City of Springfield
Benefits Department
36 Court St., Room 18
Springfield, MA 01103
Office: (413) 787 - 6055
Fax: (413) 787 - 6010

April 2, 2019

Dear City of Springfield/Springfield Public School Employee:

The City's annual health insurance open enrollment is once again upon us. Beginning on **April 3, 2019 and continuing until May 1, 2019 at 4:00PM EST,** all *eligible employees have the opportunity to enroll in new benefits, make changes to current health plans, drop dependents' from their plan, or opt out of health insurance coverage. If you do not wish to make any changes to your current GIC health insurance plan, no action is necessary at this time. If you would like to enroll for the first time or are currently participating in a Flexible Spending benefit, you are required to fill out a FSA enrollment form for the new fiscal year.

Please thoroughly review this packet, along with the Decision Guide from the Group Insurance Commission (GIC), and the City's Human Resources website to make the most informed decisions for yourself and your family.

GIC Benefits Highlights for Fiscal Year 2020

- Non-Medicare: All carriers, products, yearly deductibles remain the same.
    - One Non-Medicare benefit design change: A lower co-pay of $150 for members who utilize freestanding facilities for eye procedures and GI endoscopies. Co-pays for procedures at hospital outpatient facilities would remain the same at $250 this fiscal year.
- Express Scripts will continue to be your non-Medicare prescription carrier. You will receive two ID cards, one from your health carrier and one from Express Scripts. Don't forget to bring these with you to the pharmacy when you get your prescriptions refilled!

Canceling Coverage or Dropping Dependent(s)

If you plan on canceling your existing plan for yourself and/or your family members, you will need to complete the first page of the *GIC Municipal Enrollment/Change Form (Form-1MUN)* (check off "Decline GIC health insurance coverage") and send the form back to the Benefits Department. Please note that dropping insurance plans and/or dependents without proof of other insurance is only allowed during Open Enrollment. Outside of the Open Enrollment time period, in order to cancel your plan (or drop dependent), you will be required to provide proof of other coverage obtained within 50 days of the cancellation date as well as completing the *GIC Municipal Enrollment/Change Form (Form-1MUN)*. If you are canceling your health insurance you must also complete the *Health Insurance Refusal Form* that is included in this package.

Flexible Spending Accounts (FSA)

You may elect to put money aside directly from your paycheck for a Flexible Spending Account (Health Care FSA and/or Dependent Care FSA). The FSA benefit allows you to contribute pre-tax dollars to individual accounts for eligible uninsured or unreimbursed medical, dental, vision, and dependent care expenses.

**Eligible employees: must work at least 18.75 hours in a 37.5-hour workweek or 20 hours in a 40-hour workweek and participate in a public retirement system (OBRA is not considered a public retirement system).*

	Annual Minimum	Annual Maximum
Health Care Accounts	$300	$2,500
Dependent Care Accounts	$500	$5,000

The Health Care FSA is a DEBIT CARD which allows you to "Swipe-N-Go". You will only be able to use your debit card for eligible health care expenses.

A Dependent Care FSA (DCFSA) is a pre-tax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child or adult daycare. If you sign up for a Dependent Care Account, you will need to submit for reimbursements.

If you are currently participating in the FSA benefit, you will be required to RE-ENROLL for the new plan year July 1, 2019 through June 30, 2020.

FSA Forms can be emailed to benefits@springfieldcityhall.com**, sent via interoffice mail, or placed in our "FSA Drop Box" in City Hall Room 18.**

Dental & Vision

The City of Springfield will continue to provide dental and vision coverage through Cigna. Enrollment into the dental and vision benefit is automatic with your enrollment into any of the medical plans. You do not need to complete additional forms to be enrolled. While current Dental benefits will remain the same, the **Vision benefits have been changed. All employees enrolled in health insurance will now be automatically enrolled in a vision plan with hardware benefit. Please review the Cigna vision benefits overview included in this packet!**

Life Insurance

The City of Springfield currently offers a Basic Life Insurance policy ($2,000) and a Supplemental (Optional) Life Insurance ($25K, $50K, $100K, $150K, or $200K) benefit through Guardian Life Insurance. You may enroll in this program during Open Enrollment, but you will be required to complete an Evidence of Insurability Form and possibly submit to a physical in order to participate. If you haven't updated your beneficiary information in a while, please fill out the *Guardian Beneficiary Designation Form* to update your information.

