# Tri-Lakes Monument Fire Protection District

## Employee Benefits Guide 2018

Tri-Lakes Monument Fire Protection District offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

## When Is Open Enrollment?

The annual open enrollment for TLMFPD's 2018 employee benefits program begins November 1, 2017 and ends November 30, 2017.

[redacted]

## When Is My Coverage Effective?

If you enroll during the annual enrollment period, the coverage you select will be effective January 1, 2018 provided you have met the eligibility requirements.

## What If I Choose Not To Enroll Now Or Miss The Open Enrollment Period?

If you choose not to enroll during open enrollment or your eligibility period, you will be required to wait until the next annual open enrollment unless you have a qualifying change of status as described on the next page.

## Qualifying Event: HIPAA Special Enrollment Rights/Change of Status for Which You May Make Changes to Your Elections

You may only enroll, add family members, or cancel your elections during the annual enrollment period, or within 31 days of experiencing a qualifying life status change, including:

Marriage, death of spouse, divorce or legal separation.

Birth, adoption, placement for adoption or death of a dependent.

Termination or commencement of employment for you, spouse, or dependent.

Relocation or increase in hours of employment by you or your spouse.

Your dependent child satisfies or ceases to satisfy the requirements for coverage because of age.

A change in the place of residence or work for you, your spouse, or dependent.

You or your spouse experiences an open enrollment event.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, you may qualify for a Special Enrollment Opportunity. You must request coverage within 60 days of being determined eligible for premium assistance.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). TLMFPD may request documentation regarding termination of or change in contributions for the other coverage.


medical

# Your Plans

Tri-Lakes Monument Fire Protection District offers two Kaiser plans for eligible employees.

The Select Plan is for employees who reside in Southern Colorado. It is key that you stay within that network. Employees who reside in Denver need to go Kaiser facilities. An employee may not be covered if they seek treatment by an out-of- network doctor or facility, unless it is for life/limb emergency situation.

| Plan Features | KP Select CO Platinum 250/20 HMO | KP CO Platinum 250/20 HMO |
|---|---|---|
| **Deductible (Individual/Family)** | $250 / $500 | $250 / $500 |
| **Coinsurance (most services)** | You pay 10% | You pay 10% |
| **Out-of-Pocket Maximum (calendar year) (includes Deductible, Coinsurance, and copays)** | $2,500 per individual<br>$5,000 max per family | $2,500 per individual<br>$5,000 max per family |
| **Preventative Care** | 100% Covered | 100% Covered |
| **Office Visit**<br>**PCP** | $20 Copay | $20 Copay |
| **Specialist** | $40 Copay | $40 Copay |
| **Emergency Services** | $250 Copay | $250 Copay |
| **Urgent Care** | $75 Copay | $75 Copay |
| **Diagnostic Lab & x-ray** | You pay 10% after deductible | You pay 10% after deductible |
| **MRI, CAT, PET & Other High Tech Services** | You pay 10% after deductible | You pay 10% after deductible |
| **Inpatient Hospital** | You pay 10% after deductible | You pay 10% after deductible |
| **Outpatient Hospital/Facility** | You pay 10% after deductible | You pay 10% after deductible |
| **Physical, Speech, Occupational Therapy** (20 visits each per calendar year) | $30 Copay per visit | $30 Copay per visit |
| **Prescription Drugs – Retail & Specialty Pharmacy** | | |
| **Tier 1 - Generic** | $10 | $10 |
| **Tier 2 - Brand** | $35 | $35 |
| **Tier 3 - Non-Preferred/Speciality** | 10% | 10% |
| **Mail Order Prescriptions** | 2 x copay for 90 days | 2 x copay for 90 days |


dental

# Dental Coverage

Dental coverage is offered to eligible employees. TLMFPD will continue offering the same dental plans with no benefit changes for the 2018 plan year. You have the choice between 2 plans. The base plan is a discount plan that utilizes a smaller network of dentists. The buy-up plan is a more traditional insurance plan, with a broader network of dentists.

## SUNLIFE HMO DENTAL – BASE PLAN

| Type of Service | Network |
|---|---|
| Network Provider Required | Assurant (Delta Health Alliance) |
| Preventative Visits and X-rays | 100% Covered |
| Regular Office Visit | $5 Copay |
| Regular Cleaning | $8 Copay |
| Simple Extraction | $20 Copay |
| Specialist Office Visit | $25 Copay |

## SUNLIFE PPO - BUY UP PLAN

*PPO cost minus HMO cost is your cost as a buy-up to purchase this dental plan*

| Type of Service | Network |
|---|---|
| Deductible - Individual/Family | $50 / $150 |
| Annual Maximum | $1,200 per policy year for each member enrolled in the plan. Preventative care in not included in this amount. |
| Preventative Services (Routine cleanings, X-rays) | 100% Covered, deductible waived |
| Basic Services (Fillings, extractions) | You pay 20% after deductible |
| Major Services (Root canals, crowns) | You pay 50% after deductible |
| Orthodontia | Not Covered |

# vision

**Please note: This is an optional benefit!**

The vision carrier is Vision Service Plan (VSP). Visit www.vsp.com for more information.

