Benefits Guide

CITY OF BOULDER

BMEA

2022

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 your employee and family benefits is available on the **City of Boulder Human Resources Benefits page**.

Your 2022 Benefits

Medical Benefits

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

Pre-Tax Spending Accounts

Health Savings Account (HSA)
Alerus Flexible Spending Account (FSA)

Dental Benefits

Delta Dental High Plan
Delta Dental Low Plan

Vision Benefits

VSP Base Plan
VSP Buy Up Plan

Additional Benefits

Aflac
Life Insurance and Disability
Legal and ID Shield
Employee Wellness Program
Employee Assistance Program (EAP)

Retirement

PERA/Pension
Voluntary retirement plans (401k, 457, IRA Roth)

Eligibility

Who is eligible?

City of Boulder BMEA Employees

Boulder Municipal Employees Association (BMEA) employees who work **20 hours or more** per week are eligible for all benefits listed in this guide.

Dependents

If you are eligible to elect coverage for yourself, you may also elect coverage for eligible 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	**BMEA Employees (20+ Hours)**
Medical	✔
Dental	✔
Vision	✔
Aflac Plans	✔
City Paid Life Insurance	✔
Voluntary Life Insurance	✔
Legal & ID Plans	✔
Wellness Program	✔
EAP	✔
Retirement Benefits	✔
Vacation	✔
Sick	✔
Floating Holidays	✔

Enrollment

When can I enroll?

When You Are Hired

For newly hired employees, benefit enrollment must be completed by calling the benefits call center at 1-877-282-0808 within 31 days from your date of hire. 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

For existing employees, please make your next year elections during open enrollment for your eligible dependents and you via the **City of Boulder: Benefits Enrollment Website**.

2022 Open Enrollment

Open Enrollment for the 2022 plan year runs from October 20th – November 3rd, 2021. During this time, you must enroll in and/or decline coverage for the coming year. The effective date of the benefits selected is January 1st, 2022.

How Do I Enroll?

2022 Benefits enrollment is to be completed via the **City of Boulder: Benefits Enrollment Website**.

Can I Change My Benefits?

After the Open Enrollment period ends on November 3rd, 2021, the benefits you choose will be in place from January 1st to December 31st 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, your spouse, or civil union partner
- Change in residence (only if our current coverage isn't available in the new location)

Questions?

Benefits Call Center:
1-877-282-0808

Benefits Website:
benefits.bouldercolorado.gov

HR Benefits Team Email:
HRBenefits@bouldercolorado.gov

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 **$1000 for families** if you enroll in the city HDHP and meet the qualifications to have an HSA.

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.

