CITY OF KNOXVILLE

2024 ANNUAL RETIREE BENEFITS ENROLLMENT FORM

(Please return to Employee Benefits no later than November 30, 2023)

IN ORDER TO BE ELIGIBLE FOR COVERAGE UNDER THE CITY OF KNOXVILLE'S RETIREE MEDICAL PLAN IN 2024, YOU MUST COMPLETE, SIGN, AND RETURN THE 2024 MEDICARE ELIGIBILITY AFFIDAVIT TO EMPLOYEE BENEFITS OFFICE.

A. RETIREE / PARTICIPANT INFORMATION

Employee ID (6 digits)	Last Name	First Name	M.I.	Gender ☐ Male ☐ Female
Home/ Mailing Address		Apt.	Effective Date January 1, 2024	
City, State, Zip		Date of Birth	Contact No: (____)_____-_____ ☐ Cell ☐ Home ☐Work	
Email Address				

B. MEDICAL AND RX PLAN – BlueCross BlueShield of Tennessee/ CapitalRx

Step 1: Select which medical plan you will be participating in for a January 1, 2024 effective date or decline coverage.

Medical & Rx Plan Options:

OPTION 1	OPTION 2	OPTION 3	OPTION 4
$500 deductible / Network S	$500 deductible / Network P	$1,000 deductible / Network S	$1,000 deductible / Network P
I elect (monthly contribution):	I elect (monthly contribution):	I elect (monthly contribution):	I elect (monthly contribution):
☐ Retiree Only: $331.49	☐ Retiree Only: $344.12	☐ Retiree Only: $324.15	☐ Retiree Only: $336.50
☐ Retiree + Spouse: $762.44	☐ Retiree + Spouse: $791.49	☐ Retiree + Spouse: $745.54	☐ Retiree + Spouse: $773.95
☐ Retiree + Child(ren): $606.64	☐ Retiree +Child(ren): $629.75	☐ Retiree +Child(ren): $593.19	☐ Retiree +Child(ren): $615.79
☐ Retiree + Family: $994.49	☐ Retiree + Family: $1,032.38	☐ Retiree + Family: $972.44	☐ Retiree + Family: $1,009.49

☐ I do not want to participate in City Medical & Rx coverage effective January 1, 2023

C. MY HEALTH WELLNESS PROGRAM

Step 2: Select whether you and/ or your spouse will participate in the My Health Wellness Program by having a yearly biometric screening at The Center (must be completed by November 30th) to receive a year-long wellness credit to offset your monthly medical plan deduction (Option A), and if you also plan to participate in activities on the COKMyHealth portal to earn RHRA dollars (Option B).

Retiree:

☐ Option A only (health screening - $40 credit/ month)

☐ Option B (health screening and portal activities)

☐ Covering Children (Extra $20 credit/month)

☐ I do not want to participate in the My Health Wellness Program

Spouse: (must be enrolled in medical coverage)

☐ Option A only (health screening - $40 credit/ month)

☐ Option B (health screening and portal activities)

(Option B includes both the monthly wellness credit and quarterly RHRA dollars)

☐ I do not want to participate in the My Health Wellness Program

D. FAMILY MEMBERS TO BE COVERED - *List all dependents to be covered. Dependents will not be covered, if not listed below.*

	Last Name	First Name	M.I.	Social Security Number	Date of Birth	Gender (M/F)
Spouse						
Child						
Child						
Child						

CERTIFICATION

I certify that all information supplied on this form is true to the best of my knowledge and that I have read and understand the information entitled "Enrollment Information" provided below.

Retiree Signature _____Date _____

Enrollment Information

Acceptance: By signing this form you are certifying that all information supplied on this form is true to the best of your knowledge. You understand that all benefits for yourself and your eligible dependents will be provided in accordance with the plan contract. You agree to abide by the terms and conditions governing membership and receipt of health services covered by the plans in which you have enrolled. You authorize your former employer to reduce your pension in an amount necessary to pay for your benefit elections. You understand that your pension reduction cannot be revoked or changed unless you change your election due to a life event as noted below. Your benefit change should be requested in writing within 60 days of the event. Additional paperwork may be required from you at that time. This signature is also to verify: (1) the accuracy of the information contained on this form; and (2) your decision to elect or decline participation in the City of Knoxville's benefit plans.

Special Late Enrollment Rights: In order for these rights to apply to you, you must state in writing that the reason you are currently declining coverage is because you are covered under other health insurance coverage. You may be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Life Event: If you experience a life event, including but not limited to the list of life events below, you may be able to make certain changes to your benefits. Your benefit change must be consistent with the life event and be requested in writing within 60 days of the event. Additional paperwork may be required at that time.

- Change in retiree's legal marital status: Marriage, divorce, legal separation, death of spouse
- Change in number of dependents: Birth, adoption, placement for adoption, death of dependent
- Change in employment status of retiree or dependent: Termination, commencement of employment, coverage of dependent, loss or gain of benefit eligibility of dependent
- Dependent eligibility changes: Dependent is newly or no longer eligible (i.e., reached age 26)
- Material benefit change of retiree or dependent, including dependent's annual open enrollment
- Dependents gain or lose eligibility for Medicaid or SCHIP coverage.

Certificate of Creditable Coverage: The insurance company reserves the right to request from you a certificate of creditable coverage for any time period you are indicating you have had prior medical coverage.