## VOLUNTARY VISION - VSP

| Services | In-Network | Out-of-Network |
|---|---|---|
| **Network Provider Required** | VSP | None |
| **Eye Examinations** | $10 copay | Reimbursed up to $50 |
| **Materials** | Additional $25 copay | See Below |
| **Eyeglass Lens Benefit** | | |
| **Single Vision** | Covered in full after copay | Reimbursed up to $50 |
| **Bifocal** | Covered in full after copay | Reimbursed up to $75 |
| **Trifocal** | Covered in full after copay | Reimbursed up to $100 |
| **Contact Lenses** (in lieu of eyeglasses) | Up to $130 allowance | Reimbursed up to $105 |
| **Frames** | Up to $130 allowance | Reimbursed up to $70 |
| **Benefit Frequency** | Exam - every 12 months<br>Lenses - every 12 months<br>Frames - every 24 months | |

# finances

# FLEXIBLE SPENDING ACCOUNTS (FSA) - CONEXIS

A flexible spending account (FSA) allows you to set aside a portion of your salary, before taxes, to pay for qualified medical or dependent care expenses. Because that portion of your income is not taxed, you end up with more money in your pocket.
Set aside money to pay expenses not covered by your medical, dental or vision expenses with a Health FSA. Set aside money to help pay for dependent care expenses with a Dependent Care Account.

**Health FSA**
Use it to pay for things like copayments, coinsurance, prescriptions, dental, vision and medical equipment.

Health FSA only: You may now rollover up **to $500 of unused funds** remaining at the end the 2018 plan year in your Health FSA for qualified medical expenses incurred during 2018.

**Dependent Care Account (DCA)**
Deduct a portion of your paycheck to use for dependent care for children up to age 13, a disabled dependent of any age, or a disabled spouse. To be eligible for this type of account, both you and your spouse (if applicable) must work, seeking work, or be full-time students.
You can save approximately 25% of each dollar spent on these expenses when you participate in a FSA.

**How Much to Contribute?**
You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period of January 1, 2018 to December 31, 2018. If you do not use the money you contributed it will not be refunded to you or carried forward to a future plan year. This is the use-it-or-lose-it rule. You must submit your claims for the 2018 plan year by March 15, 2019.
The maximum that you can contribute to the:

- **Health FSA** is $2,650 per plan year (January 1, 2018 to December 31, 2018).
- **Dependent Care Flexible Spending Account** is $5,000 per plan year (January 1, 2018 to December 31, 2018) if you are a single employee or married filing jointly, or $2,500 per plan year if you are married and filing separately.

**Changing your Flexible Benefits Plan Elections**
Once the plan year has started, you cannot change your elections unless there is an IRS approved status change event. Refer to your Summary Plan Description for more information about family status changes, including how to change your election.

# FLEXIBLE SPENDING ACCOUNTS (FSA) - CONEXIS

## The CONEXIS Benefit Card

Paying out-of-pocket for eligible expenses and then waiting for the claim to be approved and reimbursed is a thing of the past. With the CONEXIS Elite Visa® Benefit Card, your participants have instant access to the funds in their health FSA.

Recent advances in card processing technology have made it easier than ever to use the benefit card to pay for eligible health care expenses. And since the card can be used at thousands of locations to pay for almost any FSA-eligible expense, offering the card to your employees will increase participation and lead to happier participants.

# contact

## Medical

| | |
|---|---|
| Provider Name: | **Kaiser Permanente** |
| Group #: | 036739 |
| Provider Phone Number: | 800-632-9700 (North CO) or 1-888-681-7878 (S. CO) or<br>The Resource Team 719-867-2170 |
| Provider Web Address: | https:healthy.kaiserpermanente.org |

## Dental

| | |
|---|---|
| Provider Name: | **SunLife** |
| Group #: | 5477850 |
| Provider Phone Number: | 800-442-7742 |
| Provider Web Address: | www.sunlife.com/us |

## Voluntary Vision

| | |
|---|---|
| Provider Name: | **VSP** |
| Group #: | 30063339 |
| Provider Phone Number: | 800-877-7195 |
| Provider Web Address: | www.vsp.com |

## Flexible Spending Account (FSA)

| | |
|---|---|
| Provider Name: | **Conexis** |
| Provider Phone Number: | For phone information, go to your web page and click on “contact us” |
| Provider Web Address: | mybenefits.conexis.com |

# terms&definitions

**Copay** – An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. The concept is similar to coinsurance, except that Copays are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.

**Deductible** – A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.

**Coinsurance** – The money that an individual is required to pay for services, after a deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20 percent of the charges while the health plan pays 80 percent.

**Out-of-Pocket Maximum** – The total amount paid each year by the member for Copays, deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100 percent of the allowable charges for covered services the rest of that calendar year.

**In-Network** – Typically refers to physicians, hospitals or other health care providers who contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-ofnetwork providers, depending on the plan.

**Out-of-Network** – Typically refers to physicians, hospitals or other health care providers who do not contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

**Pre-Admission Certification** – Also called “precertification” or “pre-admission review.” Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary.

# notes

## notes

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