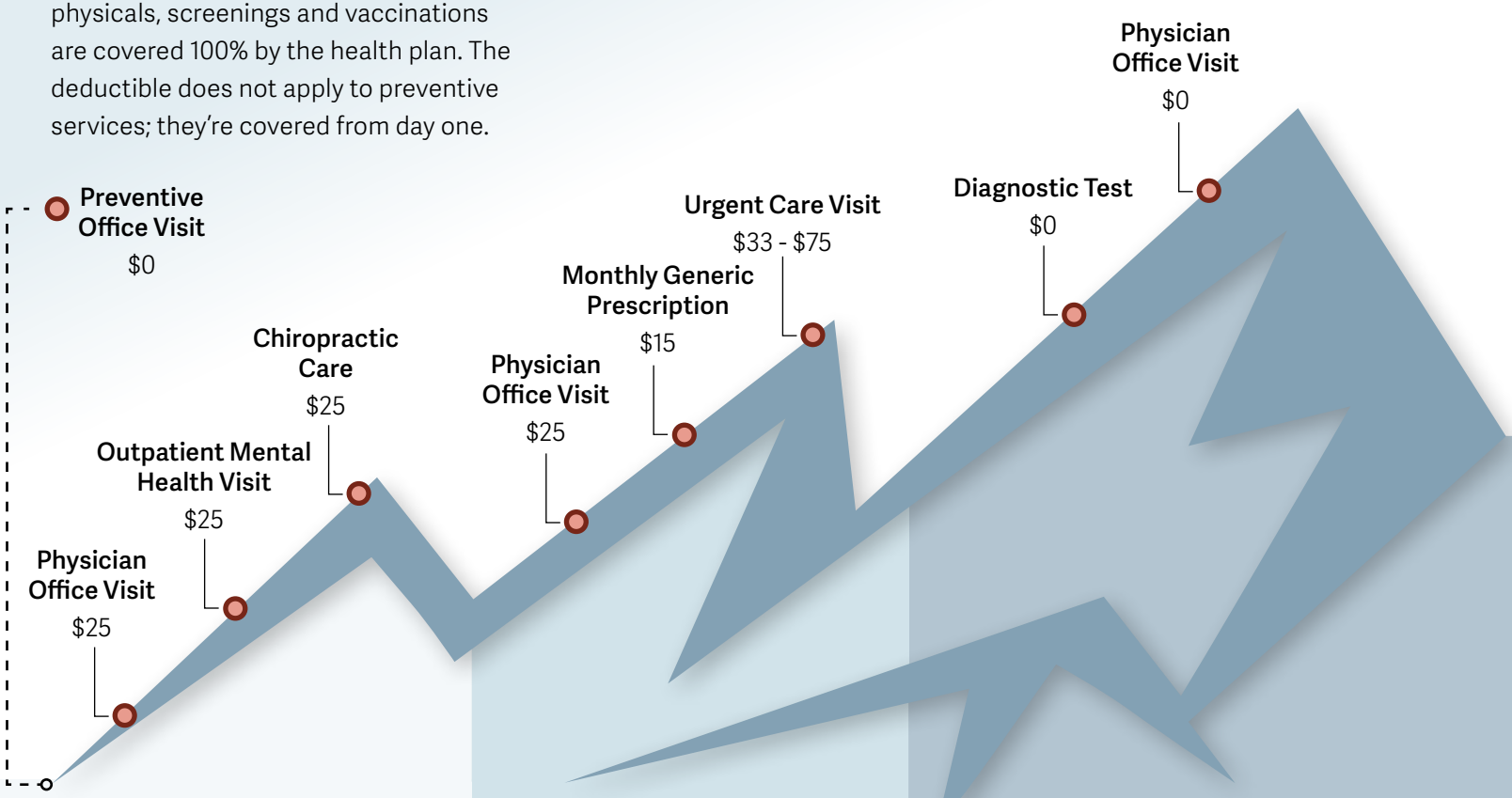
Advantages

- 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, but prefers 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% for preventive care when you use in-network providers
- Telehealth, Dispatch Health, Behavioral Health coverage, and other comprehensive options are available with this plan

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.

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. See FAQ for more detail.

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 $1000 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.

