Benefits Guide

Temporary and Seasonal

2023

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How to use this guide?

The City of Boulder recognizes the importance of providing employees with a comprehensive benefits package. These benefits help provide you and your family with the resources to maintain your health and wellbeing. We encourage you to review and select benefits that best suit your needs.

This Benefits Guide provides you with:

- Eligibility criteria and qualified life events
- Descriptions of benefits that are available
- Information on open enrollment dates
- Important phone numbers and websites to help you enroll in and manage your benefits

You can read through this benefits guide by using the tabs on the left-hand side to navigate to the pages of interest.

More information regarding employee and family benefits, including annual plan notices, is available on the **City of Boulder Human Resources Benefits page**.

This guide is intended to be a brief summary of employee benefits and is not an official policy document. If there is a discrepancy between information in this guide and official documents (such as benefit plan documents, policies or collective bargaining agreements) then official documents prevail.

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Your 2023 Benefits

Medical Benefits

Cigna Preferred Provider Organization Plan (PPO)
Cigna High Deductible Health Plan (HDHP)

Pre-Tax Spending Account

Alerus Health Savings Account (HSA)

Additional Benefits

Aflac Supplemental Policies
Life Insurance and Disability
Legal and ID Shield
Employee Wellness Program
Employee Assistance Program (EAP)
Recreation Pass

Retirement

PERA Retirement Plans
Voluntary Retirement Plans (401k, 457, IRA Roth)

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Eligibility

Who is eligible?

City of Boulder Employees

Benefits eligibility is determined by hours worked and employment status. See the descriptions of the status types and the corresponding table of eligible benefits.

1. There are two types of Seasonal Employees:
   a. (Type 1) Employee works less than six (6) months continuously and work is typically scheduled for same time of year (i.e., summer or winter)
   b. (Type 2) Employee works continuously for six (6) months AND works more than 30 avg. hours weekly
2. There are also two types of Temporary/Paid Intern Employees:
   a. (Type 1) Employee works between three (3) months and one (1) year for a predetermined duration AND works less than 30 avg. hours weekly
   b. (Type 2) Employee works between three (3) months and one (1) year continuously for a predetermined duration AND for 30 or more avg. hours weekly

Dependents

- Your spouse or partner
- Child(ren) under the age of 26 (your children, your spouse or partner's children, and children in your legal custody)

What am I eligible for?

Use the table below to determine what you are eligible for:

	Employee Type			
Benefit	Seasonal Type 1	Seasonal Type 2	Temporary/Paid Intern Type 1	Temporary/Paid Intern Type 2
Medical		✔		✔
HSA		✔		✔
Aflac Plans		✔		✔
Legal & ID Plans		✔		✔
Wellness Program	✔	✔	✔	✔
Recreation Pass		✔		✔
EAP	✔	✔	✔	✔
Retirement Benefits	✔	✔	✔	✔
Sick	✔	✔	✔	✔

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Affordable Care Act

The Affordable Care Act (ACA) requires large employers to offer medical coverage to all employees who work more than 30 hours per week. This requirement exists regardless of employment classification, position or length of employment unless the person is a true variable hour or seasonal employee. Employers can apply a measurement period to determine if a seasonal or variable hour employee has worked more than 30 hours a week, before offering benefits. ACA defines a Seasonal Position as one with a break of 26 weeks or more between "seasons," where the length of the position is less than six (6) months and where the position is by nature dependent on season.

Measurement Periods:

Initial Measurement Period – Applies to new hire employees or recurring employees with greater than 12 weeks between employment periods. This period occurs for **12 months** immediately following date of hire.

Initial Administrative Period – HR reviews new employees or recurring employees to determine medical eligibility immediately following the end of the Initial Measurement Period. If eligible, employee is offered coverage no later than the end of the month following their one year anniversary, or no longer than **30 days**.

Initial Stability Period – Applies to new hire employees, recurring employees with greater than 12 weeks between employment periods, or position changes than impact hours and/or duties (per HR approval). This period occurs for **12 months** immediately following the end of the 12 month Initial Measurement Period and of the 30 day Initial Administrative Period.

Standard Measurement Period – City-wide measurement period of 12 consecutive calendar months is used to measure all current employees' medical eligibility. This period begins **November 1 of every year and ends the following year on October 31**.

Standard Administration Period – City-wide administration period to process administrative paperwork and enroll current employees in medical plans. The administrative period begins immediately following the Standard Measurement Period and is no more than 90 days. The city's Standard Administrative Period is **November 1 - December 31** of the same year.

Standard Stability Period – The city-wide stability period begins immediately following the end of the Standard Measurement and Standard Administrative Periods. The city uses a 12 month Standard Stability Period which begins **January 1 every year and ends on December 31** of the same year (plan year).

Sum of Hours Worked in Measurement Period	Eligibility
Below 1,507	Not eligible for benefits
1,508-2,027	Benefit Eligible (30-39 hour Premium Rate)
2,028 or more	Benefit Eligible (40 hour Premium Rate)

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Enrollment

When can I enroll?

When You Are Hired

For newly hired employees, benefit enrollment must be completed within 31 days from your date of hire. You will enroll using the city's Workday platform. Benefits offered within this guide are effective on the 1st of the month following your date of hire. Supplemental Aflac coverage is effective on the 1st of the month following completion of your application.

During Open Enrollment

Existing employees will make next year's elections for themselves and eligible dependents during Open Enrollment, using the Workday platform.

2023 Open Enrollment

Open Enrollment for the 2023 plan year runs from November 14 to November 27, 2022. During this time, you must enroll in and/or decline coverage for the coming year. The effective date of benefits selected is January 1, 2023.

How Do I Enroll?

2023 benefits enrollment is to be completed via the city's Workday platform.

Can I Change My Benefits?

After the Open Enrollment period ends on November 27, 2022, the benefits you chose will be in place from January 1 to December 31 of the following year. You cannot change your benefits during this time unless you have a **qualifying life event**.

Examples of Qualifying Life Events include:

- Marriage, civil union, legal separation, or divorce
- Birth or adoption of a child
- Death of your spouse, civil union partner, or dependent child
- Spouse, civil union partner, or dependent children losing or gaining coverage
- Change in employment status for you or your spouse/civil union partner
- Change in residence (only if our current coverage isn't available in the new location)

Questions?

We encourage you to submit questions to the Benefits Team through **Service Depot**. It is the quickest way to ensure questions and issues are addressed.

Once Workday launches on November 14, 2022, many of our forms will become obsolete. So instead of emailing most forms, you will complete processes through Workday.

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Medical

What medical plans are available?

The City of Boulder offers two distinct medical plans, both through Cigna. One is the Preferred Provider Organization Plan (PPO or "Copay") plan and the other is the High Deductible Health Plan (HDHP) plan. The plan designs differ based on a variety of factors including: deductibles, out-of-pocket maximums, and cost sharing with Cigna. The plan designs have no effect on the quality of care you receive.

The medical plan options are as follows:

- Cigna Preferred Provider Organization Plan (PPO or "Copay")
- Cigna High Deductible Health Plan (HDHP)

What you can expect

100% Coverage for Your Preventive Care.

All of our medical plans pay 100% for preventive care when you use in-network providers, even before you meet your annual deductible.

Employer HSA Contribution

- Our high deductible health plan (HDHP) is eligible for a health savings account (HSA), which lets you save money for medical expenses.
- The City of Boulder will contribute up to **$500 for individuals** and up to **$1,000 for families** if you enroll in the city HDHP and meet the qualifications to have an HSA.

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PPO ("Copay") Plan

How it Works

Copay: A copay is the fixed dollar amount you pay when you use medical services. For example, your plan could require you to pay $25 for primary care doctors, $50 for specialists, and $15 for generic prescription drugs. When you go to the doctor or fill a prescription, this is the amount you'll pay.

Deductible: The city's copay plan has a deductible. For medical services for which a deductible applies, you will be required to pay the full cost of services until you meet your deductible. For example, if you visit your primary care physician, you pay a $25 copay for the visit. If you receive services during the visit, such as lab work or diagnostic testing, the cost of service is subject to your deductible. Copays do not count toward your deductible.

Coinsurance: The copay plan has coinsurance (the cost sharing with Cigna). Once you meet your deductible, you pay coinsurance for medical services received until you satisfy your annual out-of-pocket maximum.

Annual Out-of-Pocket Maximum: The copay plan has an annual out-of-pocket maximum. Copays, deductible, and coinsurance count toward your out-of-pocket maximum. If you reach your out-of-pocket maximum, the insurance company pays 100% of covered medical services for the remainder of the plan year.