Enrollment Requirements

All enrollment forms must be received in the Benefits Office no later than Wednesday, May 1, 2019 at the close of business (4:00PM EST). All Health insurance forms require a wet signature; no copies, emails, or faxes are allowed at this time. FSA forms are the only exception to the wet signature rule and can be emailed with an electronic signature. FSA can also be filled out and dropped in the Room 18 waiting area "FSA DROP BOX".

If you wish to enroll or change any of your benefits with the City of Springfield, please return your completed form(s) to:

City of Springfield
Attention: Benefits Department
36 Court Street, Room 18
Springfield, MA 01103

**FSA forms will be available on the counter and can be placed in the "FSA Drop Box" on the side wall to the left.

Please ensure that all information requested on the form is complete and all applicable required documents are included. Incomplete forms will be returned to you. We will not process incomplete forms until all information is complete. Please note that the **May 1, 2019 (4:00PM EST) deadline** still applies even if your form has been returned to you.

If you are enrolling for the first time, you must complete the *Municipal Employee Acknowledgement Form* and return it with your completed enrollment forms and any other needed documentation.

The Benefits Department will be attending the Pre-Retirement & Benefits Seminar and will have a table to answer your Open Enrollment questions and help you fill out forms.

Pre-Retirement & Benefits Seminar
Raymond A. Jordan Senior Center
1476 Roosevelt Ave, Springfield, MA 01109
April 25th 4:00PM-7:00PM

Friendly Reminders

Payroll deductions – All Open enrollment changes are for an effective date of July 1st. Health insurance deductions with the New FY2020 rates begin in June. Deductions for FSA begin in July or your first paycheck of fiscal year 2020.

Address Changes – Please update your address through the Employee Self Service (ESS) portal so that the Benefits Office may notify your vendor(s).

Beneficiaries – Please be sure that your beneficiary information is up to date.

Dependent Children – If your child reaches the limiting age on the plan, please notify the Insurance Department in advance so we can make the appropriate changes to your plan. If your child is between 19 and 26 years old, the *GIC Dependent age 19-26 Form* is required; one form for each child between 19 and 26 who will be enrolled under your health insurance plan.

Ex- Spouses – If you are covering an ex-spouse on your health insurance and either you or your ex-spouse remarries, the ex-spouse is no longer an eligible dependent on your plan.

Status Changes – Please notify the Benefits Department if your dependent has a change in status:

- Dependent child turns age 26
- Spouse to ex-spouse
- Dependent passes away
- You (re)marry
- Non-student dependent moves out of plan service area

If you have any questions or concerns, please feel free to visit our Human Resources website at http://www.springfield-ma.gov/hr/. You may also call us at 413-787-6055 or send an email to benefits@springfieldcityhall.com. Our office is open during normal business hours Monday through Thursday 8:15AM - 4:00PM and Fridays 9:00AM – 4:00PM.

Thank you,

City of Springfield Benefits Team

City of Springfield
Benefits Department
Medical/Dental Insurance Premium
Coverage for 7/1/19 – 6/30/20

Non-Medicare Rates for Active Employees & Retirees
(Rates begin June 2019 for July 1st Coverage)

Plan Name	Coverage	52 Weeks	39 Weeks	26 Weeks	22 Weeks	Monthly
Cigna Dental/Vision Plan	Individual	1.63	2.18	3.27	3.86	7.08
	Family	3.78	5.04	7.56	8.94	16.39
Unicare Basic Indemnity with CIC	Individual	62.66	83.55	125.32	148.10	271.53
	Family	138.84	185.12	277.68	328.17	601.65
Unicare Basic Indemnity without CIC	Individual	59.69	79.58	119.37	141.07	258.64
	Family	132.07	176.09	264.14	312.16	572.30
Unicare Indemnity Community Choice	Individual	29.86	39.81	59.71	70.57	129.38
	Family	73.67	98.23	147.34	174.13	319.24
Unicare Indemnity Plus	Individual	40.16	53.55	80.32	94.92	174.03
	Family	95.46	127.28	190.92	225.63	413.65
Harvard Pilgrim Independence	Individual	51.33	68.43	102.65	121.32	222.41
	Family	125.28	167.04	250.56	296.11	542.87
Harvard Pilgrim Primary Choice	Individual	37.26	49.68	74.52	88.06	161.45
	Family	94.99	126.65	189.98	224.52	411.62
Tufts Navigator	Individual	43.14	57.52	86.28	101.97	186.94
	Family	105.12	140.16	210.24	248.47	455.52
Tufts Spirit	Individual	32.65	43.53	65.30	77.17	141.48
	Family	78.40	104.53	156.80	185.31	339.74
Fallon Select Care	Individual	46.83	62.45	93.67	110.70	202.95
	Family	113.76	151.68	227.53	268.89	492.97
Fallon Direct Care	Individual	34.65	46.21	69.31	81.91	150.17
	Family	87.36	116.48	174.72	206.49	378.56
Health New England	Individual	32.93	43.91	65.86	77.84	142.70
	Family	78.26	104.35	156.52	184.98	339.14
AllWays Health Partners	Individual	37.32	49.76	74.65	88.22	161.73
*Formerly NHP Prime	Family	96.79	129.05	193.58	228.78	419.42