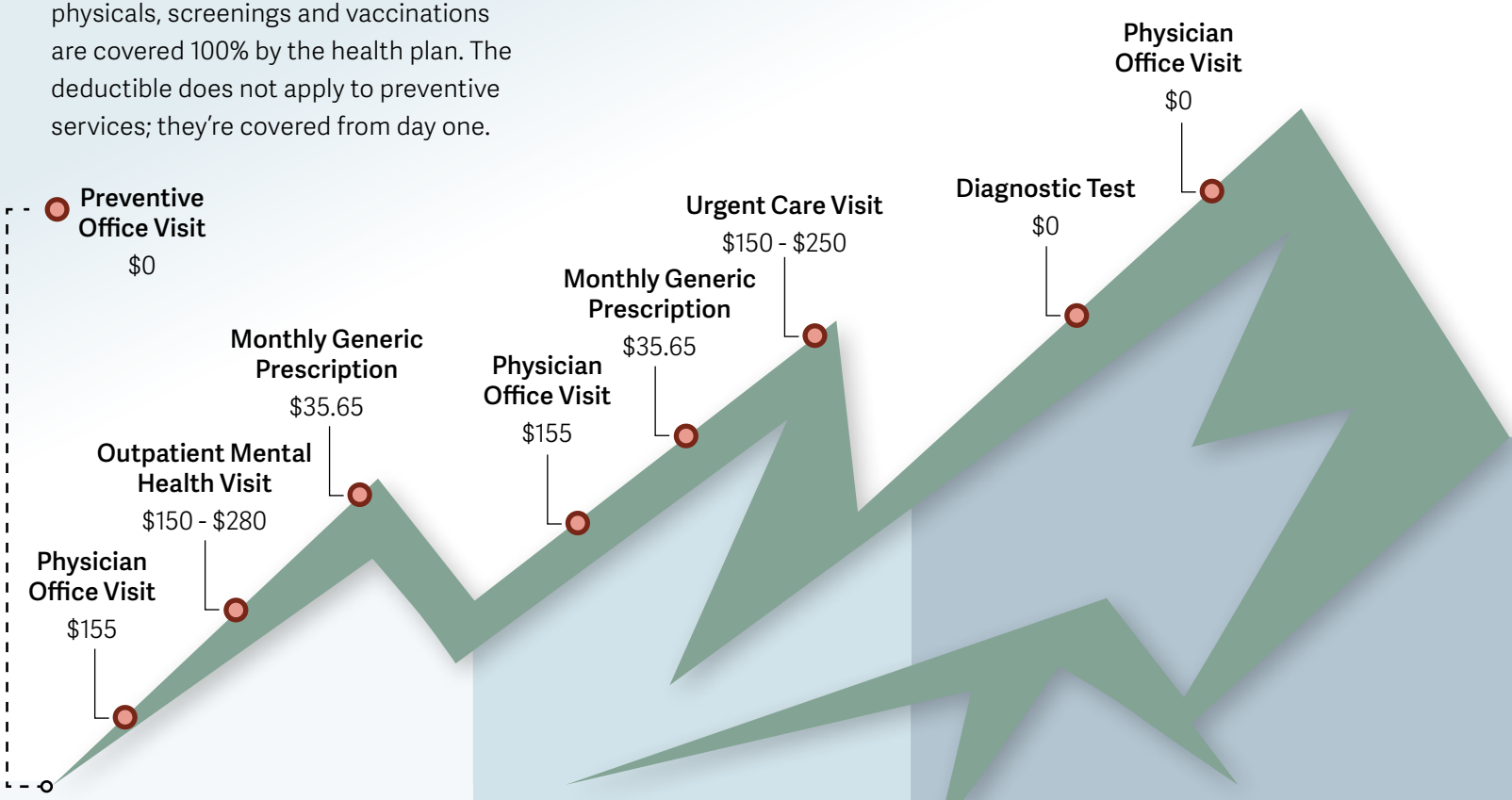
Advantages

- 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% for preventive care when you use in-network providers
- Telehealth, Dispatch Health, Behavioral Health coverage, and other comprehensive options are available with this plan

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.

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	$1,571.04	$1,326.12
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:	**$1,416.04**	**$784.68**

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	$3,383.40	$2,856.12
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:	**$3,638.40**	**$5,869.88**

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	$4,725.36	$3,988.80
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:	**$8,865.36**	**$12,628.80**

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

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		Full family out-of-pocket must be met for anyone covering dependents	
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	

Dental

Delta Dental

The city's Delta Dental plans allow you to use an extensive network of providers and offer flexibility based upon where you choose to access care. The city offers two dental plans:

- High Plan
- Low Plan

The table below summarizes the benefits of each dental plan. For a comprehensive description of coverage, view the Summary Plan Description (SPD) located on the **City of Boulder Benefits website**.

Delta Dental Benefits
Delta PPO plus Delta Premier Network

	Low Plan		High Plan	
NETWORK:	PPO Provider	Premier or Non-Network Provider	PPO Provider	Premier or Non-Network Provider
Calender Year Deductible	$50 / Individual $150 / Family		$50 / Individual $150 / Family	
Calendar Year Maximum Benefit	$1,000 per Individual		$2,000 per Individual	
Diagnostic/Preventive Care (X-ray/Oral Exams/Cleanings)	100% Covered, no deductible	80% Covered after deductible	100% Covered, no deductible	100% Covered, no deductible
Restorative Services (Fillings/Extractions)	80% Covered after deductible	50% Covered after deductible	80% Covered after deductible	80% Covered after deductible
Endodontics (Root Canal Therapy)	80% Covered after deductible	50% Covered after deductible	80% Covered after deductible	80% Covered after deductible
Periodontics (Treatment of the gums)	80% Covered after deductible	50% Covered after deductible	80% Covered after deductible	80% Covered after deductible
Oral Surgery (Extracts)	80% Covered after deductible	50% Covered after deductible	80% Covered after deductible	80% Covered after deductible
Major Services (Dentures/Partials/Crowns)	50% Covered after deductible	50% Covered after deductible	50% Covered after deductible	50% Covered after deductible
Orthodontic Treatment (Dependents up to age 19)	Not Covered	Not Covered	50% Coinsurance	50% Coinsurance
Orthodontic Lifetime Maximum	Not Covered		$2,000 per Individual Age 19 or Younger	

To find a provider visit **deltadentalco.com**, or call 800-610-0201

Vision

VSP

Regular eye examinations can not only determine your need for corrective eyewear, but also may detect general health problems in their earliest stages. The VSP vision plan operates much like a PPO - see any vision care provider and receive the greatest benefits if you choose a provider within the network.

The table on the following page summarizes the benefits of the VSP plan. For a comprehensive description of the plan, view the Summary Plan Description (SPD) located on the **City of Boulder Benefits website**.

