2021 **Employee Benefits Summary**

Important Dates

- November 2nd - 13th Open Enrollment
- Last week of November - Benefit Confirmation Statements Mailed out
- Notify HR of any Correction no later than 12/18

Benefits Effective
01/01/2021 — 12/31/2021

What's New?

- The Flexible Spending Account program is moving to Connect Your Care.
- You will be receiving a debit card if you enroll in either of these benefits.
- You can roll over up to $550 at the end of the next plan year (2022).
- Starting on 1/1/2021 Over the Counter Drugs will be eligible expenses on your FSA.
- All claims for the 2020 plan year need to be filed with WageWorks by 12/31/2020.

2021 Premiums

	Employee Monthly Contribution			
CONTRIBUTIONS	Medical	Dental	Vision Gold 150	Vision Gold 100
Employee Only	$60.83	$9.82	$6.15	$5.50
Employee +Spouse	$320.56	$36.10	$10.50	$9.30
Employee + Child(ren)	$249.08**	$34.96	$11.15	$9.90
Employee + Family	$434.35	$54.34	$16.70	$14.80

** Cost for up to 3 children - An additional premium of $15.15 semi-monthly or $30.30 per month will be added for each additional child over 3.

See pages 16 & 17 of your benefits guide for Voluntary Life/AD&D Rates.

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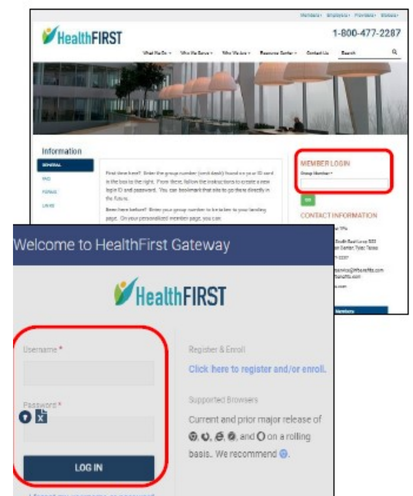
Download the App from the IPhone App Store or Google Play.

Enrollment will be completed through HealthFirst

- Only those making changes need to complete open enrolment.
  - Current benefits will rollover.
- For online enrollment see enrollment instructions handout.



Benefit Summaries*

Note; These are summaries, please refer to your plan documents for a full outline of your coverage.

	BENEFIT BY TYPE OF NETWORK		
	Platinum Access Direct In-Network	In-Network Other Counties	Out-Of-Network
Deductible	$1,000 Individual / $3,000 Family	$1,600 Individual / $4,800 Family	Not Covered
Out-of-Pocket Maximum	$6,350 Individual / $12,700 Family		Not Covered
Physician/ Specialist Office Copay	$30 copay	30% after deductible	Not Covered
Preventive Care	Covered at 100%	Covered at 100%	Not Covered
Emergency Room & Physician			
Accidental Injury & Emergency Care	$250 copay	$250 copay	$250 copay
Non Emergency Care	20% coinsurance after deductible	30% coinsurance after deductible	Not Covered
Urgent Care Copay	$30 copay per visit	30% after deductible	Not Covered
	PRESCRIPTION DRUG BENEFITS		
Prescription Drugs			
Generic	$15 copay (Retail 90 $37.50 copay)		Not Covered
Preferred Brand Name	$60 copay (Retail 90 $150 copay)		Not Covered
Brand Name	$100 copay (Retail $250 copay)		Not Covered
Specialty	$125 copay		Not Covered
Mail Order - Up to 90 Day Supply Max	3X retail copay for 90 day supply		Not Covered

Dental

	Delta Dental
Deductible	$50 Individual $150 Family
Diagnostic/Preventive	100%
Restorative/Basic	80%
Major	50%
Calendar Year Maximum	$1,200
Orthodontia Coverage	50%
Orthodontia Maximum	$1,000

Basic Life and AD&D Insurance - Paid by the City

Employee Life Amount	$10,000
Employee AD&D Amount	$10,000
Line of Duty	$10,000 - *Additional amount of basic AD&D for public safety officers that suffer a loss while he or she is performing his or her customary duties for the City.*

Voluntary Life and AD&D Insurance

Maximum Benefit	$500,000
Guarantee Issue	$250,000
Line of Duty	*Additional amount of AD&D paid to public safety officers that suffer a loss while in an act of duty. Amount will match current election, not to exceed $100,000 dollars*
Spouse Benefit	Up to $250,000
Child Benefit	Up to $20,000

If already enrolled and participating in voluntary life, during Open Enrollment you can increase coverage by $10,000 up to guarantee issue amount of $250,000 without answering evidence of insurability. If you have a dependent child or children you can elect amounts of $5,000, $10,000, $15,000 or $20,000 dollars without evidence of insurability.

Vision

	Gold $150 Buy Up Plan 1	Gold $100 Base Plan 2
	In-Network	In-Network
Exam (with dilation)	$10 copay	$10 copay
LENSES: STANDARD	Once every 12 months	
Single Vision	After $25 copay	After $25 copay
Bifocal	After $25 copay	After $25 copay
Trifocal	After $25 copay	After $25 copay
FRAMES	Once every 24 months	
Standard	Up to $150 Allowance after $25 copay + 20% discount	Up to $100 Allowance after $25 copay + 20% discount
CONTACTS	Once every 12 months	
Elective Contact Lenses	$150 allowance after $25 co-pay + 20% discount	$125 allowance after $25 co-pay + 20% discount
Medically Necessary	Covered in Full after $25 copay	Covered in Full after $25 copay
Laser Vision Correction	$200 Allowance	

Voluntary Short Term Disability

Active, regular, non-civil service, full-time employees are eligible to participate in this plan at a cost of **$15.00** per month.

Benefit Percentage	60%
Maximum Weekly Benefit	$1,200
Elimination Period	7th Day Sickness/7th Day Accident
Maternity	6 weeks – Normal Delivery
Benefit Duration	Up to 26 weeks