NHP Prime (Neighborhood Health) changed its name to **AllWays Health Partners effective January 1, 2019.*

City Hall Room 018 • Phone 413.787.6055 • Email benefits@springfieldcityhall.com

City of Springfield
Benefits Department
Medical/Dental Insurance Premium
Coverage for 7/1/19 – 6/30/20

Medicare Rates for Retirees

(Rates begin June 2019 for July 1st Coverage)

Plan	Coverage	Monthly
Cigna Dental/Vision Plan	Individual	7.08
	Family	16.39
UniCare State Indemnity Plan/Medicare Extension	Individual	96.73
(OME) with CIC (Comprehensive)	Family	193.47
UniCare State Indemnity Plan/Medicare Extension	Individual	94.08
(OME) without CIC (Non-Comprehensive)	Family	188.16
Health New England MedPlus	Individual	97.95
	Family	195.91
Harvard Pilgrim Medicare Enhance	Individual	97.78
	Family	195.56
Tufts Health Plan Medicare Complement	Individual	92.88
	Family	185.75
Tufts Health Plan Medicare Preferred*	Individual	80.61
	Family	161.22

**Benefits and rates for Tufts Health Plan Medicare Preferred are subject to Federal approval and may change January 1, 2020.*

Required Documents for GIC Coverage

If you are planning to cover yourself only:

- There is no documentation needed unless you are a retiree or survivor who is (and/or whose spouse is) age 65 or over *(see Additional Documents for Retirees and Survivors section below).*

If you are planning to cover a current and/or former spouse, you will need the following:

- If you are married – Copy of Certified Marriage Certificate

If you are divorced or legally separated, the following sections of the Separation Agreement are required. Note that that if you were divorced prior to March 27, 1985, or either you or your former spouse has remarried, your former spouse is not eligible for GIC coverage:

- Divorce Absolute Date
- Signature Page
- Health Insurance Provisions
- Your Former Spouse's Last Known Address

If you are planning to cover dependent children, you will need the following:

- Dependent Child Coverage – Copy of Certified Birth Certificate (*must have parent/child relationship listed*)
- Dependent Age 19-26 – Complete a Dependent Age 19-26 Application for coverage *(form available on the GIC's website)*
- Handicapped Dependent – complete Handicapped Dependent form *(form available on the GIC's website)*
- Adoption – Copy of Adoption Placement Letter
  - Letter must be on Adoption Agency Letterhead and include the following:
  - Name of Adoptive Parents
  - Name of Adopted Child
  - Date Child Placed in the Home
- Grandchild – Copy of Court Guardianship Appointment
  - However, if grandchild is a dependent of a dependent under age 19, copy of grandchild's certified *(Long Form)* birth certificate

Documents such as marriage certificates and birth certificates can be obtained by contacting the Clerk's Office of the town in which the event occurred.

Adoption verification and Grandchild verification information can be obtained by contacting the adoption agency used or the Clerk of Court's office in the town in which the event occurred.

We encourage you to contact the appropriate offices as soon as possible. There may be a waiting period to obtain information.

Additional Required Documents for Retirees and Survivors

If you and/or your spouse are on Medicare, you will need the following documentation:

- See above for spousal and dependent coverage.
- Photocopy of Medicare Card (include a copy of spouse's card if applicable).
- Photocopy of your latest 1099 or Benefit Verification Letter printed off Social Security's website stating how your monthly Part B premium is paid (e.g., you are being directly billed by Social Security or it is being deducted from your Social Security check). Include this same documentation for your spouse, if applicable.