Vision Service Plan (VSP) Vision Benefits

VSP Choice Network

	Base Plan		Buy-Up Plan	
NETWORK:	**In Network**	**Out-of-Network**	**In Network**	**Out-of-Network**
Eye Exam	$20	Up to $45 reimbursement	$20	Up to $45 reimbursement
Lenses Single Vision Bifocal Trifocal	100% after $20 Copay	Reimbursement: Up to $30 Up to $50 Up to $65	100% after $20 Copay	Reimbursement: Up to $30 Up to $50 Up to $65
Frames	100% up to $130 allowance for wide selection of frames 100% up to $150 allowance for featured frames 20% discount on the amount over the allowance	Up to $70 reimbursement	100% up to $150 allowance for wide selection of frames 100% up to $170 allowance for featured frames 20% discount on the amount over the allowance	Up to $70 reimbursement
Contact Lenses (instead of glasses)	$130 allowance; copay does not apply	Up to $105 reimbursement	$150 allowance; copay does not apply	Up to $105 reimbursement
Diabetic Eyecare Plus Program	$20 Copay	N/A	$20 Copay	N/A
Additional Glasses and Sunglasses	Extra $20 to spend on featured frames 20% savings on additional glasses and sunglasses, including lens enhancements	N/A	Extra $20 to spend on featured frames 20% savings on additional glasses and sunglasses, including lens enhancements	N/A
Retinal Screening	No more than a $39 copay on routine screening as an enhancement to a WellVision Exam	N/A	No more than a $39 copay on routine screening as an enhancement to a WellVision Exam	N/A
Laser Vision Correction	15% off the regular price or 5% off the promotional price	N/A	15% off the regular price or 5% off the promotional price	N/A
Benefit Frequency Examinations/ eyeglass lenses/ contacts	Once every 12 months		Once every 12 months	
Frames	Once every 24 months		Once every 12 months	

To find a network provider visit **vsp.com**, or call 800-877-7195

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.

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 2022 is as follows:

- $3,650 if you are enrolled in Employee Only (Single) coverage
- $7,300 if you are enrolled in Family (Two Person, 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

Setting up your HSA account

You may open an HSA at the financial institution of your choice. The City will administer pre-tax contributions via payroll deductions once you have completed the **HSA enrollment form** and provided it to the **benefits team**.

NOTE: Failure to provide all requested information will cause delays in the City's contribution to your HSA.

For more information refer to the **HSA Guide** on Boulder@Work.

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 monthly throughout the plan year. 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 a financial institution of your choice

FSA

How does the FSA work?

A Flexible Spending Account (FSA) allows you to set aside pre-tax money from your paycheck to pay for eligible out-of-pocket expenses for healthcare and dependent care.

Healthcare Flexible Spending Account (HCFSA)

Contribute up to $2,750 per employee (per calendar year) for reimbursement of health-related expenses you may need to pay for out-of-pocket. Expenses can be incurred from January 1, 2022, to March 15, 2023, as long as you are an active participant in the plan. You have access to your full plan year election amount of Health Care FSA funds immediately. This plan is use it or lose it. Any funds not used in the plan year will be forfeited. There is a grace period to submit for reimbursement through March 31, 2023.

Examples of Eligible Expenses:

- Copays, coinsurance, and deductibles
- Dental and orthodontia expenses
- Contact lenses, eyeglasses, vision surgery
- Hearing aids
- Chiropractic care
- Over the counter medications, with a prescription

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

Dependent Care Flexible Spending Account (DCFSA)

Contribute up to $5,000 per household (per calendar year) towards out-of-pocket dependent care expenses for children under age 13 and disabled dependents of any age. Expenses can be incurred from January 1, 2022, to December 31, 2022, as long as you are an active participant in the plan. Dependent care expenses are only reimbursable up to what has been deducted from payroll and deposited to your account.

Examples of Eligible Expenses:

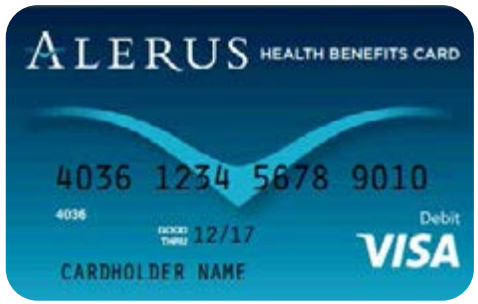
- Licensed day care centers for children and disabled dependents
- Costs for family or adult day care facilities
- Babysitters outside or inside your home while you are working
- Day camp expenses (but not overnight camp)

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

How the Alerus Health Benefits Card Works

The Alerus Health Benefits Card draws funds directly from your account to pay for eligible expenses. It can only be used at places where you might obtain medical, dental, vision, or dependent care services with providers accepting Visa. You will use your debit card for the life of your Healthcare Flexible Spending Account. If you lose or misplace your debit card, you will need to contact Alerus at 800-837-4817 to be issued a new card.

For more information refer to the **FSA guide** on Boulder@Work.



HSA — vs — FSA

HSA		FSA
A personal bank account		An employer-sponsored Alerus account
The City of Boulder contributes $500 individual/$1000 family to an HSA through the financial institution of your choice.		City of Boulder does not contribute to an FSA.
Must be paired with an HDHP. If you have an HSA, you cannot have a Healthcare FSA. You may have a Dependent Care FSA with an HSA.		Compatible with PPO "copay" plan and HDHP. (The Healthcare FSA cannot be paired with an HSA. You may have a Dependent Care FSA with an HSA).
Unused money will be rolled over into the next year. You can invest HSA funds and use earned interest for medical health expenses.		Funds not used by the end of the year are forfeited.
IRS Employee Contribution Limits: $3,650 individual $7,300 family		IRS Employee Contribution Limits: $2,750 individual/family

Shared benefits: Health Savings Accounts (HSA) and Healthcare Flexible Spending Accounts (FSA) are tax-advantaged accounts that can be used to pay for qualified out-of-pocket medical expenses.

