November 2, 2009

Dear City of Hollywood Retiree Health Plan Participant:

2010 Open Enrollment for additions and/or changes to Group Health, Dental and/or Life Insurance will begin November 9th through December 1, 2009.

This enrollment package contains important information regarding your City of Hollywood Health Plan Coverage. Please read and retain this information for future reference.

The City's group health will continue to be administered by Blue Cross Blue Shield of Florida (BCBSFL), and the dental plan will continue to be administered by Florida Combined Life Insurance Company (FCL), a subsidiary of BCBSFL. The rates, however, have increased from last year and are reflected in the charts below. The new rates are effective January 1, 2010.

If you do <u>not</u> want to make any changes – NO ACTION IS NECESSARY.

Health Insurance – Participants who reside within the State of Florida may continue to access the Blue Options' Network Blue Provider Network as well as the physicians from the Traditional Network. Participants who live outside the State of Florida may continue to access any Blue Cross PPO Network Provider. Call 1-877-352-2583 (1-800-810-BLUE) in order to access in-network Blue Cross providers in your state.

Dental Insurance – If you live in Florida, the dental network will continue to be Blue Cross' "Florida Combined Life" Choice. Outside the State of Florida, any dental provider will be paid at the In-Network benefit level.

<u>HEALTH RATES FOR 2010 – ALL RATES ARE EFFECTIVE JANUARY 1, 2010.</u>

Medical Rates for Plan participants that pay for their dependent health coverage with the cost of Single Coverage paid by the City*:

Medical Coverage	Monthly Contribution
Single Coverage	$0
Plus One Dependent	$499.91
Plus Two or More Dependents	$1,099.81

*<u>Note to Fire Retirees</u>:
If you retired between:
10/1/2004 and 9/30/2005, please add an additional $54.17 to the above rates.
10/1/2005 and 9/30/2006, please add an additional $65.00 to the above rates.
10/1/2006 and 9/30/2007, please add an additional $75.83 to the above rates.
10/1/2007 and 9/30/2009, please add an additional $86.67 to the above rates.
10/1/2009 and 9/30/2010, please add an additional $97.50 to the above rates.

Medical Coverage Rates for Plan participants that pay for single and dependent health coverage:

Medical Coverage	Monthly Contribution
Single Coverage	$499.92
Retiree + One Dependent	$999.83
Retiree + Two or More Dependents	$1,599.73

DENTAL RATES FOR 2010 – ALL RATES ARE EFFECTIVE JANUARY 1, 2010.

COMPREHENSIVE ($1,000/yr coverage per person):	**Monthly Contribution**	**PREMIUM** ($2,000/yr coverage per person):	**Monthly Contribution**
Single Coverage	$29.28	Single Coverage	$63.28
Plus One Dependent	$49.49	Plus One Dependent	$103.83
Plus Two or More Dependents	$68.16	Plus Two or More Dependents	$141.26

LIFE INSURANCE

Life insurance rates will continue at the same rate as 2009. $5,000 of coverage continues to be $8.90 per month. However, effective January 1, 2010 the carrier will be Mutual of Omaha. As always, we encourage you to review your beneficiary, making any changes necessary.

Life Insurance Beneficiary Designation – You may take this opportunity to update and/or change your beneficiary designations. Please note: even if you have a Last Will and Testament the insurance carrier will pay claims to the beneficiaries designated on the Beneficiary Designation Form.

WHAT DO I NEED TO DO?

I you are making no beneficiary/dependent changes, NO ACTION IS NECESSARY.

If you are making changes, please complete the appropriate forms and return to Human Resources & Risk Management by December 1, 2009.