Advantages

- You'll have a set dollar amount, or copay, when you visit the doctor and pharmacy
- Works well for people who do not want to pay the full cost of a medical bill or prescription out-of-pocket and prefer the predictability of copays
- Makes sense for people who are willing to pay a higher premium each month for the security of knowing how much they will pay when they visit the doctor
- 100% coverage for preventive care when you use in-network providers
- Telehealth, Dispatch Health, Behavioral Health coverage, and other comprehensive options are available with this plan

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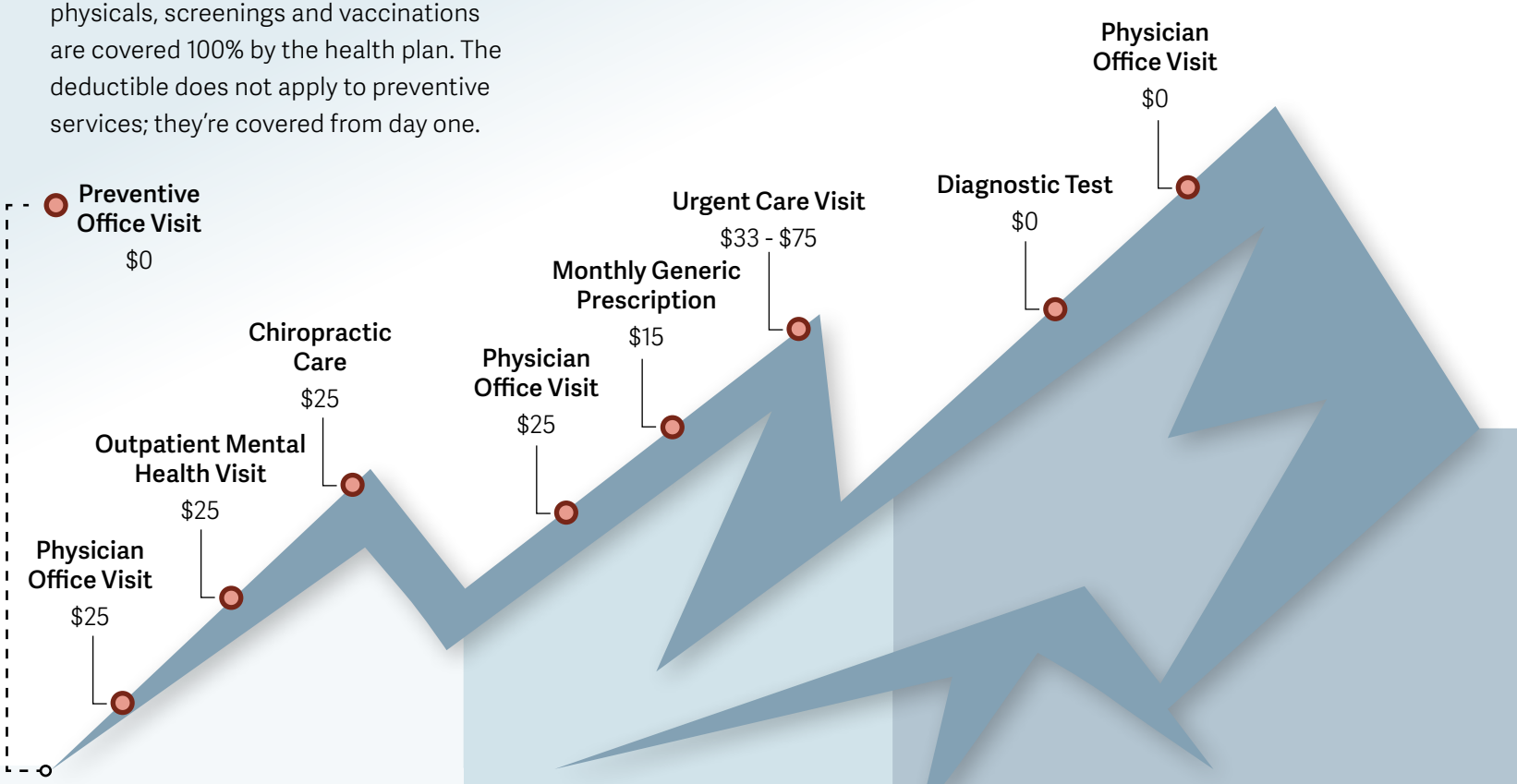
How Deductible Copay Plans Work

Free Preventive Care

Preventive Services, such as routine physicals, screenings and vaccinations are covered 100% by the health plan. The deductible does not apply to preventive services; they're covered from day one.



Annual Deductible

Most diagnostic services are billed on top of your copay and are applied to your annual deductible. Your copays are not subject to deductible but go toward your out-of-pocket maximum. Until your out-of-pocket maximum is met, you will pay set copays determined by your health plan.

Coinsurance

Once your deductible has been met, you pay 20% while Cigna pays 80% for in-network medical services. Each covered individual is subject to an individual deductible limit.

Out-of-Pocket Maximum

When you have reached your out-of-pocket maximum, your health plan pays 100% of any additional health cost. Cigna's out-of-pocket maximums are $4,500 individual/$9,000 family.

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High Deductible Health Plan (HDHP)

How it Works

High deductible health plans are designed to help keep premium costs low for you and your family. How much you pay out-of-pocket depends on two things: your deductible and out-of-pocket maximum.

Deductible: You are expected to pay the full charges for services until you meet the deductible.

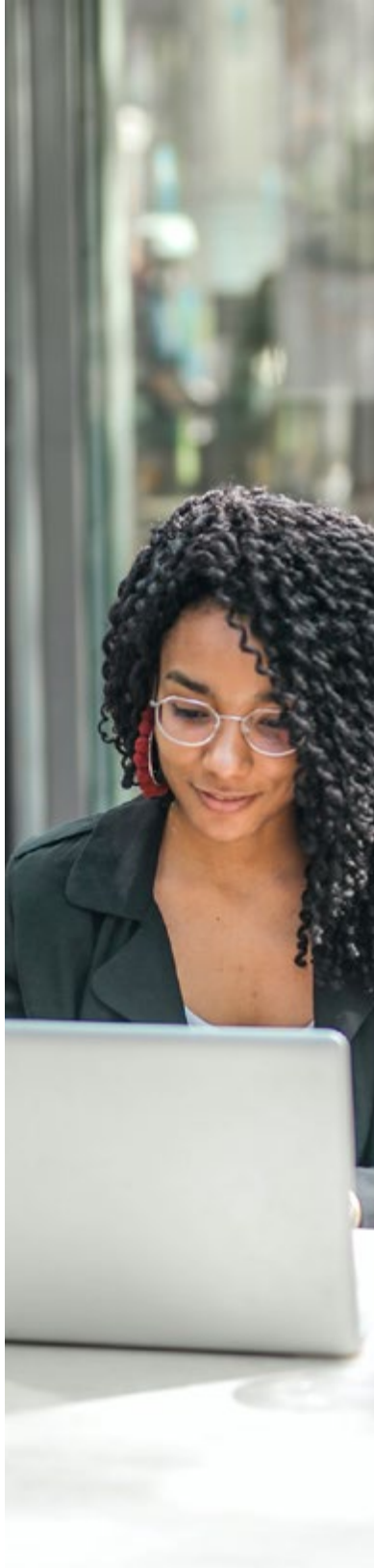
HSA Helps You Pay Your Deductible: Your HDHP with the City of Boulder is HSA qualified and eligible for an employer contribution of up to $500 per year for employee only coverage or up to $1,000 per year for family coverage. You can use your HSA to cover eligible medical expenses.

Coinsurance: Once you meet your deductible, you share in coinsurance with Cigna, meaning, Cigna will pay 80% of your in-network medical costs and 60% of your out-of-network costs.

Annual Out-of-Pocket Maximum: You'll continue to pay coinsurance until you meet your out-of-pocket maximum. If you reach your out-of-pocket maximum, the insurance company pays 100% of medical services.