Life & Disability

Life & Disability insurance provides loss of income protection to employees and their families in the event of a serious injury, illness, or death.

Public Employee's Retirement Association (PERA) Disability Program

Once you have achieved vesting (5 years of service credit) with PERA, you are automatically eligible for their short-term disability coverage and/or disability retirement. Please review the **Colorado PERA Disability Program** brochure.

City-Paid Short Term and Long Term Disability Benefits (STD and LTD)

This coverage can provide security while working toward PERA vesting. The employee is required to exhaust all accrued unused sick time before the city coverage provides a benefit for them (60% of an employee's wages for STD for BMEA), (50% for LTD for BMEA). STD is only provided for the first 5 years. Additional information can be found on the **City's Leave Benefits** website.

City Paid Life & Accidental Death & Dismemberment (AD&D) Coverage

The City of Boulder provides $50,000 of Life and AD&D insurance to BMEA employees through the age of 69; reduced to 50% coverage for age 70 and over. The city pays the total premium for all employees working 20 or more hours per week. All Basic Life and Accidental Death & Dismemberment benefits will reduce to 50% at the age of 70.

You can change your beneficiary for your City Paid Life and AD&D benefit at any time by completing a **change form**.

Voluntary Life Insurance

You may elect to purchase up to $300,000 in additional Voluntary Life Insurance coverage.

- New employees may enroll into Voluntary Life Insurance within 30 days of their hire date to receive the guaranteed issue amount without submitting additional medical underwriting
- Existing employees may also enroll anytime throughout the year or during open enrollment, but you will be required to complete an **Evidence of Insurability (EOI)** medical underwriting form to be approved for additional insurance coverage

Please refer to the **Voluntary Life Rates and Plan Details** for more information.

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 2022 Voluntary Benefits Brochure Booklet**.

The City of Boulder provides the following:

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

Aflac

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

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

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.

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.

Premium Credit Requirements:

You can receive the wellness premium credit if you:

- Are enrolled in a medical plan through the City of Boulder
- Complete the Health Risk Assessment on **MyCigna.com** AND an annual physical with your primary care physician (PCP) OR via a MDLive virtual wellness visit by 10/31 of each plan year

  * If you are hired as a new employee, you need only to complete the Health Assessment on MyCigna.com to receive the premium credit for the remainder of the plan year in which you were hired.

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.

Magellan Employee Assistance Program (EAP)

No matter where you are on your journey, there are times when a little help can go a long way. The city-paid Employee Assistance Program offers you and your family members assistance with anything from financial coaching to counseling services.

Key Features

- Provided at no cost to you and your family members
- Includes up to 6 counseling sessions per issue, per year
- Confidential in-person and virtual services available

EAP Provides Confidential Support

- Lifestyle coaching
- Counseling
- Self-care programs
- Manager support
- Financial wellness
- Work-life web resources
- Legal support
- Identify theft resolution
- Live and on-demand events

How to Access EAP Services

Give Magellan Healthcare a call at **800-523-5668** or visit the **Magellan EAP website** to explore resources and connect with the support you need.

For TTY (hearing and speech impaired) Users:
800-456-4006

Retirement

Employee Pension Plan

City of Boulder BMEA employees including temporary and seasonal employees are to participate in the employee and city contributed **Public Employees' Retirement Association (PERA)** Defined Benefit Pension.

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
- 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.

Glossary

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

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.

Flexible Spending Account (FSA)

An FSA is a tax-advantaged account that lets you put money aside on a pre-tax basis to pay for a wide range of health and/or dependent care expenses (as defined by the IRS). Unlike the HSA, any unused funds remaining after the plan year ends will be forfeited.

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

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.

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)	Magellan Health	800-523-5668	www.magellanascend.com
Dental Plan Group #W2274	Delta Dental	800-610-0201	www.deltadentalco.com
Vision Plan Group #12106494	Vision Service Plan (VSP)	800-877-7195	www.vsp.com
Flexible Spending Accounts (Health/Dependent)	Alerus	800-837-4817	www.alerusrb.com
Life / AD&D and Supplemental Life Insurance Plan Group #645601-A	The Standard	877-276-6616	www.standard.com
Short Term Disability Group #645601-C **Long Term Disability** Group #645601-B	The Standard	877-276-6616	www.standard.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	Ashley Tracey	303-441-3480	www.mywell.site/active/CityofBoulder
Identity Theft Protection Group # 203798	IDShield	888-807-0407	www.benefits.legalshield.com/cob
Accident / Critical Illness / Hospital Indemnity Group # 24628	Aflac	720-207-2347	keanu.vela@hubinternational.com
Legal Services Group # 203798	LegalShield	888-807-0407	www.benefits.legalshield.com/cob
Human Resources		303-441-3070	hrbenefitsforms@bouldercolorado.gov
Additional Questions or Escalated Claims Issues	HUB Advocacy	888-795-0300	boulderadvocacy@hubinternational.com

