# **OPEN ENROLLMENT GUIDE**

2024



## Commissioners

Begins: Monday, September 18, 2023, 8:00 a.m. Deadline: Friday, October 13, 2023, 4:00 p.m. Changes effective: Monday, January 1, 2024

Commissioners are eligible to enroll in a dental and/or vision plan through the City. If you choose to enroll in a dental and/or vision plan, you are responsible for paying the full premium. Enrollment forms are attached to this flyer.

#### **DENTAL PLANS**

#### Delta Preferred – PPO

Employee Only - \$50.25

Family Coverage - \$97.52

- Deductible for non-management groups: In-network \$40/Out-of-network \$50
- Diagnostic & Preventative covered at 100%
  - Two cleanings per year
  - Bitewing x-rays once per year / Full mouth x-rays every 3 years
- Basic benefits covered at 80%
- Crowns and other Cast restorations covered at 50%
- Prosthodontics covered at 50%
- Annual maximum benefit per calendar year per person \$1,000
- No orthodontia benefit

#### DeltaCare USA – HMO

Employee Only - \$17.34

Family Coverage - \$38.05

- \$0 deductible / \$0 for cleanings and exams (once every 6 months)
- Fee schedule for services
- Orthodontia benefit \$1,600 for child or adolescent to age 19
- Orthodontia benefit \$1,800 for adults, including adult children
- Metallic fillings covered, ceramic or porcelain are considered a materials upgrade (for a fee)

#### **VISION PLAN**

Accepted at in-network optometrists, ophthalmologists, Costco Optical, Walmart, and Sam's Club. Additional savings available on prescription sunglasses, retinal screening and laser vision correction services. You are eligible for your exam, lenses, frames/contacts every 12 months.

#### **VSP**

### Employee Only - \$15.75

Family Coverage - \$35.15

- Exam copay \$10
- Glasses copay \$25
- Deductible \$0
- Frames benefit in-network \$150 / Costco frames benefit \$80
- Contacts in-lieu of glasses up to \$130 benefit / free to participant if deemed medically necessary
- Standard progressive lenses \$50-\$160
- Single vision, bifocal, trifocal, lenticular covered in full

#### **Additional Benefits**

- Extra Pair Benefit \$20 copay
- Corrective Vision Services In-network 15% discount

If you wish to enroll, please complete the appropriate form and submit to Janna Bradley in Human Resources. You may also scan and email your form to jannab@ggcity.org.

Deadline to submit: October 13, 2023 at 4:00 p.m.



# City of Garden Grove VISION SERVICE PLAN ENROLLMENT FORM

Employee Name:		Emp#					
Employee Social Security #Date of Birth							
Address							
Phone							
·	- '	dents (circle one): Yes and relationship of each depend	No Nont:				
Dependent Name	Date of Birth (mm/dd/year)	Relationship	Social Security Number				
Берепцент Манте	(IIIII/dd/year)	(Spouse / Ciliu)	Number				
Signature	Date						
	Human Re	esources Use Only					
Coverage Begins:			☐ Pick ☐ Website ☐ Log				



# **ENROLLMENT/CHANGE FORM - CA DUAL CHOICE**

**Enrollment and Billing Department** 

FOR GROUP USE ONLY

Division

Group No.

				E	nrollm	ent and Bi	iling D	epartn	nent				Effective	Hire	, ,
deltadentalins.com	n	Select a Plan:		P.O. Box	429086	rvice (PPC A 94142-9086	) OR		Р	O. Box		JSA (HMC 0023	Date / Name of Employ  Location	/ Date	Benefit Package
VERY IMPORTA	NT - Please P	rint Legibly													61 41
		Enrollee/Cha	ange	Informa	tion					Chang	ge Der	ntal Plan*	Enrol	lee Classi	fication
New Enrollmer Add/Delete De Marital Status *Enrollees can cha	ependent	Address Change Ferminate Enrollee Cover Change Dental Plans* ing open enrollment or c	rage lue to a q	SSN/Enrollee ID Number Correction or previous ID under which benefits are received  DeltaCare USA - Cancel  a qualifying status change unless allowed by the group contract.						Part-Time Retired	COBRA (if applicable)				
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First Name		Las	st Name									Middle Initial	<b>  I</b>	t Child No Long	
Mailing Address (S	Street)					ity			State		Zip Cod	de	<b>_  </b>   '		, , ,
													Indicate qualifyi	ng date:	/ /
E-mail Address (in	nternal use only)				Phone N	Number (	)	-			one Type	ork 🔲 Home [	**If a dependent security number under must be	the SSN curre	
Network Facility N	lame (DeltaCare U	SA only)					Netw	ork Facility	y Number	(DeltaC	are USA c	only)			
Name of Other De	ntal Carrier		Po	licv Holder N	ame (first	/last)						Date of Birth			
				<u>110 y 110 140 1 14</u>	omi omot	TGOC)						/ /	_		
Effective Date of Other Policy	/ /	Policy Holder Street	Address			City				State	Zip (	Code			
						Depend	dent Ir	ıforma	tion						
Relationship		nt First Name different from enrollee)	Add / T	erm Soc	<del>cial Secur</del>	ity Number	Date (	of Birth	Male /	Female	Student	/ Disabled***	Name of School (overage student)***		ork Facility Number‡ DeltaCare USA only)
Spouse/Partner							/	1							
Dependent							1	1							
Dependent							1	/							
Dependent							/	/							
Please attach a sep	arate sheet for add	litional dependent inforr	nation. A	III dependent	s listed wi	II be considered e	enrolled. *	**Addi tion	al docume	entation v	will be requ	uired for disable	ed and student st atus.‡	Maximum of thr	ee facilities per family

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event , or as may otherwise be provided by the group contract.

☐ I decline coverage at this time.				
Signature of Enrollee	Date	1	1	

Form 3460 CA (Rev. 12-10)

<sup>&</sup>lt;sup>1</sup>DeltaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enr ollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.