800.432.8315