2022 Rates

	Medical		Dental Base		Vision	
Premiums	OAP PPO	HDHP/ HSA	Low PPO	High PPO	Base	Buy-Up
Employee	$654.58	$552.55	$25.38	$43.18	$8.14	$17.16
Employee +1	$1,409.77	$1,190.03	$50.77	$87.42	$11.58	$24.44
Family	$1,968.91	$1,662.00	$87.14	$149.57	$20.78	$43.84
Boulder Contribution						
Employee	$523.66	$442.04	$20.30	$34.54	$0.00	$0.00
Employee +1	$1,127.82	$952.02	$40.62	$69.94	$0.00	$0.00
Family	$1,575.13	$1,329.60	$69.71	$119.66	$0.00	$0.00
Wellness Non-Participant						
Full-Time Employee Contribution						
Employee	$130.92	$110.51	$5.08	$8.64	$8.14	$17.16
Employee +1	$281.95	$238.01	$10.15	$17.48	$11.58	$24.44
Family	$393.78	$332.40	$17.43	$29.91	$20.78	$43.84
Part-Time Employee Contribution						
Employee	$392.75	$331.53	$15.23	$25.91	$8.14	$17.16
Employee +1	$845.86	$714.02	$30.46	$52.45	$11.58	$24.44
Family	$1,181.35	$997.20	$52.28	$89.74	$20.78	$43.84
Wellness Participant - $30 per month credit						
Full-Time Employee Contribution						
Employee	$100.92	$80.51	$5.08	$8.64	$8.14	$17.16
Employee +1	$251.95	$208.01	$10.15	$17.48	$11.58	$24.44
Family	$363.78	$302.40	$17.43	$29.91	$20.78	$43.84
Part-Time Employee Contribution						
Employee	$362.75	$301.53	$15.23	$25.91	$8.14	$17.16
Employee +1	$815.86	$684.02	$30.46	$52.45	$11.58	$24.44
Family	$1,151.35	$967.20	$52.28	$89.74	$20.78	$43.84

City of Boulder

Voluntary Benefits Guide 2022

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 Walking Boot, Knee Scooter, Body Jacket Wheelchair, Back Brace, Walker, Crutches, Leg Brace	 $20 $50 $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;	$50,000
• 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.)	
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:	LIFE
• Loss of a hand -The hand is removed at or above the wrist joint;	CHANGING
• Loss of a foot -The foot is removed at or above the ankle;	EVENTS
• 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	BENEFITS
• 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.	
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.*	

Monthly Premiums	
Employee Only	$14.45
Employee & Spouse	$21.19
Employee & Children	$25.10
Family	$31.84

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

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

Employee Only -> $14.45 monthly

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

Adjusted Monthly Cost = $6.67

Employee & Spouse -> $21.19 monthly

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

Adjusted Monthly Cost = $7.56

Employee & Children -> $25.10 monthly

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

Adjusted Monthly Cost = $10.49

Family -> $31.84 monthly

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

Adjusted Monthly Cost = $11.38

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

Monthly Rates

NON-TOBACCO -- Employee			
Issue Age	$10,000	$15,000	$20,000
18-30	$5.31	$7.28	$9.25
31-40	$8.08	$11.43	$14.78
41-50	$14.26	$20.70	$27.15
51-60	$25.54	$37.62	$49.70
61+	$46.78	$69.48	$92.18

NON-TOBACCO -- Spouse			
Issue Age	$10,000	$15,000	$20,000
18-30	$5.31	$7.28	$9.25
31-40	$8.08	$11.43	$14.78
41-50	$14.26	$20.70	$27.15
51-60	$25.54	$37.62	$49.70
61+	$46.78	$69.48	$92.18

TOBACCO -- Employee			
Issue Age	$10,000	$15,000	$20,000
18-30	$7.00	$9.81	$12.61
31-40	$11.88	$17.13	$22.38
41-50	$21.63	$31.76	$41.88
51-60	$40.48	$60.03	$79.58
61+	$72.06	$107.40	$142.75

TOBACCO -- Spouse			
Issue Age	$10,000	$15,000	$20,000
18-30	$7.00	$9.81	$12.61
31-40	$11.88	$17.13	$22.38
41-50	$21.63	$31.76	$41.88
51-60	$40.48	$60.03	$79.58
61+	$72.06	$107.40	$142.75

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

	Monthy Rates:
Employee	$9.94
Employee + Spouse	$19.88
Employee + Children	$16.02
Family	$25.96

Don't Forget

To Submit For Your Wellness & Health Screening Benefits

You Can File A Claim Online At: Aflacgroupinsurance.com

Please remember when filling out the claim on-line you only need to provide info where there is an orange asterisk. You do not need to provide Employee ID, Group number or Certificate number.