If you and/or your spouse are over age 65 and Medicare eligible, but not enrolled in Medicare, you will need the following:

- See above for spouse and dependent coverage.
- Between January 1 and March 31, you must enroll in Medicare Part A and Part B and send to the GIC the document listed above (third bullet) for retirees in Medicare.
- During the GIC spring open enrollment you must enroll in a GIC Medicare plan.

If you and/or your spouse are over age 65 and *not eligible* for Medicare you will need the following documentation:

- See above for spousal and dependent coverage
- Social Security Denial Letter stating that you and/or your spouse is not eligible for Medicare Part A for free.

GIC MUNICIPAL ENROLLMENT/CHANGE FORM (FORM-1MUN)

Health Insurance

Commonwealth of Massachusetts
Group Insurance Commission

REQUIRED

INSURED INFORMATION

Insured Information	GIC-ID (usually Soc. Sec. #) – –	Sex ☐M ☐F	Date of Birth / /	Dept. ID # or Agency/Division # 666 /0281
	Name – Last	First		MI
Address	Street	City	State	Zip
Contact Information	Home or Cell Phone ( )	Work Phone ( )	Email	Country *(if not USA)*
Employment Information	Date of Hire (must be completed): / /	Name of Municipality: CITY OF SPRINGFIELD		

REQUIRED FOR ALL NEW ENROLLMENTS

For Agency Use Only	Does the employee participate in a public retirement system? ☐Yes ☐No	Check one: ☐Full-time ☐Part-time	Number of work hours/week:

REQUIRED

Select all that apply:

- ☐ New Enrollment
- ☐ Adding Dependent(s)
- ☐ Dropping Dependent(s)
- ☐ Decline GIC health insurance coverage
- ☐ Annual Enrollment
- ☐ Address Change
- ☐ Name Change

Qualifying Status Change Date of Event: ____ / ____ / _____

- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce/Legal Separation
- ☐ Change in Dependent Eligibility Status
- ☐ Gain of Other Coverage
- ☐ Involuntary Loss of Other Coverage
- ☐ Return from FMLA or Military Leave
- ☐ Death of spouse/dependent
- ☐ Spouse's Annual Enrollment
- ☐ Moved out of health plan's service area

HEALTH PLAN

Effective Date: / 01 /

Health Plan

- ☐ AllWays Health Partners Complete (HMO)
- ☐ Fallon Direct (HMO)
- ☐ Fallon Select (HMO)
- ☐ Harvard Pilgrim Independence (POS)
- ☐ Harvard Pilgrim Primary Choice (HMO)
- ☐ Health New England (HMO)
- ☐ Tufts Health Plan Navigator (POS)
- ☐ Tufts Health Plan Spirit (HMO-type)
- ☐ UniCare State Indemnity/Basic CIC: ☐Yes ☐No
- ☐ UniCare Community Choice (PPO-type)
- ☐ UniCare/PLUS (PPO-type)

Coverage Election: ☐Individual ☐Family

Cancel Health Insurance Coverage: ☐Yes ☐No

SPOUSE/DEPENDENT INFORMATION *(See instructions on back)*

For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
☐Add ☐Drop					/ /	☐M ☐F	
☐Add ☐Drop					/ /	☐M ☐F	
☐Add ☐Drop					/ /	☐M ☐F	
☐Add ☐Drop					/ /	☐M ☐F	
☐Add ☐Drop					/ /	☐M ☐F	

FORMER SPOUSE INFORMATION – If Listed Above

Date of Divorce: / /

Are you remarried? ☐Yes ☐No	Date of your remarriage: / /	Has your former spouse remarried? ☐Yes ☐No	Date of former spouse's remarriage: / /
Address: Street	City	State	Zip

SIGNATURE REQUIRED

AUTHORIZATION – I have read the instructions on the reverse side of this form and authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected. I understand that due to IRS regulations, my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, death of a dependent, and involuntary loss of coverage). I understand that the GIC must receive any required documentation for health insurance changes within 60 days of the event. **All divorces and remarriages must be reported to the Group Insurance Commission, failure to notify the GIC of a legal separation, divorce, or remarriage can result in financial liability to you.**

Signature of Applicant: _____ Date: _____

Signature of Authorized Official: _____ Date: _____

For GIC Use Only	Entered	Verified	Political Subdivision

(See over for Form-1MUN instructions)

MUNICIPAL ENROLLMENT/CHANGE FORM (FORM-1MUN) INSTRUCTIONS

For an overview of your GIC benefit options, see your GIC Benefit Decision Guide mass.gov/lists/gic-benefits-decision-guides.