INFORMATIONAL AND ENROLLMENT SESSIONS:
Informational meetings will be held on the following dates, times and locations to provide information about our Plans:

DATE	LOCATION	TIME
Monday November 9th, 2009	**Fire Rescue (1st floor Multi Purpose Room) 2741 Stirling Road**	**9:30am – 10:30am**
Tuesday November 10th, 2009	**Fire Rescue (1st floor Multi Purpose Room) 2741 Stirling Road**	**9:30am – 10:30am**
Friday, November 13th, 2009	**Waste Water Treatment Plant (2nd floor) 1621 North 14th Avenue**	**8:00am – 9:00am**
Monday, November 16th, 2009	**Public Works (2nd floor Conference Room) 1600 South Park Road**	**8:00am – 9:00am**
Tuesday November 17th, 2009	**Commission Chambers Room 219 2600 Hollywood Boulevard**	**1:30pm – 3:30pm**
Thursday November 19th, 2009	**Police Department (1st floor Classroom) 3250 Hollywood Boulevard**	**8:00am –9:00am**
Friday November 20th, 2009	**Fire Rescue (1st floor Multi Purpose Room) 2741 Stirling Road**	**9:30am – 10:30am**

Additionally, the Office of Human Resources and Risk Management have set aside the following dates and times where we will be available to assist you regarding any changes to your elections. If you need forms or need assistance with the completion of your forms, please visit us in the *Human Resources Conference Room* (located in City Hall, Room 206) on any of the following dates and times.

DATE	TIMES
Monday, November 23, 2009	2:00pm – 4:00pm
Tuesday, November 24, 2009	8:30am – 10:30pm
Tuesday, December 1, 2009	11:00am – 1:00pm

Please note: If you are not currently participating in the City's medical or dental plan, you may **not** elect to begin coverage at this time. However, if you are currently participating in either the medical or dental plan, this is the time to make changes (i.e. add/drop legal dependents, or switch between dental plans). All changes will be effective January 1, 2010. **Important**: If you intend to add any dependents, please remember to provide all proper documentation – enrollment forms cannot be processed without documentation proving a legal relationship/dependency. Proper documentation includes birth certificates, marriage certificates, court orders, social security numbers, and dates of birth.

Please complete the enclosed enrollment form **only** if you wish to make changes to your current health or dental coverage, and return the completed form to the Office of Human Resources and Risk Management no later than December 1, 2009.

Your beneficiary may be updated at any time, not just during open enrollment. A beneficiary form is attached for your convenience. If and when a change is made, the completed form should be returned to the Office of Human Resources and Risk Management.

If you and/or your dependent are Medicare eligible, please read the attached notice concerning Medicare Part D.

The Office of Human Resources and Risk Management is available to answer your insurance questions. Please contact Gloria Casale at 954 921-3505 if you have any questions.

Sincerely,

Lisa Powell
Assistant Director of Human Resources and Risk Management

City of Hollywood, Florida **THIS ENROLLMENT FORM REPLACES ALL PREVIOUSLY COMPLETED ENROLLMENT FORMS**
2600 Hollywood Blvd., Rm. 206, Hollywood, FL 33020
Group Medical and Dental Plan __New Enrollment, __Open Enrollment, __Change, __Reinstate
Office Use Only Classification: **RETIREE**
Effective Date of Coverage:____/____/_____ Medical Code:_____ Dental Code:_____

Subscriber Information

Retiree Last Name	First Name	M.I.	Social Security Number*	Date of Birth	Gender __M __F
Mailing Address Apt City State Zip					
Retirement Plan (circle): Police, Fire, Employee's Retirement Fund		Job Class (circle): Management, Executive, Confidential, Fire, General, Police, Professional, Supervisory or Other:_____			
Last Department/Division	Date of Retirement	Home Phone ( ) _____-_____	e-mail address		

If this is a Change, Indicate Type: __Add Dependent(s), __Cancel Dependent(s), __Cancel Retiree and Dependent(s), if any
(attach document for proof)
__New address(as above), __New Name: From_____ to _____
This Change is due to: __Marriage __Birth __Medicare Eligibility __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 (required for new enrollees only).