For Claims Escalations:
Keanu Vela - HUB International
Account Manager - Voluntary Benefits
Office: (720) 207-2347
keanu.vela@hubinternational.com

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.

The Aflac Value Added Services Are Included At No Additional Cost When You Are Enrolled In One of The Aflac Programs.

Get care anywhere.

Introducing Telemedicine from MeMD™

Aflac® | Value-Added Services

Now, when an illness strikes, you can get care right where you are — from your phone, app or online. That's because your Aflac group plan now comes with telemedicine service from MeMD™ that allows you to reach a health provider, day or night, using your phone or computer. And it's available as soon as your Aflac coverage starts.

You're in the best position to get care for your condition.

It's simple to see a provider, no matter where you are:

1. Activate and log into your account at www.MeMD.me/Aflac
2. Consult a physician, pediatrician, nurse practitioner or physician assistant. On-demand visits when you need them most – nights, weekends and holidays
3. When a prescription* is medically necessary, you can have it sent electronically to your pharmacy of choice

Connect with a board-certified, U.S. licensed medical provider for just **$25** per visit!

Avoid the waiting room and still get quality care for all kinds of concerns:

- Abrasions, bruises, minor headaches, arthritic pains
- Allergies, hives, skin infections, bites and stings
- Colds, flu, fever, sore throat, cough, congestion
- Diarrhea, vomiting, nausea, urinary tract infections
- Eye infections, conjunctivitis, earache, body ache
- Medication refills (short-term)* **and more**

Start using Telemedicine from MeMD™ as soon as your Aflac coverage begins.

Call **855-423-8585** to get started or visit **www.MeMD.me/Aflac.**

MeMD™ Aflac®

MeMD Services At-a-Glance

Service	Cost	Appointment Length	Eligibility	Details
Urgent Care (traditional telemedicine visit)	Each visit: $25	Varies by visit	All ages	• Available 24/7/365 from almost anywhere in the United States • Treatment for minor injuries and illnesses • Medications can be prescribed*** • Spanish language portal and visits available
Talk Therapy	Each visit: $65	50 minutes	You and your family members that are 18+	• Initial appointment scheduled in as little as 24 hours after requesting a visit • Personal treatment plan created by second visit • Patient can meet with the same therapist for all visits • No prescriptions provided • Available in all 50 states
Telepsychiatry*	Initial visit: $195 Follow-up/ Medication refill visit: $95	Initial visit: 45 minutes Follow-up visit: 15 minutes	You and your family members that are 18+	• Initial appointment scheduled in as little as 24 hours after requesting a visit • Patient can meet with the same psychiatrist for all visits • Medications can be prescribed*** • Lab results can be sent directly to MeMD
Teen Therapy*	Each visit: $65	50 minutes	Children ages 10-17**	• Initial appointment scheduled in as little as 24 hours after requesting a visit. • Initial visit includes parent/guardian • Treatment plan created by second visit • No prescriptions provided • Patient can meet with the same therapist for all visits

*Availability varies by state

**Age restrictions may vary by state.

Aflac has entered into a marketing alliance with MeMD whereby MeMD may provide up to one year of complimentary telehealth services from MeMD to individuals who are employees of accounts that choose to make MeMD available to them. Other than this marketing alliance, Aflac and MeMD are not affiliated in any way. Aflac makes no representations or warranties regarding MeMD's products or services, and is not responsible for any products or services provided by MeMD. If you have questions regarding MeMD's products or services, please contact MeMD by calling 855-636-3669 or emailing solutions@memd.me. The complimentary telehealth services provided by MeMD is not available to employees of Aflac accounts located in ID, MD, MN, NY or PR. Telehealth services are not available to residents of ID or MN. Additional state restrictions may apply and benefits may vary by state. Customers will be responsible for a visit fee at time of each telehealth visit.

***When medically necessary, MeMD's providers (except therapists) can submit a prescription electronically for purchase and pick-up at your local participating pharmacy; however, MeMD providers cannot prescribe elective medications, narcotic pain relievers, or controlled substances. MeMD's providers are each licensed by the appropriate licensing board for the state in which they are providing services and all have prescriptive authority for each of the states in which they are licensed.

Aflac herein means American Family Life Assurance Company of Columbus. WWHQ I 1932 Wynnton Road I Columbus, GA 31999.