Deadlines and Required Documentation

- **Required Documentation:** To add a spouse or dependent to coverage, documentation is required. Refer to dependent information section below for details.
- **New Hire:** Completed forms and required documentation must be received by your GIC Coordinator no later than your 10th calendar day of regular, benefit eligible employment. If you miss the deadline, you must wait until the next Annual Enrollment period to enroll in GIC health insurance benefits.
- **Annual Enrollment:** Completed forms and required documentation must be received by your GIC Coordinator by the end of the Annual Enrollment period.
- **Qualifying Status Change for Health Insurance:** Municipal employees and retirees who have a qualified status change during the year can enroll in GIC health insurance or change from individual to family or family to individual coverage with proof of the family status change. Documentation of the event and the completed form must be received at the GIC within 60 days of the qualifying event. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.
- **Return from FMLA or Military Leave:** If you voluntarily canceled GIC health insurance coverage at the beginning of your FMLA or military leave of absence, you can re-enroll in GIC health insurance coverage upon your return from leave. The enrollment form must be received at the GIC within 60 days of the return to work. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.

Work Hours and Eligibility

Active municipal employees must work at least 18.75 hours in a 37.5-hour workweek or 20 hours in a 40-hour workweek and must contribute to your employer's public sector retirement system. For GIC purposes, OBRA is not such a retirement system. For additional eligibility details, refer to the GIC's regulations: mass.gov/law-library/gic-regulations.

Dependent Information and Required Documentation

In order to enroll your eligible spouse, former spouse and/or dependents in GIC health insurance, you must enter their information in the spouse/dependent box and provide a copy of a marriage certificate, birth certificate or hospital announcement letter (newborns only), separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. If covering a former spouse, also complete the former spouse information section. Failure to provide required documentation with this enrollment/change form will result in your spouse/dependent not being covered. If you are removing a spouse or dependent under age 19, you must do so during Annual Enrollment or within 60 days of a qualifying event. Under federal health care reform, Social Security Numbers must be provided for each spouse/dependent to be covered under the health plan. For a newborn only, the Social Security Number can be provided at a later date. Please indicate the exact date of birth for each dependent. To cover a dependent age 19 to 26, you must also provide a completed Dependent Age 19 to 26 Enrollment and Change Form.

Form and Documentation Submission

Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

Active Employees: Return completed form and documentation to your GIC Coordinator.

(See over for Form-1MUN)

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

DEPENDENT AGE 19 TO 26 ENROLLMENT/CHANGE FORM – FEDERAL HEALTH CARE REFORM (ACA)

Use this form to enroll your dependent age 19 to 26 for the first time or to report your dependent's age 19 to 26 status change. Upon receipt of a complete application, the GIC will determine coverage eligibility and effective date. For new insureds, coverage for the dependent age 19 to 26 will begin on the new insured's effective date. Dependents of existing GIC enrollees who are already over age 19 must have a qualifying event to enroll during the year or may apply during the GIC's Annual Enrollment. Incomplete applications will be returned. PLEASE USE ONE FORM FOR EACH DEPENDENT AGE 19 TO 26.

I am applying for coverage or reporting a status change for my dependent age 19 to 26. The GIC may require proof of relationship for the dependent you plan to cover and will contact you for any documents, if necessary.

Name of Insured_____ Social Security # _____/_____/_____

_____ Telephone #_____

Address

_____ PLEASE COMPLETE ONLY ONE SECTION BELOW

City State Zip SECTION A – ENROLL YOUR DEPENDENT

SECTION B – CHANGE DEPENDENT STATUS

A) ENROLLMENT DEPENDENT AGE 19 TO 26 **Use this section to enroll your dependent**

Name of Dependent Age 19 - 26_____ Social Security #_____/_____/_____

_____ Dependent's Date of Birth ____/___/____

Address

_____ Relationship to Insured _____

City State Zip

_____Check here if your dependent is a full-time student attending an accredited institution **outside your health plan's service area and provide school name and address below:** (Check with your health plan for benefits available to full-time students that are attending school outside the service area.)

