Evans Fire District - Benefits Summary 2021

Medical Insurance - CEBT

The District offers three health care plans - a traditional PPO, Kaiser, and High Deductible Health Plan (HDHP). Employees may choose the plan that offers the greatest benefit covering themself, spouse, childred, or full family. See attached CEBT benefits comparison for details.

Premiums costs are shared by the District and Employee. The District's share of premiums ranges from 75% - 95%. Coverage for employee-only in the HDHP is covered at 95%. An employee plus family in PPO or Kaiser plans is covered at 75% - the employee on these plans would pay $186 per pay for PPO or $151 per check for Kaiser.

employee % of total premium

	PPO & Kaiser	HDHP
employee only	10%	5%
employee + spo	20%	10%
employee + chil	20%	10%
employee + fam	25%	15%

Additionally, CEBT offers Health Care Blue Book and Surgery Plus Conceirge Services to further benefit employee's and their families seeking medical care.

Health Savings Account - Rocky Mountain Reserve

A Health Savings Account is a tax-exempt account with a financial institution in which you accumulate savings to pay for medical expenses. Contributions are TAX DEDUCTIBLE and income earned on funds in the HSA are 100% TAX FREE. An HSA allows you to enjoy tax reductions while having affordable premiums and decreasing your out-of-pocket expenses without risking your insurance protection.

Maximum Contributions for 2021

Single	$3,600
Family	$7,200
Catch-up (over ag	$1,000

* When you enroll in the HDHP/HSA the District will initially contribute $800 for employee only coverage and $1,200 for employee with dependent coverage into the employee's HSA account. For each subsequent year enrolled, the District will contribute $600 for employee coverage and $1,000 for dependent coverage.

HSA deduction will remain in place until a contribution change is made. Your deduction can be changed at any time.

Flexible Spending Account - Rocky Mountain Reserve

On a pre-tax basis, you may contribute a maximum of $2,750 per plan year to the Health Care Spending Account to pay for medical expenses that are not covered under a medical, dental or vision plan (for example, co-payments, co-insurance, and deductible obligations). You may also contribute a maximum of $5,000 per plan year to the Dependent Care Spending Account to cover day care expenses for a dependent child or a disabled dependent requiring day care. You must re-enroll every year.

Vision Insurance - EyeMed

Vision Insurance is provided through EyeMed Vision. The District and Employee share the premium cost with the District paying $2.99, per pay, for all employees. Employee costs range from $0 to $5.80 per pay.

Dental Insurance - Delta Dental

Dental premiums are shared by the District and Employee. See attached Delta Dental benefits guide for coverage details.

	employee % of total premium
employee only	0%
employee + spo	43%
employee + chil	44%
employee + fam	47%

Retirement Plan - Empower Retirement

457(b)

All full-time employees may contribute a percent of their base wages to a 457(b) Retirement Plan. Annual amounts are restricted by the IRS.

401(a)

The District will match an employee's contribution to the employee's 457b plan, up to 6%. This match is only paid if the employee is contributing to their 457b.

The District contributes 3% of an employee's base salary to the employee's 401(a) after 12 months of employment.

Pension and D&D - FPPA

The District offers a pension plan administered by the Fire and Police Pension Association of Colorado. Participation in the plan is required by all employees. The contribution levels are determined by a vote of the membership.

Employee Contribution	11.5% - contribution rate will increase .5% per year through 2022 when the contribution reaches 12%
District Contribution	8.5% - contribution rate will increase .5% per year through 2030 when the contribution reaches 13%
Death & Disability Coverage	3% - paid by District. FPPA can adjust this rate by .1% every two years, as necessary.

Employee Assistance Program (EAP)

The Employee Assistance Program is a confidential, short-term counseling and referral system designed to help employees and their families. Eligible employees, their spouse or significant other, and dependents 26 and under can access six counseling sessions per year, per incident with a choice of in-person or telehealth counseling options. Services include on-line behavioral health services, crisis intervention, conflict mediation services, financial services, legal services, tax consultation/preparation, civil issues, real estate, estate planning, retirement planning, college funding. For complete details on the services available: www.triadeap.com, username: CEBT, password: eap.

Short Term Disability - The Standard Company

Benefit:	60% of the first $2,500 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$1,500 weekly before reduction by Deductible Income.
Minimum:	$15
Waiting Period:	14 days from first date unable to work
Maximum Benefit Period:	365 days. However, STD Benefits will end on the date long term disability benefits become payable to you under a group plan provided by your Employer, even if that occurs before the end of the Maximum Benefit Period.
Eligibility:	You are disabled if you are unable to perform with reasonable continuity the Material Duties of your Own Occupation;

Coverage paid for by District, no employee cost.