Advantages

- The monthly premiums are lower than the PPO plan
- If you enroll in the HDHP, you're eligible for an HSA to help pay for eligible medical expenses while also lowering your taxable income
- HSA funds roll over from year-to-year and are portable
- Works well for those who are not anticipating frequent or significant medical expenses for the upcoming year
- 100% coverage for preventive care when you use in-network providers
- Telehealth, Dispatch Health, Behavioral Health coverage, and other comprehensive options are available with this plan



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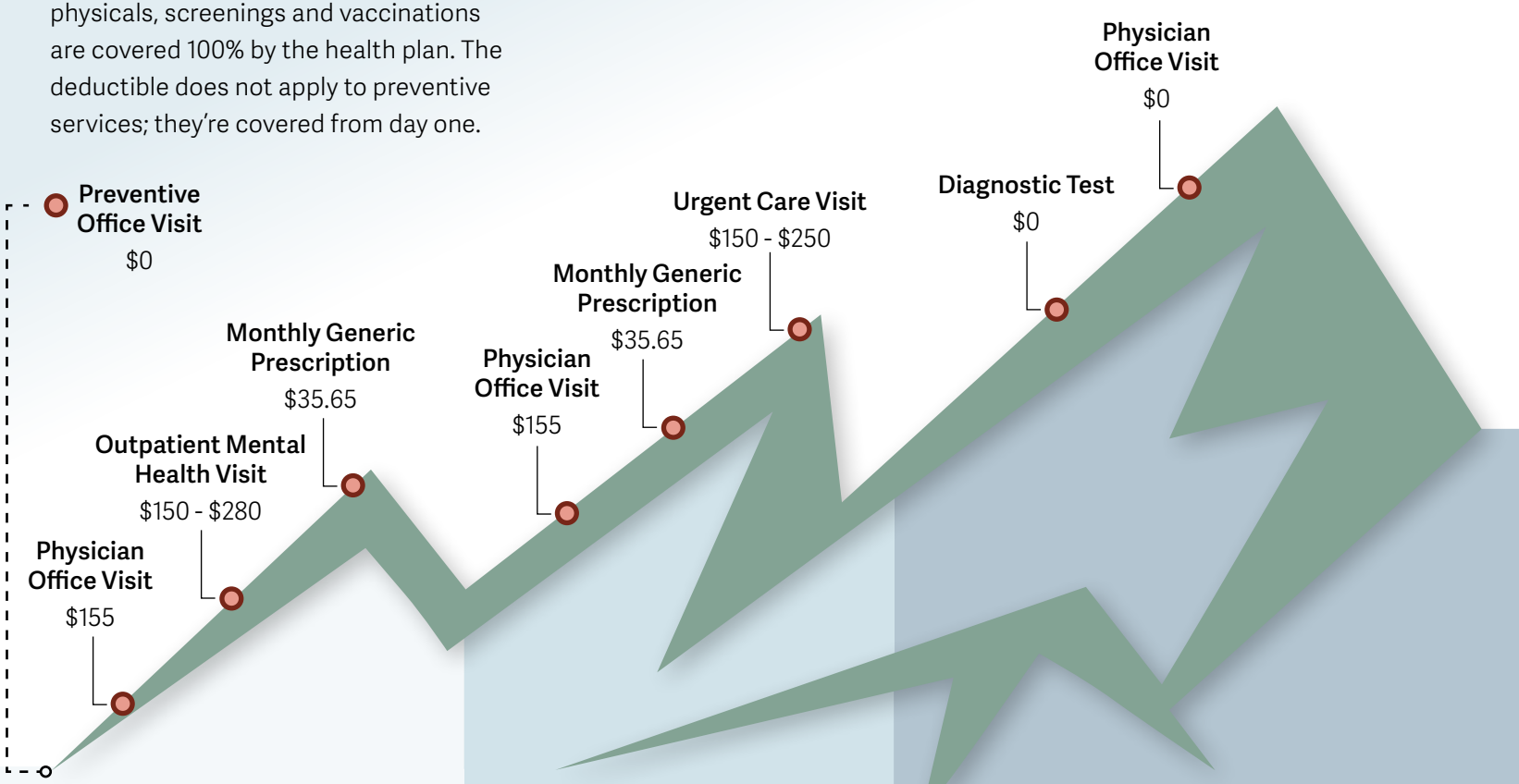
How High Deductible Health Plans Work

Free Preventive Care

Preventive Services, such as routine physicals, screenings and vaccinations are covered 100% by the health plan. The deductible does not apply to preventive services; they're covered from day one.



Annual Deductible

For services other than preventive care, you are responsible for the full cost of services until your deductible is met.

Coinsurance

Once your deductible has been met, you pay 20% while Cigna pays 80% for in-network medical services. For those with family coverage, the full family deductible must be met before any individual coinsurance applies.

Out-of-Pocket Maximum

When you have reached your out-of-pocket maximum, your health plan pays 100% of any additional health cost. Cigna's out-of-pocket maximums are $5,000 individual/$10,000 family.

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A Little Help to Make the Decision Easier

Please note that these examples below are for illustrative purposes only and that cost of care can vary based on procedure, physician billing, and location of services.

Meet Mary

Employee only coverage with low utilization

Mary is relatively healthy with no chronic conditions. Mary does not have a partner or dependents to cover and is looking for the most cost-effective medical plan with low monthly payments that still provides coverage in case unexpected health incidents occur. During the year, Mary receives the following care:

Type of Cost	PPO "Copay" Plan	HDHP
Yearly Premium	$1,622.92	$1,369.94
Medical Expenses		
Preventive Care Visit	$0	$0
Sick Visit to Primary Care Physician	$25 copay	~$155
Monthly Generic Tier 1 Birth Control Prescription	$15 copay x 12 = $180.00	$13.63 x 12 = $163.56
Savings		
City of Boulder Wellness Premium Credit	$360	$360
City of Boulder HSA Contribution	N/A	$500
Total Cost to Mary:	**$1,467.92**	**$828.50**

Meet Jacob

Employee plus partner with moderate utilization

Jacob is seeking medical coverage for himself and a spouse. Jacob has asthma and is on routine care with a prescription. His partner seeks mental health support in addition to using the city's EAP. Their yearly care is as follows:

Type of Cost	PPO "Copay" Plan	HDHP
Yearly Premium	$3,495.18	$2,950.48
Medical Expenses		
Preventive Care Visit	$0	$0
Three Outpatient Mental Health Visits	$25 copay x 3 = $75	$215 x 3 = $645
Monthly Tier 2 Asthma Prescription	$45 copay x 12 = $540.00	$310.73 x 12 = $3,728.76
Savings		
City of Boulder Wellness Premium Credit	$360	$360
City of Boulder HSA Contribution	N/A	$1,000
Total Cost to Jacob:	**$3,750.18**	**$5,964.24**

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Meet Sophia

Employee plus family coverage with high utilization

Sophia covers her spouse and son on her plan and is expecting a second child. Sophia is experiencing high blood pressure with this pregnancy which is being treated with a prescription. They are anticipating more medical expenses this year:

Type of Cost	PPO "Copay" Plan	HDHP
Yearly Premium	$4,881.50	$4,120.48
Medical Expenses		
Preventive Care Visit	$0	$0
6 Specialist OBGYN Office Visits	$50 copay x 6 = $300	~$175 x 6 = $1,050
Monthly Non-Formulary Brand/Tier 3 Blood Pressure/ Heart Prescription	$60 copay x 12 = $720	$9.90 x 12 = $118.80
Hospital Stay for Labor & Delivery ($11,000)	$3,480*	$8,831.20*
Savings		
City of Boulder Wellness Premium Credit	$360	$360
City of Boulder HSA Contribution	N/A	$1,000
Total Cost to Sophia:	**$9,021.50**	**$7,760.48**

***Note:** With this high utilization, the maximum out-of-pocket is reached under both plans. Under both the PPO Plan and HDHP Plan, only the individual maximum out of pocket needs to be reached before additional in-network care is covered at 100%.