Name of School _____ School Address _____

(That is outside health plan's service area) _____

You must contact the GIC when your dependent is no longer a full-time student to continue coverage to age 26.

B) CHANGE OF DEPENDENT'S AGE 19 TO 26 STATUS **Use this section to report dependent address and full-time student status changes**

Name of Dependent Age 19 - 26_____ Social Security #_____/_____/_____

_____ Dependent's Date of Birth ____/___/____

Address

_____ Relationship to Insured _____

City State Zip

_____Dependent Address Change New Address: _____

_____

_____Dependent is no longer a full-time student as of _____.

(Date)

SIGNATURE REQUIRED **Please sign and date below**

Full-time student and non-student adult children age 19-26 may reside outside of your health plan's service area but will be subject to the plan's coverage rules. Be sure to review your plan's out of service area coverage and consider whether you should change to a plan providing greater geographical coverage for your dependent. ***Under the pains and penalties of perjury, I attest that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies and financial consequences, at the GIC's discretion.***

Signature of Insured _____ Date _____

Return to: Group Insurance Commission, PO Box 8747, Boston, MA 02114

GIC USE ONLY APPROVED _____Effective Date _____ Expiration Date _____ DENIED _____

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
City of Springfield
C1 - Standard PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	**In-Network Benefit**	**Out-of-Network Benefit**	**Frequency Period ****
Exam Copay	$5	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$20	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	 Up to $130 Covered 100%	 Up to $105 Up to $210	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $130	Up to $71	24 months
** Your Frequency Period begins on January 1 (Calendar year basis)			

Definitions:
Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).
Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance.
Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.
Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes:
- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
  - Polycarbonate lenses for children under 19 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

7/1/2019

- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription (minimum Rx required) eyeglasses, includes frame, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log into myCigna.com,"Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click Cigna Vision Directory, under Additional Directories.

3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
• Go to **Cigna.com** and go to Forms, Vision Forms
• Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Cigna Dental Benefit Summary
City of Springfield, Massachusetts
Plan Renewal Date: 07/01/2019

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Cigna Dental PPO				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Out-of-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II and VII expenses	$500		$500	
Calendar Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: Bridges, Crowns and Inlays	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class VII: Denture Repairs, Relines and Rebases	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the plan maximum, when applicable.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. The Alternate Benefit Provision does not apply to fillings.

Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations	2 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 60 months
Cleanings	Prophylaxis cleanings - 2 per calendar year; Periodontal cleanings – 4 per calendar year
Fluoride Application	2 per calendar year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 48 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Denture and Bridge Repairs	Reviewed if more than once
Denture Adjustments, Rebases and Relines	Covered if more than 6 months after installation
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive: instruction for plaque control, oral hygiene and diet;	
Restorative: inlays; onlays; crowns; Prosthodontics: bridges, dentures or any related services;	
Implants: implants or implant related services; prosthesis over implants; Orthodontic: orthodontic treatment;	
Procedures, appliances or restorations, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

FLEXIBLE SPENDING ACCOUNTS

Active Employees Only

Health Care & Dependent Care Expense Accounts

If you wish to continue your existing Flexible Spending Account
YOU MUST RE-ENROLL EVERY YEAR!

The FSA benefit allows you to contribute pre-tax dollars to individual accounts for eligible uninsured or unreimbursed medical, dental, vision care and dependent care expenses.

	Annual Minimum	Annual Maximum
Health Care Accounts	$300	$2,500
Dependent Care Accounts	$500	$5,000

The **Health Care FSA Debit Card** feature allows you to "Swipe-N-Go". You will only be able to use your debit card for eligible health care expenses. You can use the debit card for specific expenses rather than paying for them and submitting forms for reimbursement. Under IRS Notice 2006-69, the FSA debit card is not valid for Dependent Care expenses.

Some Qualified Medical Expenses:

- ✓ Eyeglasses/Contacts
- ✓ Co-payments (office visits or prescription co-payments)
- ✓ Braces
- ✓ Chiropractor
- ✓ Dental work not covered by dental insurance
- ✓ Vitamins (by Rx)

A **Dependent Care FSA** (DCFSA) is a pre-tax benefit account used to pay for eligible **dependent care** services, such as preschool, summer day camp, before or after school programs, and child or adult daycare. **If you sign up for a Dependent Care Account, you will need to submit for reimbursements.** You may only submit for a reimbursement up to the amount that you have contributed via payroll.