CEBT 2021
MEDICAL BENEFITS COMPARISON

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 3	PREFERRED PROVIDER ORGANIZATION (PPO)* HD 2800	KP-HMO 40
Office Visits	PPO $35 co-pay; Non PPO subject to deductible then 60/40	PPO subject to deductible then 80/20 Non PPO subject to deductible then 60/40	$40 co-pay
Lab Charges	PPO $35 co-pay; Non PPO subject to deductible then 60/40	PPO subject to deductible then 80/20 Non PPO subject to deductible then 60/40	$0 co-pay
X-Ray Charges	PPO $35 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40	PPO subject to deductible then 80/20 Non PPO subject to deductible then 60/40	$0 co-pay for diagnostic $50 co-pay for therapeutic
Prescriptions Retail - for 30 day supply:	Generic $20 Preferred Brand $40 Non-Preferred Brand $60	Subject to deductible, then $20 Generic $40 Preferred Brand $60 Non-Preferred Brand co-pays up to maximum out of pocket	Generic $20 Preferred Brand $40 Non-Preferred Brand $60 Specialty Drugs 20% coinsurance up to a maximum of $250 per drug fill.
Mail Order - for 90 day supply:	$40 / $80 / $120	Subject to deductible, then $40 Generic $80 Preferred Brand $120 Non-Preferred Brand co-pays up to maximum out of pocket	$40 / $80 / $120
Deductible	$1,000 individual $3,000 family	$2,800 individual $5,600 maximum for family No deductible carryover	Co-pay where indicated
Co-insurance	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then 80/20 PPO, Non PPO 60/40	$0
Maximum Out of Pocket	PPO $3,750 ($7,500 family)	PPO $5,000 individual	$4,500 single

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 3	PREFERRED PROVIDER ORGANIZATION (PPO)* HD 2800	KP-HMO 40
	Non PPO $7,500 ($15,000 family)	$10,000 family Non PPO $10,000 individual $20,000 family	$9,000 family
Hospital Charges	Subject to deductible then PPO 80/20, Non PPO 60/40 Precertification is required for inpatient stays, and for surgeries, whether inpatient or outpatient	Subject to deductible, then PPO 80/20, Non PPO 60/40, Precertification is required for inpatient stays and for surgeries, whether inpatient or outpatient	$1,000 co-pay per admission
Emergency Care	Subject to deductible then PPO 80/20	Subject to deductible then PPO 80/20	$50 co-pay / urgent care $250 co-pay / emergency care
Urgent Care Services	PPO $50 co-pay; Non PPO subject to deductible then 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	$50 co-pay
Ambulance	Subject to deductible then PPO 80/20 of "reasonable & customary"	Subject to deductible then, 80/20 of reasonable & customary	20% to $500 per trip
Out Patient Surgery	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	$500 co-pay per surgery
Maternity / Prenatal Care	PPO $35 co-pay (applies to the first prenatal care visit); Non PPO subject to deductible then 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40	$0 co-pay
MRI or CT Scan with or without Contrast	Subject to deductible then PPO 80/20, Non PPO 60/40	PPO subject to deductible then 80/20 Non PPO subject to deductible then 60/40	$250 co-pay per test
Pet Scans and SPECT Scans	Subject to deductible then PPO 80/20, Non PPO 60/40	PPO subject to deductible then 80/20 Non PPO subject to deductible then 60/40	$250 co-pay per test
Durable Medical Equipment	Subject to deductible then PPO 80/20, Non PPO 60/40	PPO subject to deductible then 80/20 Non PPO subject to deductible then 60/40	100% benefit — coverage is limited to items on the * DME Formulary list
Physical, Occupational and Speech Therapy	PPO $35 co-pay; Non PPO subject to deductible then 60/40; pre-	Subject to deductible then PPO 80/20, Non PPO 60/40; pre-authorization	$40 co-pay per visit up to 20 visits per year for each type of therapy

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 3	PREFERRED PROVIDER ORGANIZATION (PPO)* HD 2800	KP-HMO 40
	authorization required, 20 visit limit per injury or sickness	required, 20 visit limit per injury or sickness	
Chiropractor	PPO/Non PPO $35 co-pay, benefits subject to "reasonable & customary" guidelines, 20 visits limit per year	Subject to deductible then PPO Non PPO 80/20, benefits subject to "reasonable & customary" guidelines, 20 visits limit per year	$40 co-pay; 20 visit limit

*Ambulance, chiropractic and out of network charges are all subject to reasonable and customary guidelines (R&C)

ROUTINE SERVICES – will be processed following the Federal Patient Protection and Affordable Care Act.