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Cigna Medical Plans

Open Access Plus Network

	Copay PPO Plan		HDHP/HSA Plan	
NETWORK:	In Network	Out-of-Network	In Network	Out-of-Network
Calender Year Deductible	$1,250 Individual $2,500 Family	$2,500 Individual $5,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
Deductible Basis	Each covered individual is subject to individual deductible limit		Full family deductible must be met before any individual coinsurance applies	
Coinsurance Split (after deductible - Plan Pays/You Pay)	80% / 20%	60% / 40%	80% / 20%	60% / 40%
Calendar Year Out-of-Pocket Max	$4,500 Individual $9,000 Family	$10,000 Individual $20,000 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Out-of-Pocket Basis	Each covered individual is subject to individual out-of-pocket limit		Each covered individual is subject to individual out-of-pocket limit	
Physician Office Visit	$25 Copay/$50 Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
Preventive Visit	100% Covered	40% Coinsurance	100% Covered	40% Coinsurance
Inpatient Hospital	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Emergency Room	20% Coinsurance		20% Coinsurance	
Urgent Care	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Ambulance	20% Coinsurance		20% Coinsurance	
X-Ray	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Laboratory	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Maternity	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Outpatient Physical Therapy	$25 Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
Speech, Hearing, and Occupational Therapy	$25 Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
Durable medical equipment	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Home health care	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Hospice	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Skilled nursing	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Hearing aids (testing & fitting)	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Chiropractic care (20 Days)	$25 Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
Mental health/substance (inpatient)	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Mental health/substance (outpatient)	$25 Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
Prescription Drugs Administered by Cigna				
Generic Brand/Tier 1	$15 Copay	Not Covered	20% Coinsurance	Not Covered
Formulary Brand/Tier 2	$45 Copay		20% Coinsurance	
Non-Formulary Brand/Tier 3	$60 Copay		20% Coinsurance	
Mail Order (90 day supply)	$37 / $112 / $150		20% Coinsurance	
Preventive Maintenance Medication	$0		$0	

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HSA

How does the HSA work?

A Health Savings Account (HSA) is a type of member-owned savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses. HSA funds roll over year-to-year if you do not spend them and are portable.

You can find a complete list of eligible expenses **here**.

Eligibility

- You must be enrolled in the City's High Deductible Health Plan (HDHP)
- You cannot have any other first-dollar coverage
  - Military, Medicare, or Tricare coverage
  - A spouse's or parent's PPO plan
- You cannot be claimed as a dependent on someone else's tax return

Your Contribution

Per IRS regulations, the maximum amount you can contribute for 2023 is as follows:

- $3,850 if you are enrolled in Employee Only (Single) coverage
- $7,750 if you are enrolled in Family (Two Person or Family) coverage
- **Catch-up contributions**: Employees who turn 55 during the plan year may contribute an additional $1,000 per year until enrollment into Medicare

Please note that contribution limits reflect the TOTAL amount that may be contributed by both the employee AND the employer.

City of Boulder Contribution

The City of Boulder will also contribute funds into your HSA. Initial deposits from the city will be made after the first pay period in which you have met all the requirements listed in this section. Please note, if you and a spouse are both employed by the city, you are only eligible for an HSA contribution from the city up to $1,000 annually or prorated if applicable.

City Contribution Schedule

HSA contributions will be made evenly over 26 pay periods. Once your medical coverage begins and your HSA account has been opened and verified, you will begin receiving monthly employer HSA contributions.

- **Employee Only (Single) Coverage**: up to $500 deposit per year
- **Family Coverage (Two Person, Family)**: up to $1,000 deposit per year

To receive the City's contribution, you must:

- Be enrolled in the city's High Deductible Health Plan (HDHP) with Cigna
- Open and maintain an HSA account with Alerus

Setting up your HSA account

Starting November 14, employees wishing to enroll in an HSA will do so through Workday.

Once the account has been established with Alerus, you will receive a welcome email to your City of Boulder email address, containing instructions on registering your online profile. This will allow you to authorize how you will be reimbursed. Registration must be completed within 30 days of HSA enrollment.

After your account is active, HSA debit cards will be mailed to your address on file.

Questions? Contact Alerus directly: **alerusrb.com**, **info@alerus.com** or 877-661-4727.

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Additional Voluntary Benefits

What voluntary benefits are available?

Voluntary Benefits can be elected at the time of hire or during open enrollment. Detailed information on our Voluntary Benefits can be found by clicking the following link: **City of Boulder 2023 Voluntary Benefits Brochure Booklet**.

The City of Boulder provides the following:

- Aflac Critical Illness
- Aflac Accident
- Aflac Hospital Indemnity
- LegalShield
- IDShield

Critical Illness Insurance

Critical Illness Insurance is designed to help offset costs associated with the initial occurrence of a heart attack, stroke, cancer, or other serious illness as outlined in the policy.

Accident Insurance

Whether you experience an accident at home or at work, this benefit allows you to receive funds to help pay for medical bills, replace income while you may be away from work, or help cover the mortgage or energy bill.

Hospital Indemnity Insurance

The Hospital Indemnity plan is meant to help offset any costs associated with a hospital stay.

IDShield

IDShield will monitor your Social Security number, credit cards, bank accounts, and more. Specialists are available 24/7 to answer your questions and walk you through the steps you can take to protect yourself. If any change in your status or compromise occurs, you receive an e-mail update immediately.

LegalShield

LegalShield provides legal advice and representation in the event you have need for an attorney. Services include:

- Name Changes
- Bankruptcy
- Foreclosure
- Landlord/Tenant Issues
- Driver's License Restoration
- Traffic Ticket Violations
- Living Wills
- Power of Attorney
- and more

NOTE: If you elect any of these voluntary benefits, premiums will be paid through convenient payroll deductions.

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Wellness Program

Well-Being@Work

The Well-Being@Work program offers a wide range of benefits and wellness initiatives to help you maintain or achieve optimal health and well-being. Your well-being is vital to the success of the city and its service to the community, and we encourage you to take advantage of all the programs and benefits Well-Being@Work has to offer, including monthly wellness challenges, well-being Wednesday events, health improvement programs, personal health coaching, and more.

How Do I Earn Wellness Incentives?

All benefits eligible employees can earn up to $150 in gift card incentives each year by participating in City-wide wellness challenges and events, meeting and achieving personal wellness goals, and more via the **Wellness Portal**.

Wellness Premium Credit

You are eligible to receive an insurance premium credit of $30 credit per month ($360 per year) if you are an existing employee or a new hire with the City and enrolled in the Cigna PPO or HDHP medical plan. Beginning in 2023, the credit will be paid evenly over 26 pay periods ($13.85 per pay period).

Premium Credit Requirements:

You can receive the wellness premium credit if you:

- Are enrolled in a medical plan through the City of Boulder
- Complete ONE of the following actions by October 31 of each plan year:
  1) Annual preventative exam with your primary care provider
  2) MDLive wellness visit
  3) Lab work at Quest Diagnostics Center

New hires should complete a Health Assessment on **MyCigna.com** to begin receiving their premium credit in the year in which they are hired.

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Employee Recreation Pass

An employee recreation pass is available if you are a benefits eligible existing employee or new hire. You must elect your rec pass during open enrollment for existing employees or during new hire benefits selection. The discounted value of the employee recreation pass is taxable (you will be taxed on $11.50 per pay period) and the exact amount paid each year depends on your tax bracket.

If you are a non-benefits eligible employee and wish to purchase a recreation pass, please visit the **Well-Being@Work home page** for details.

Want to Add a Family Member to Your Rec Pass?

You have the option to purchase recreation center passes for your immediate family members at a discounted fee of $100 per family member. Family member passes are not taxed on your paycheck and will be prorated based on when they are purchased. Please bring the **Family Affidavit Form** into one of the recreation centers to complete this process after you have elected your employee rec pass.

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New EAP Vendor for 2023: Cigna

Beginning January 1, 2023, the city is pleased to announce Cigna as its new Employee Assistance Program (EAP) vendor! Cigna offers much more robust EAP and additional resources to managers, employees and employee household family members. EAP services through Magellan will be discontinued on December 31, 2022.

EAP Is a 24/7/365 program to support employees with issues they may be facing. This program is provided at no cost. Services available include:

- 10 face-to-face or video-based sessions with a counselor in your area for topics such as family and relationships, grief and loss, emotional health, stress management and job/career support
- 30-minute legal assistance with an attorney face-to-face or by phone
- 30-minute financial phone consultation (debt, financial planning, retirement, etc.)
- 60-minute identity theft consultation with a fraud resolution specialist
- Resources and referrals for
  - Parenting: childcare providers, before/after school programs, camps, adoption organization, child development and prenatal care
  - Eldercare: home health agencies, assisted living facilities, social/recreation programs and long-distance caregiving
  - Pet care: pet sitting, obedience training, veterinarians and pet stores

How to Access EAP Services

In 2023, contact Cigna any day, anytime:

Call: 1-877-622-4327 or
Login to **myCigna.com** (website or app)

Employee ID: cityofboulder

If you are already registered on **myCigna.com**, simply login and visit the EAP link under the "Coverage" tab

Cigna's EAP network of licensed therapists includes psychologists, counselors, marriage/family therapists and social workers. These providers can evaluate and treat mental health and substance use needs, as well as facilitate referrals to other type of care.