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 Option	Office use Only	Indicate Option	Office use Only	Indicate Option	Office use Only
Retiree Only	( )		( )		( )	
Retiree and One Dependent*	( )		( )		( )	
Retiree and Two or More Dependents*	( )		( )		( )	

*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. Only dependents listed below will have coverag

Last Name First M.I.	Date of Birth	Gender	Social Security Number*	Coverage Selections
(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 the Pension Administrato 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. *The social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Retiree Signature _____ **Date**_____

Declination - complete this section only if canceling your single coverage

I hereby **DECLINE** ___Medical and/or ___Dental coverage. I realize that once I cancel my single medical and/or dental coverage, I may not elect the canceled coverage in the future. Coverage must be continued from the time of retirement and, if canceled, cannot be reinstated.

Retiree Signature _____ **Date**_____

Distribution: Human Resources Pension Administrato

Rev: 6/2009

Brought to you by:

Mutual of Omaha

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** _____/_____/_____

In 2006, Medicare prescription drug coverage, Medicare Part D, became available. This benefit fills an important gap within the current Medicare program by covering prescription drugs. Below is a notice that will provide you with important information about your rights under Medicare's Part D prescription drug benefit.

As required by Federal law, all employers must notify their Medicare-eligible employees/ retirees and dependents of this benefit and inform those employees/retirees if the current prescription drug coverage is creditable, that is, if that coverage, on average, pays as much in benefits as the standard Medicare Part D prescription drug plan.

If you or any dependent are not eligible for Medicare coverage, this Notice does not apply to you. However, it may be beneficial to read the enclosed information so you are aware of the changes in the Medicare prescription drug benefits for the future.

Please note: If you are eligible for Medicare coverage but would like to keep your current prescription drug coverage through the City of Hollywood Health Plan, there is no need to contact us.

If you or any dependents are eligible for Medicare, please read this information carefully. For more information, visit the Medicare website at www.medicare.gov or call 1-800-633-4227.

Important Notice from the City of Hollywood Health Plan about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Hollywood Health Plan and prescription drug coverage available for people with Medicare. It also explains options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

2. The City of Hollywood has determined that the prescription drug coverage offered by the City of Hollywood Health Plan (Plan) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Please note: If you would like to keep your current prescription drug coverage through the City of Hollywood Health Plan there is no need to contact us.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare, each year from November 15th through December 31st, or during a Special Enrollment Period.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you want to review the current prescription drug coverage available through the City of Hollywood Health Plan, please refer to the BCBSFL Medication Guide available at http://www.bcbsfl.com/DocumentLibrary/ProductsServices/Pharmacy/MedicationGuide.pdf

With the City of Hollywood Health Plan, you pay 20% of the prescription cost after an annual deductible of $50 and you are allowed to obtain a 90-day supply of medications.

You should know that your current City of Hollywood Health Plan <u>includes</u> medical coverage as well as prescription drug coverage. If you decide to enroll in a Medicare prescription drug plan and drop the City of Hollywood Health Plan, be aware that you and your dependents may not be able to get this coverage back.

As a beneficiary you will have two options available to you during the Medicare Part D open enrollment period:

- retain your existing coverage and choose not to enroll in Medicare Part D plan; or
- enroll in a Medicare Part D plan as a supplement to, or in lieu of, your current coverage.

You should also know that if you drop or lose your coverage with the City of Hollywood Health Plan and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. (For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage.) In addition, you may have to wait until the following November to enroll.

NOTE: You may receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

• Visit <u>www.medicare.gov</u>
• Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA) online at <u>www.socialsecurity.gov</u> or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: <u>Keep this notice</u>. If you enroll in one of the new plans approved by Medicare, which offer prescription drug coverage you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: November 2, 2009
City of Hollywood Health Plan
Contact: Gloria Casale
Office of Human Resources and Risk Management
2600 Hollywood Blvd, Room 206
Hollywood, FL 33020
Phone Number: 954-921-3505