* DURABLE MEDICAL EQUIPMENT-Formulary items include Prosthetic arms and legs

The Summary of Benefits and Coverage (SBC) is posted on the www.cebt.org website.

PPO NOTE: Combination of PPO and Non PPO out of pocket limit will never exceed the Non PPO out of pocket limit.

HMO Note: The member must use a contracted Kaiser Permanente provider for all care. Out of network providers are only covered if the charges are for emergency treatment. If this is not done, there is no guarantee that the charges will be covered.

This comparison of coverages is intended only as a general description for the principle features of the benefit plans. Please refer to the plan document for details. 08/01/2020

DELTA DENTAL PPO PLUS PREMIER
CEBT – PLAN B

(EFFECTIVE JANUARY 1, 2020)

MAXIMUM BENEFIT **Calendar Year Maximum**	$1,500 per member, per calendar year
CALENDAR YEAR DEDUCTIBLE **Applies to Basic and Major Services**	Individual Deductible – $50.00 Combination of in and out-of-network Family Deductible – $150.00 Combination of in and out-of-network
PREVENTION FIRST PPO and Premier Networks Only	Diagnostic and Preventive services do not count against the annual maximum when you see a PPO or Premier provider for all services.
RIGHT START 4 KIDS **PPO and Premier Networks Only**	Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier provider to receive the 100% coinsurance. If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontics, if selected as part of the group's plan, is not covered at 100% but at the plan's listed coinsurance.

PPO Dentist	PREMIER Dentist	*NONPAR Dentist	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
DIAGNOSTIC AND PREVENTIVE SERVICES				
100%	100%	100%	Oral Exams and Cleanings	Twice each in a calendar year. Two additional cleanings may be covered for those with a documented Evidence Based Dentistry (EBD) condition.
			Sealants	Once per tooth in a 36-month period for unrestored permanent molars, through age 15
			Bitewing X-Rays	Once in a calendar year
			Full Mouth X-Rays	Once in a 5-year period
			Fluoride	Twice in a calendar year, through age 15
			Space Maintainers	One per quadrant, per lifetime to maintain space for eruption of permanent posterior teeth, through age 13
BASIC SERVICES (including occlusal guards)				
80%	80%	80%	Fillings	Once per tooth in a 12-month period; composite (white) fillings
			Simple Extractions	
			Oral Surgery	
			Endodontics / Periodontics	
MAJOR SERVICES				
50%	50%	50%	Crowns	Once per tooth in 5-year period. Not a benefit under age 12.
			Implants	Once per tooth in a 5-year period. Not a benefit under age 16.
			Dentures, Bridges	Once in a 5-year period, only when existing prosthesis cannot be made serviceable. Fixed bridges or removable partials are not a benefit under age 16.
ORTHODONTICS			**$1,500 lifetime maximum**	
50%	50%	50%	For covered children to age 19	

You are enrolled in a Delta Dental PPO plus Premier plan. You and your family members may visit any licensed dentist, but will enjoy the greatest out-of-pocket savings if you see a Delta Dental PPO dentist. There are three levels of dentists to choose from.

PPO Dentist - Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.
Premier Dentist - Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.
***Non-Participating Dentist** – Payment is based on the non-participating Maximum Plan Allowance. Members are responsible for the difference between the non-participating MPA and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.

Members may add coverage once a year at Open Enrollment. Coverage may only be dropped by an employee or dependent with proof of qualifying event. This is a brief description of services covered under your dental plan. Please refer to the Plan Document for full plan details. If differences exist between this
summary and the Plan Document, the Plan Document will govern.

01/01/2020

EVANS FIRE PROTECTION DISTRICT

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Select Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$0 copay	Up to $30
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES		
Single Vision	$25 copay	Up to $25
Bifocal	$25 copay	Up to $40
Trifocal	$25 copay	Up to $60
Lenticular	$25 copay	Up to $60
Progressive - Standard	$90 copay	Up to $40
Progressive - Premium	$90 copay; 20% off retail price less $120 allowance	Up to $40
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Standard < 19 years of age	$0 copay	Up to $5
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $104
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $104
Contacts - Medically Necessary	$0 copay; paid in full	Up to $200
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 24 months from the date of service	Once every 24 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows member to receive either contacts and frame, or frames and lens services)

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1] Based on weighted average of sample transactions; EyeMed Insight network/$10 exam copay/$10 materials copay/$120 frame or contact lens allowance.

Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 TARGET OPTICAL

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