Remember: EAP is completely confidential. The city does not receive information about who accesses which services through EAP. It is as confidential and personal as visiting your family doctor.

Cigna surpassed all the city's program requirements in evaluating EAP vendors, because they:

- Provide on-site services for employees, such as group and individual sessions when needed, including office hours and critical incident debriefing.
- Have a robust network in the Boulder area so that plan members can quickly access care.
- Have demonstrated experience with First Responders.
- Offer specialized care for LGBTQIA+ and other groups employees identify with.
- Provide customized programming for peer support leaders in Fire, currently working with the Building Warriors program.

Cigna also provides easy continuity of care for those employees that need to transition services from EAP to a medical provider.

Learn more about Cigna's forthcoming EAP offering for City of Boulder employees by clicking **here**.

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Retirement

Employee Pension Plan

Temporary and seasonal employees participate in the **Public Employees' Retirement Association (PERA) Pension Plan (Defined Benefit or Defined Contribution)**. Both the city and the employee contribute into this plan.

Supplemental Retirement Savings Plans

The city also encourages employees to participate in voluntary retirement savings plans. The city offers two types of supplemental plans:

- 457 Plan- Administered by **MissionSquare**
  - Available to all employees
- IRA Roth- Administered by **MissionSquare**
  - Available to all employees
- 401(k) Plan- administered by **PERA**
  - Available to PERA retirement plan participants

For more detailed information on each plan, visit the **Retirement Resources** page on Boulder@Work.

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Leave Benefits

Temporary/Paid Intern and Seasonal employees receive paid Sick Leave. This benefit can be used when the employee is:

- Unable to work due to sickness
- Injured or pregnant
- Receiving medical treatment
- Caring for the health needs of a sick or injured family member.

Employees may use Sick Leave to care for family members including:

- Spouse
- Domestic partner
- Mother, father, sister, brother, or child,
- Step-child, father-in-law, mother-in-law, brother-in-law, or sister-in-law
- Grandparent

Employees receive 2.67 hours of paid Sick Leave per active pay period. They can accrue a maximum of 48 hours.

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Coinsurance

The percentage of costs of a covered health care service you pay after you've paid your deductible. For example, after the deductible is met, the plan may be 80% and you may pay 20% until the Out-of-Pocket Max is reached.

Copayment (Copay)

A copay is a flat dollar amount you pay for specific covered services upon each visit to the provider. It is not impacted by the plan deductible, coinsurance, or out-of-pocket maximum.

Deductible

The amount you must pay out of pocket for covered expenses before the insurance company starts to pay.

Embedded Deductible (PPO Plan)

In an embedded deductible health plan, the policy will have two deductibles: the individual deductible for each family member and the family deductible. When one family member accrues enough medical expenses to meet the individual deductible, coinsurance and cost-sharing will be provided by the insurer for that specific family member. Once multiple family members' medical expenses surpass the family deductible, the insurer begins to provide cost sharing for all members of the family.

Evidence of Insurability (EOI)

This is documentation that provides a record of a person's past and current health events; it is used by insurance companies to verify whether a person meets the definition of good health. It is only required in certain circumstances.

Explanation of Benefits (EOB)

After you receive medical services, your insurance will provide you with an EOB. It will outline details regarding how your insurance processed your medical claim, including what portion of the charges your insurance paid and what portion, if any, you are responsible for paying.

Formulary

A formulary is a list of drugs (both generic and brand name) selected by the health plan as the drugs preferred to treat certain health conditions.

Health Savings Account (HSA)

An HSA is a tax-advantaged medical savings account available to enrollees in a Qualified High Deductible Health Plan (HDHP). Pre-tax contributions are made to the member's account and can be used for a variety of IRS qualifying medical, dental, vision, and prescription expenses. The HSA is a member-owned account and funds roll over from year to year. The HSA is subject to the IRS contribution limits

In- and Out-of-Network Providers

Benefit plans develop networks by contracting with doctors, hospitals, labs, etc., who have agreed to provide health care services to members at negotiated rates. You generally pay less out of pocket when you use in-network providers.

Non-Embedded Deductible (HDHP Plan)

There is no individual deductible. This means that the overall family deductible must be reached, either by an individual or by the family, in order for the insurance carrier to begin paying benefits.

Out-of-Pocket Maximum

The maximum amount you will pay out of pocket for covered medical expenses per calendar year, including your deductible. After your share of covered expenses reaches this annual limit, the plan pays 100 percent for eligible network services for the remainder of the calendar year.

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Resources

For Questions About...	Contact	Phone #	Web/E-Mail
Medical & Prescription Plan Group # 3338899	Cigna	800-244-6224	www.mycigna.com
TeleHealth	MDLive	888-726-3171	www.mdlive.com/COB
DispatchHealth		303-500-1518	www.dispatchhealth.com
Healthcare Exchange	Connect for Health Colorado	855-752-6749	www.ConnectforHealthCO.com
Medicaid	Colorado Medicaid	800-221-3943	www.colorado.gov/peak
Employee Assistance Program (EAP)	Cigna	1-877-622-4327	www.mycigna.com
Health Savings Account	Alerus	800-837-4817	www.alerusrb.com
Retirement	PERA Defined Benefit–City of Boulder	303-832-9550	www.copera.org
	Supplemental 401(k)	303-832-9550	www.copera.org
	Supplemental 457	MissionSquare 800-669-7400	www.icmarc.org/missionsquare-retirement
Well-Being@Work	WisemanH@bouldercolorado.gov	303-441-3559	www.mywell.site/active/CityofBoulder
EcoPass **Guaranteed Ride Home**	RTD GRH	303-299-6000 866-970-7480	www.rtd-denver.com
Identity Theft Protection Group # 203798	IDShield	888-807-0407	www.idshield.com
Accident / Critical Illness / Hospital Indemnity Group # 24628	Aflac	720-207-2391	jennifer.foss@hubinternational.com
Legal Services Group # 203798	LegalShield	888-807-0407	www.legalshield.com
Human Resources		303-441-3070	HRBenefits@bouldercolorado.gov
Additional Questions or Escalated Claims Issues	HUB Advocacy	888-795-0300	boulderadvocacy@hubinternational.com

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Medical Rates					
Health Plan	Coverage	Total Pay Period Premium	City Pay Period Cost	Employee Pay Period Cost	
				With NO Wellness Credit	*With Wellness Credit - $13.85 per Pay Period*
Full-Time Employees					
PPO	Employee	$312.09	$249.67	**$62.42**	**$48.57**
	Employee +1	$672.15	$537.72	**$134.43**	**$120.58**
	Family	$938.74	$750.99	**$187.75**	**$173.90**
HDHP	Employee	$263.45	$210.76	**$52.69**	**$38.84**
	Employee +1	$567.38	$453.90	**$113.48**	**$99.63**
	Family	$792.41	$633.92	**$158.48**	**$144.64**
Part-Time Employees					
PPO	Employee	$312.09	$124.84	**$187.26**	**$173.41**
	Employee +1	$672.15	$268.86	**$403.29**	**$389.44**
	Family	$938.74	$375.49	**$563.24**	**$549.40**
HDHP	Employee	$263.45	$105.38	**$158.07**	**$144.22**
	Employee +1	$567.38	$226.95	**$340.43**	**$326.58**
	Family	$792.41	$316.96	**$475.44**	**$461.60**