HealthAdvocate℠

Aflac® | Value-Added Services

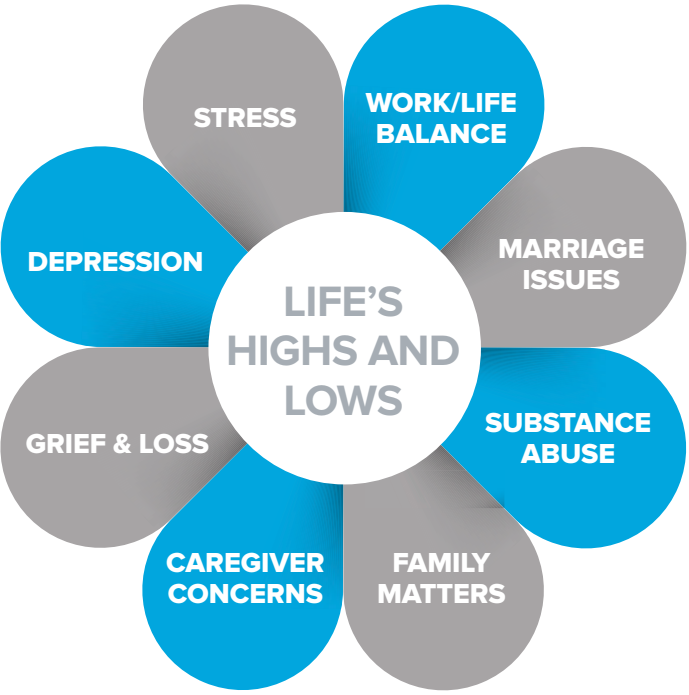
Telephonic EAP

Need help for life's highs and lows? Just call.

Introducing the Telephonic EAP Program, available through Aflac.

We never know what life can bring from one day the next. But you can be sure you have help when you need it. Health Advocate's Telephonic Employee Assistance Program provides support for a range of personal, family and work/life balance matters.

Telephonic EAP provides 24/7 phone access to licensed, professional counselors, prepared to help with your personal situation. They can also provide referrals for long-term counseling or specialized care, with customized plans to meet your specific needs.



USE ANY COMBINATION OF TOOLS, ANY TIME:

24/7 phone access to trained counselors

Long-term referrals and treatment plans

Support for full range of personal and work/life issues

Whatever life brings, call on EAP for help:

- **Confidential telephone counseling sessions** with highly trained, licensed professionals
- **24/7 phone access** to professional counselors
  Referrals for long-term counseling or specialized care **Customized treatment plans**
- **Resource website** for work/life matters
- **Help for depression** and other mental health issues
- **Stress management**
- **Support for dealing with grief** and loss
- **Substance abuse counseling**

Count on Telephonic EAP to be here when you need it.

Call **855.423.8585** or visit **healthadvocate.com/aflac.**

Available through Aflac, powered by Health Advocate.

Aflac | Value-Added Services

HealthAdvocate℠

High medical bills? We're coming in with the save

Introducing Medical Bill Saver™ from Health Advocate

When you seek medical or dental treatment, it can be overwhelming to get an expensive bill just when you're feeling better. That's why your Aflac group insurance plan now includes Medical Bill Saver at no extra charge. It gives you access to skilled negotiators who can help reduce your out-of-pocket costs from bills you incur from out-of-network providers or care not covered by insurance. And it's as easy as just sending in your bill.

Need help cutting costs? Just send in your bill

You can use Medical Bill Saver™ for your spouse, dependent children, parents and parents-in-law, too! Call 855.423.8585 to get started.

Here's how it works:

Medical Bill Saver™ gives you access to skilled negotiators who can help reduce your out-of-pocket costs from medical bills not covered by insurance. And it's as easy as just sending in your bill.

- Send in your medical or dental bills of **$400 or more.**
- Your negotiator contacts the provider to try **negotiate a discount**.
- Once an agreement is made, **the provider approves payment terms and conditions.**
- Get an easy-to-read, personal Savings Result Statement **summarizing the outcome and payment terms**.

Start using Health Advocacy. Call 855-423-8585

Aflac

AGC150135 R4

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:	$3.48
Family:	$6.48
Pay Period	

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.

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

$15.75

Ind/Family Monthly 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.

Voluntary Benefits Contact Information

Carrier	Website / Email	Phone #
Aflac	www.aflacgroupinsurance.com	800-433-3036
Aflac Value-Added Services: Telemedicine from MeMD	www.MeMD.me/Aflac	855-425-8585
Aflac Value-Added Services: HealthAdvocate EAP & Medical Bill Saver	www.healthadvocate.com/Aflac	855-423-8585
LegalShield	www.legalshield.com	800-654-7757
IDShield	www.idshield.com	800-654-7757
HUB International Voluntary Benefits Division: Keanu Vela	keanu.vela@hubinternational.com	720-207-2347