City of Boulder

Voluntary Benefits Guide 2023

Aflac

Accident Coverage

Critical Illness

Hospital Indemnity

LegalShield

IDShield

HUB

GROUP ACCIDENT INSURANCE

HOSPITALIZATION BENEFITS	BENEFIT AMOUNT
HOSPITAL ADMISSION (once per accident, within 6 months after the accident) Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury. This benefit is not payable for confinement to an observation unit, for emergency room treatment or for outpatient treatment.	$1,000 Per Confnement
HOSPITAL CONFINEMENT (maximum of 365 days per accident, within 6 months after the accident) Payable for each day that an insured is confined to a hospital as an inpatient because of a covered accidental injury. If we pay benefits for confinement and the insured is confined again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury. This benefit is not payable for confinement to an observation unit or a rehabilitation facility.	$300 Per Day
HOSPITAL INTENSIVE CARE (maximum of 30 days per accident, within 6 months after the accident) Payable for each day an insured is confined in a hospital intensive care unit because of a covered accidental injury. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accidental injury. If we pay benefits for confinement in a hospital intensive care unit and an insured becomes confined to a hospital intensive care unit again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.	$250 Per Day
INITIAL TREATMENT BENEFITS / LISTED BENEFIT AMOUNTS COVER • EMPLOYEE / SPOUSE / CHILD	
INITIAL TREATMENT (once per accident, within 7 days after the accident, not payable for telemedicine services) Payable when an insured receives initial treatment for a covered accidental injury. This benefit is payable for initial treatment received under the care of a doctor when an insured visits the following: Hospital emergency room with X-Ray / without X-Ray Urgent care facility with X-Ray / without X-Ray Doctor's office or facility (other than a hospital emergency room or urgent care) with X-Ray / without X-Ray	 $350 / $200 $300 / $150 $300 / $150
AMBULANCE (within 90 days after the accident) Payable when an insured receives transportation by a professional ambulance service due to a covered accidental injury.	$200 Ground $1,000 Air
MAJOR DIAGNOSTIC TESTING (once per accident, within 6 months after the accident) Payable when an insured requires one of the following exams: Computerized Tomography (CT/CAT scan), Magnetic Resonance Imaging (MRI), or Electroencephalography (EEG) due to a covered accidental injury. These exams must be performed in a hospital, a doctor's office, a medical diagnostic imaging center or an ambulatory surgical center.	$200
EMERGENCY ROOM OBSERVATION (within 7 days after the accident) Payable when an insured receives treatment in a hospital emergency room, and is held in a hospital for observation without being admitted as an inpatient because of a covered accidental injury.	$100 Each 24 hour period
ACCIDENT FOLLOW-UP TREATMENT (maximum of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident) Payable for doctor-prescribed follow-up treatment for injuries received in a covered accident. Follow-up treatments do not include physical, occupational or speech therapy. Chiropractic or acupuncture procedures are also not considered follow-up treatment.	$50
THERAPY (maximum of 6 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured has doctor-prescribed therapy treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.	$50

GROUP ACCIDENT INSURANCE

	Benefit Amount
FRACTURES (once per accident, within 90 days after the accident) Payable when an insured fractures a bone because of a covered accident and is treated by a doctor. If the fracture requires open reduction, 200% of the benefit is payable for that bone. For multiple fractures (more than one bone fractured in one accident), we will pay a maximum of 200% of the benefit amount for the bone fractured that has the highest dollar amount. For a chip fracture (a piece of bone that is completely broken off near a joint), we will pay 25% of the amount for the affected bone. This benefit is not payable for stress fractures.	INITIAL TREATMENT BENEFIT EMPLOYEE / SPOUSE & CHILD
Hip / Thigh	$6,000 / $3,000
Vertebrae (except processes	$5,400 / $2,700
Pelvis	$4,800 / $2,400
Skull (depressed	$4,500 / $2,250
Sternum	$4,050 / $2,025
Leg	$3,600 / $1,800
Forearm / Hand / Wrist / Foot / Ankle / Kneecap	$3,000 / $1,500
Shoulder Blade / Collar Bone / Lower Jaw (mandible)	$2,400 / $1,200
Skull (simple) / Upper Arm / Upper Jaw	$2,100 / $1,050
Facial Bones (except teeth)	$1,800 / $900
Vertebral Processes	$1,200 / $600
Sacral / Sacrum	$900 / $450
Coccyx / Rib / Finger / Toe	$480 / $240
DISLOCATIONS (once per accident, within 90 days after the accident) Payable when an insured dislocates a joint because of a covered accident and is treated by a doctor. If the dislocation requires open reduction, 200% of the benefit for that joint is payable. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of his certificate and then dislocates the same joint again, it will not be covered by the plan. For multiple dislocations (more than one dislocated joint in one accident), we will pay a maximum of 200% of the benefit amount for the joint dislocated that has the highest dollar amount. For a partial dislocation (joint is not completely separated, including subluxation), we will pay 25% of the amount for the affected joint.	
Hip	$2,000
Knee	$1,300
Shoulder	$1,000
Foot / Ankle	$800
Hand	$700
Lower Jaw	$600
Wrist	$500
Elbow	$400
Finger / Toe	$160
FAMILY MEMBER LODGING (greater than 100 miles from the insured's residence, maximum of 30 days per accident, within 6 months after the accident) Payable for each night's lodging in a motel/hotel/rental property for an adult member of the insured's immediate family. For this benefit to be payable: • The insured must be confined to a hospital for treatment of a covered accidental injury; • The hospital and motel/hotel must be more than 100 miles from the insured's residence; and • The treatment must be prescribed by the insured's treating doctor.	$100 per day
TRANSPORTATION (greater than 100 miles from the insured's residence, 3 times per accident, within 6 months after the accident) Payable for transportation if, because of a covered accident, an insured is injured and requires doctor-recommended hospital treatment or diagnostic study that is not available in the insured's resident city.	$300 Plane $150 Any groud transportation

GROUP ACCIDENT INSURANCE

	Benefit Amount
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in hospital or ambulatory surgical center, within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a hospital or ambulatory surgical center. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	$400
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in a doctor's office, urgent care facility, or emergency room; maximum of two procedures per accident, within one year of the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a doctor's office, urgent care facility or emergency room. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this plan, we will pay the higher benefit amount.	$25
INPATIENT SURGERY AND ANESTHESIA (per day / within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an inpatient surgical procedure performed by a doctor. The surgery must be performed while the insured is confined to a hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	$750
APPLIANCES (within 6 months after the accident) Payable if, as a result of an injury received in a covered accident, a doctor advises the insured to use a listed medical appliance as an aid in personal locomotion.	
Cane, Ankle Brace, Cervical Collar	$20
Walking Boot, Knee Scooter, Body Jacket	$50
Wheelchair, Back Brace, Walker, Crutches, Leg Brace	$100
FACILITIES FEE FOR OUTPATIENT SURGERY (surgery performed in hospital or ambulatory surgical center, within one year after the accident) Payable once per each eligible Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).	$50
EYE INJURIES Payable for eye injuries if, because of a covered accident, a doctor removes a foreign body from the eye, with or without anesthesia.	$50
EMERGENCY DENTAL WORK (once per accident, within 6 months after the accident) Payable when an insured's natural teeth are injured as a result of a covered accident.	$50 Extraction $150 Repair with a crown
COMA (once per accident) Payable when an insured is in a coma lasting 30 days or more as the result of a covered accident. For the purposes of this benefit, Coma means a profound state of unconsciousness caused by a covered accident.	$5,000
CONCUSSION (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a doctor with a concussion due to a covered accident.	$100
BLOOD/PL ASMA /PL ATELETS (3 times per accident, within 6 months after the accident) Payable for each day that an insured receives blood, plasma or platelets due to a covered accidental injury.	$100
BURNS (once per accident, within 6 months after the accident) Payable when an insured is burned in a covered accident and is treated by a doctor. We will pay according to the percentage of body surface burned. First degree burns are not covered.	
Second Degree	
Less than 10%	$100
At least 10% but less than 25%	$200
At least 25% but less than 35%	$500
35% or more	$1,000
Third Degree	
Less than 10%	$1,000
At least 10% but less than 25%	$5,000
At least 25% but less than 35%	$10,000
35% or more	$20,000
RESIDENCE / VEHICLE MODIFICATION (once per accident, within one year after the accident) Payable for a permanent structural modification to an insured's primary residence or vehicle when the insured suffers total and permanent or irrevocable loss of one of the following, due to a covered accidental injury: • The sight of one eye; The use of one hand/arm; or The use of one foot/leg.	$500

GROUP ACCIDENT INSURANCE

	Benefit Amount
PROSTHESIS (once per accident, up to 2 prosthetic devices and one replacement per device per insured)* Payable when an insured receives a prosthetic device, prescribed by a doctor, as a result of a covered accidental injury. Prosthetic Device/Prosthesis means an artificial device designed to replace a missing part of the body. This benefit is not payable for hearing aids, wigs, or dental aids (to include false teeth), repair or replacement of prosthetic devices* and /or joint replacements. * We will pay this benefit again once to cover the replacement of a prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.	$500
PARALYSIS (once per accident, diagnosed by a doctor within six months after the accident) Payable if an insured has permanent loss of movement of two or more limbs for more than 90 days (in Utah, 30 days) as the result of a covered accidental injury.	
Paraplegia	$2,500
Quadriplegia	$5,000
SUCCESSOR INSURED BENEFIT If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time. Surgical Procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.	
ACCIDENTAL DEATH BENEFIT (within 90 days after the accident*) Payable if a covered accidental injury causes the insured to die.	$25,000
ACCIDENTAL COMMON-CARRIER DEATH BENEFIT Payable if the insured: • Is a fare-paying passenger on a common carrier; • Is injured in a covered accident; and • Dies within 90 days* after the covered accident. The spouse benefit is 50% of the employee benefit shown. The child benefit is 10% of the employee benefit shown. (Applicable to both the Accidental Death Benefit and Accidental Common-Carrier Death Benefit.)	$50,000
DISMEMBERMENT (once per accident, within 6 months after the accident) Payable if an insured loses a hand or foot or experiences loss of sight as the result of a covered accident. Dismemberment means: • Loss of a hand -The hand is removed at or above the wrist joint; • Loss of a foot -The foot is removed at or above the ankle; • Loss of a finger/toe - The finger or toe is removed at or above the joint where it is attached to the hand or foot; or • Loss of sight - At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable). If the Dismemberment Benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.	LIFE CHANGING EVENTS BENEFITS
SINGLE LOSS (the loss of one hand, one foot, or the sight of one eye)	
Employee	$12,500
Spouse	$5,000
Child(ren)	$2,500
DOUBLE LOSS (the loss of both hands, both feet, the sight of both eyes, or a combination of any two)	
Employee	$25,000
Spouse	$10,000
Child(ren)	$5,000
LOSS OF ONE OR MORE FINGERS OR TOES	
Employee	$1,250
Spouse	$500
Child(ren)	$250
PARTIAL DISMEMBERMENT (INCLUDES AT LEAST ONE JOINT OF A FINGER OR A TOE)	
Employee	$100
Spouse	$100
Child(ren)	$100
WELLNESS BENEFIT (once per calendar year) Payable for the following wellness tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations: Annual physical exams, Flexible Sigmoidoscopy, Mammograms, PSA Tests, Pap Smears, Ultrasounds, Eye Examinations, Blood Screening, Immunizations. THE AMOUNT PAID WILL BE BASED ON WHEN THE WELLNESS TEST WAS PERFORMED: First year of certificate and thereafter	$50

Aflac Accident Insurance

Benefits At A Glance	
Initial Doctor Visit at Urgent Care or Doctors Office	$150 without x-ray $300 with x-ray
Emergency Room Visit	$200 without x-ray $350 with x-ray
Follow Up Treatment	$50
Physical Therapy	$50
Ambulance	Ground: $200 Air: $1,000
Blood / Plasma	$100
Prosthesis	$500
Appliance	Up to $100
Injury Specific	$50-$13,500 (up to $9,000 x 200%)
Family Lodging (100+ miles)	$100 / night
Transportation (100+ miles)	Ground: $150 Air: $300
Accidental Death	$25,000/$12,500/$2,500
Accidental Dismemberment	$200 - $25,000
Hospital Admission	$1000
Regular Room	$300 / per day
Intensive Care	$550 / per day
**Wellness Benefit examples are figured on minimum amount of participants per plan.*	

Bi-Weekly Premiums	
Employee Only	$6.67
Employee & Spouse	$9.78
Employee & Children	$11.58
Family	$14.70

YOUR WELLNESS EXAM WILL HELP *PAY* FOR YOUR POLICY!

Wellness Benefit -> $50 (per person per year)

Employee Only -> $6.67 Bi-Weekly

Annual Cost = $173.40
Pretax 25% = $129.95 annually
Wellness Exam = $50.00

Adjusted Bi-Weekly Cost = $3.08

Employee & Spouse -> $9.78 Bi-Weekly

Annual Cost = $254.28
Pretax 25% = $190.71 annually
Wellness Exam x 2 = $100.00

Adjusted Bi-Weekly Cost = $3.49

Employee & Children -> $ 11.58 Bi-Weekly

Annual Cost = $301.20
Pretax 25% = $225.90 annually
Wellness Exam x 2 = $100.00

Adjusted Bi-Weekly Cost = $4.84

Family -> $14.70 Bi-Weekly

Annual Cost = $382.08
Pretax 25% = $286.56 annually
Wellness Exam x 3 = $150.00

Adjusted Bi-Weekly Cost = $5.25

AFLAC GROUP CRITICAL

Benefits Overview - Lump Sum Benefit Amount That you Choose	Benefit Amount
COVERED CRITICAL ILLNESSES:	
CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
SEVERE BURNS*	100%
PARALYSIS**	100%
COMA**	100%
LOSS OF SPEECH / SIGHT / HEARING**	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%
*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.	
**These benefits are payable for loss due to a covered underlying disease or a covered accident.	
OPTIONAL BENEFITS RIDER (Included)	
BENIGN BRAIN TUMOR	100%
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKINSON'S DISEASE	25%
These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis. We will pay the optional benefit if the insured is diagnosed with one of the conditions listed in the rider schedule if the date of diagnosis is while the rider is in force.	
PROGRESSIVE DISEASES RIDER	
AMYOTROPHIC LATERAL SCLEROSIS (ALS or Lou Gehrig's Disease)	100%
SUSTAINED MULTIPLE SCLEROSIS	100%
This benefit is paid based on your selected Progressive Disease Benefit amount. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.	
INITIAL DIAGNOSIS	
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.	
ADDITIONAL DIAGNOSIS	
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.	

AFLAC GROUP CRITICAL

	Benefit Amount
REOCCURRENCE We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.	
CHILD COVERAGE AT NO ADDITIONAL COST Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.	
SKIN CANCER BENEFIT We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.	$250
WAIVER OF PREMIUM If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.	
SUCCESSOR INSURED BENEFIT If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.	
HEALTH SCREENING BENEFIT (Employee and Spouse only) We will pay $50 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year. This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children. COVERED HEALTH SCREENING TESTS INCLUDE: •Blood test for triglycerides •CEA (blood test for colon cancer) •Flexible sigmoidoscopy •Bone marrow testing •Chest X-ray •Hemocult stool analysis •Breast ultrasound •Colonoscopy •Mammography •Spiral CT screening for lung cancer •DNA stool analysis •Pap smear •Thermography •Fasting blood glucose test •Stress test on a bicycle or treadmill •CA 125 (blood test for ovarian cancer) •PSA (blood test for prostate cancer) •CA 15-3 (blood test for breast cancer) •Serum cholesterol test to determine level of of HDL and LDL •Serum protein electrophoresis (blood test for myeloma)	$50

Aflac
Critical Illness Insurance

Bi-Weekly Rates			
NON-TOBACCO -- Employee			
Attained Age	$10,000	$15,000	$20,000
18-25	$1.89	$2.84	$3.78
26-30	$2.50	$3.76	$5.01
31-35	$2.88	$4.33	$5.77
36-40	$3.73	$5.60	$7.47
41-45	$4.50	$6.74	$8.99
46-50	$5.36	$8.04	$10.71
51-55	$8.29	$12.44	$16.59
56-60	$8.07	$12.11	$16.14
61-65	$16.69	$25.03	$33.38
66+	$29.56	$44.34	$59.12
NON-TOBACCO -- Spouse			
Attained Age	$10,000	$15,000	$20,000
18-25	$1.89	$2.84	$3.78
26-30	$2.50	$3.76	$5.01
31-35	$2.88	$4.33	$5.77
36-40	$3.73	$5.60	$7.47
41-45	$4.50	$6.74	$8.99
46-50	$5.36	$8.04	$10.71
51-55	$8.29	$12.44	$16.59
56-60	$8.07	$12.11	$16.14
61-65	$16.69	$25.03	$33.38
66+	$29.56	$44.34	$59.12
TOBACCO -- Employee			
Attained Age	$10,000	$15,000	$20,000
18-25	$2.52	$3.78	$5.05
26-30	$3.36	$5.04	$6.72
31-35	$4.19	$6.28	$8.37
36-40	$5.65	$8.48	$11.31
41-45	$6.80	$10.20	$13.61
46-50	$8.13	$12.19	$16.26
51-55	$12.84	$19.26	$25.68
56-60	$12.97	$19.45	$25.93
61-65	$26.48	$39.48	$52.49
66+	$44.97	$67.45	$89.94
TOBACCO -- Spouse			
Attained Age	$10,000	$15,000	$20,000
18-25	$2.52	$3.78	$5.05
26-30	$3.36	$5.04	$6.72
31-35	$4.19	$6.28	$8.37
36-40	$5.65	$8.48	$11.31
41-45	$6.80	$10.20	$13.61
46-50	$8.13	$12.19	$16.26
51-55	$12.84	$19.26	$25.68
56-60	$12.97	$19.45	$25.93
61-65	$26.48	$39.48	$52.49
66+	$44.97	$67.45	$89.94

HOSPITAL INDEMNITY

Benefits Overview	Benefit Amount
HOSPITAL ADMISSION BENEFIT per confinement (once per covered sickness or accident per calendar year for each insured) Payable when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment. We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).	$500
HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each insured) Payable for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.	$100
HOSPITAL INTENSIVE CARE BENEFIT per day (maximum of 10 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.	$100
HEALTH SCREENING BENEFIT The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for each insured. Residents of Massachusetts are not eligible for the Health Screening Benefit.	$50 Per Calendar Year

Hospital Indemnity Insurance

Bi-Weekly Rates	
$500 Benefit	
Employee Only	$4.59
Employee + Spouse	$9.18
Employee + Child(ren)	$7.39
Family	$11.98
Hospital Benefits At A Glance	
Hospital Admission (per confinement)	$500
Hospital Confinement (per day benefit)	$100
Maximum Days Payable	Up to 31 Days
Hospital ICU Confinement (per day benefit)	$100
Maximum Days Payable	Up to 10 Days
Wellness Benefit	
$50 Health Screening benefit per calendar year!	

DON'T FORGET!

To Submit For Your Annual Wellness & Health Screening Benefits

File All Claims Online At:

AflacGroupInsurance.com

Please remember when filling out a claim on-line you will need the **SSN, DOB, Certificate Number** and **Home Zip Code** of the primary insured person with Aflac Group to register your employee account.

For Claims Escalations:
voluntaryclaims@hubinternational.com

HUB

Aflac's claims process:
Peace of mind when you need it most

If you're sick or hurt, the last thing you need is an insurer that drags its feet when it's time to pay your claims. Aflac prides itself on being an insurer with a difference: Our goal is to process and pay, not deny and delay. That's why we make it easy to file your claims online. Here's how:

1

Visit Aflacgroupinsurance.com and click on "Customer Service" and then "File a claim."

2

Choose from accident, hospital, critical illness or wellness and follow the instructions.

3

Complete and upload your HIPAA authorization, claim details and documents, and direct deposit information.

4

Feel secure in the knowledge that claims on group coverage like yours are processed in an average of two days.[1]

Aflac helps pay expenses health insurance doesn't cover – and because your medical bills won't wait, we do so promptly and fairly. In fact, we paid 7.1 million claims last year to people just like you: people who trusted us to keep our promises.[2] For all other plans, download the proper forms and follow the instructions for filing by fax or email.

1 second

We pay a claim every second between Aflac Individual and Aflac Group*

7.1 million

Aflac Individual and Aflac Group Claims paid in 2018[2]

2 days

Average processing of Aflac Group Claims.

Get to know Aflac.
Visit aflacgroupinsurance.com to learn more.

[1] Aflac proprietary data, 2019.
[2] Aflac proprietary data, 2018.
*Based on a 40-hour work week, 52 weeks a year.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, group coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York. This service available only to Aflac Group customers. Continental American Insurance Company - Columbia, South Carolina

AGC1901242

HUB

LegalShield®

Affordable Legal Protection AT YOUR FINGERTIPS

Shielding Over 4 Million People With Our Legal Plans.

LegalShield provides you and your family the legal protection you not only need but deserve.

The LegalShield plan provides benefits for the following*:

ESTATE PLANNING

- Codicils
- Living Wills
- Power of Attorney
- Trusts
- Wills

FAMILY

- Administrative Hearing
- Adoption
- Conservatorship
- Domestic Violence Protection
- Elder Care Assistance
- Guardianship
- Immigration Assistance
- Incompetency Defense
- Juvenile Court Defense
- Name Change
- Parental Responsibility
- Prenuptial Agreements
- School Hearings

FINANCIAL

- Affidavits
- Bankruptcy
- Civil Litigation
- Consumer Protection
- Debt Collection
- Identity Theft
- Medicaid/Medicare Disputes
- Personal Property Disputes
- Promissory Notes
- Small Claims Assistance
- Social Security Disputes
- Tax Audit Protection
- Veterans Benefits Disputes

AUTO

- Driver's License Restoration
- Motor Vehicle Property Damage
- Moving Traffic Violations
- Traffic Tickets

HOME

- Boundary/Title Disputes
- Contractor Disputes
- Deeds
- Foreclosure
- Home Equity Loans
- Landlord/Tenant Issues
- Mortgages
- Property Tax Assessments
- Purchase/Sale of Home (primary or secondary)
- Refinancing
- Zoning Applications

GENERAL

- 24/7 Emergency Legal Access
- Document Review
- Legal Forms
- Live Member Support
- Mobile App
- Office Consultation
- Telephone Advice

Affordable legal protection

$7.27

Ind/Family Bi-Weekly Pricing

For more information visit:

benefits.legalshield.com/cob

*Limitations may apply. This is a general overview of coverage. See a summary plan description for full details. The following items are not covered with any service, including advice and consultation: business or commercial matters; fines, court costs, filing fees, ad litem fees, penalties, expert witness fees, bonds, bail bonds and any out-of-pocket expense; matters or disputes between the participant and/or the employer, and/or Provider Attorney and/or LegalShield; any matter covered by any insurance policy; Native American legal issues; requested service that lacks merit, is frivolous or would violate any ethical rule or law; items related to patent, trademark, or copyright matters. Services outside the United States. For all other personal legal matters, advice and consultation is provided.

Marketed by: Pre-Paid Legal Services, Inc. dba LegalShield® and subsidiaries; Pre-Paid Legal Casualty, Inc.; Pre-Paid Legal Access, Inc.; LS, Inc.; In VA: Legal Service Plans of Virginia; and PPL Legal Care of Canada Corporation.

IDShield®

Affordable Identity Theft Protection AT YOUR FINGERTIPS

Every year millions of people have their identity stolen.

IDShield provides the identity theft protection and identity restoration services you not only need but deserve.

The IDShield plan includes the following covered services:

MONITORED INFORMATION

- Bank Accounts
- Credit/Debit/Retail Cards
- Date of Birth
- Driver's License
- Email Addresses
- Home Address
- Medical ID
- Mother's Maiden Name
- Name
- Passport Number
- Phone Numbers
- Social Security Number
- And More

MONITORING AND DETECTION

- High Risk Application Monitoring
- Public Record Monitoring
- Sex Offender Monitoring
- Telecom Monitoring
- Credit Monitoring
- Social Media Monitoring
- Court and Criminal Record Monitoring
- Child monitoring (Family Plan Only)
- Internet and Dark Web Monitoring Online Chat Rooms and Social Feed Monitoring
- Payday Loan Monitoring
- Local, State and Federal Database Monitoring

ALERTS

- Hard Credit Inquiry Alerts
- Customizable Social Media Alerts
- Sex Offender Alerts
- Identity and Credit Threat Alerts

UNLIMITED CONSULTATION

- Assistance in Analyzing and Interpreting Credit Reports
- Assistance in Reviewing
- Medical Data Reports
- Consultation on Common Trends and Scams
- Data Breach Safeguards
- Identity Theft Consultation
- Lost/Stolen Wallet Assistance

COMPREHENSIVE IDENTITY RESTORATION

- $1 Million Protection Policy
- Full Service Restoration by Licensed Private Investigators
- Pre-Existing Identity Theft Restoration

GENERAL

- 24/7 Emergency Assistance
- Direct Access to Licensed Private Investigators
- Live Member Support
- Mobile App
- Monthly Credit Score Tracker

Affordable identity theft protection

Employee:	$3.21
Family:	$5.98

Pay Period: Bi-Weekly

For more information visit:

benefits.legalshield.com/cob

IDShield is a product of LegalShield and provides access to identity theft protection and restoration services. For complete terms, coverage and conditions, please see a summary plan description. Licensed Private Investigators are licensed in the state of Oklahoma. $1 Million policy is issued by a leading insurance carrier. Certain limitations apply.

Voluntary Benefits Contact Information

Carrier	Website / Email	Phone #
Aflac	www.aflacgroupinsurance.com	800-433-3036
LegalShield	www.legalshield.com	800-654-7757
IDShield	www.idshield.com	800-654-7757
HUB International Voluntary Benefits Division: Claims Escalations	voluntaryclaims@hubinternational.com	