If you are currently participating in the FSA benefit, you will be **required to re-enroll** for the new plan year every Open Enrollment for the next Fiscal Year (July 1 – June 30) you choose to participate. An enrollment form will be made available to every eligible employee during open enrollment and the form has been included in this package for your convenience.

take Care by Wageworks

Register your card and create your FSA Account through myFlexOnline!

Here you can view your elected amounts, any claims you have used your Health Care FSA Debit Card for, and your available balance!

Be sure to keep all of your receipts as back up until your purchase has been cleared on take care by WageWorks! You may need to upload a copy of your receipt to your account for proof of purchase.

For assistance regarding myFlexOnline or your card, please call TakeCare at (800) 950-0105

City of Springfield MA

FY2020 Flexible Spending Account Deduction Authorization Form

For all Eligible COS and SPS Employees

Please use this form to make your elections. Return your completed and signed form to the City Benefits Office during Open Enrollment, which begins on April 3, 2019 and ends May 1, 2019 @ 4:00PM EST, or **within 10 days** after your first day of employment. Forms submitted after these deadlines time will not be accepted. **These elections remain in effect from July 1, 2019 through June 30, 2020.** You must **re-enroll** in a Flexible Spending Account each year that you wish to participate. Election changes can not be made after you enroll without a Qualifying Status Change per IRS regulations.

Employee Information

Employee ID _____ Re-Enrolling ☐ New Enrollee ☐

Last Name _____ First Name_____ Middle Initial_____

Street_____ City_____ State _____ Zip_____

Email Address_____ Phone Number_____

Last 4 Social Security No. _____ Date of Birth (MM/DD/YYYY)____/____/_____

Election of Contribution

Please enter the Annual amount you wish to contribute to your flexible spending account (FSA) and select the number of Pay Periods you have yearly (52 / 39 / 26 / 22). The amount that will be taken from each paycheck is automatically calculated for you. **(Teachers & Paras please use 22 pay periods)**

Health Care FSA *(Minimum $300 - Maximum $2,500; Debit Card & Reimbursement)*

Annual Amount		Number of Pay Periods		Contribution per Paycheck
$_____	÷	_____	=	$_____

Dependent Care FSA *(Minimum $500 - Maximum $5,000; Reimbursement only)*

Annual Amount		Number of Pay Periods		Contribution per Paycheck
$_____	÷	_____	=	$_____

Employee Signature_____ Date_____

Return Your Signed and Completed Form

By Mail or Drop Off Box:
City of Springfield, MA
Attn: Insurance Department
36 Court St, Room 018
Springfield, MA 01103

By Email:
benefits@springfieldcityhall.com

Submit via Email

Please be advised that incomplete forms will be returned to the employee for correction and resubmission.

If you have any questions, please view the Human Resources website, send us an email, or call the Benefits Office at 413-787-6055, Monday through Thursday from 8:15AM to 4:00PM, and Friday 9:00AM to 4:00PM.

The City of Springfield participates in FSA accounts through Take Care by WageWorks. To create an account and log in, visit http://www.takecarewageworks.com/. Here you can view your account balance and all claims or by calling Plan Support at 800-950-0105.

Basic and Supplemental (Optional) Life Insurance

Guardian Life Insurance Company
Group Number: 00459295

Guardian Customer Service: 1-888-600-1600 www.guardianlife.com

All enrollments/changes during open enrollment are subject to Evidence of Insurability, as well as elected volumes over $150,000, and enrollment/changes outside of your 10 day new hire window.

Basic Life: You may elect $2,000 of Basic Term life insurance coverage, of which the City pays 50% of your monthly premium. The Basic Life includes Enhanced Accidental Death and Dismemberment coverage equal to one times the employee's life benefit.

Optional Term Life: You may elect $25,000, $50,000, $100,000, $150,000, or $200,000. Optional Life volumes reduce by 35% at age 65 and by 60% at age 70 (on birthdays).

Spouse Term Life: You may elect 50% of the employee optional coverage up to the maximum $25,000.

Dependent Term Life: Coverage of $10,000 for each dependent. Dependent Term Life covers children age 14 days to 23 years who are unmarried. Additional documents are required for dependents between 23 years and 25 years who are unmarried and enrolled in an accredited school.

Coverage	52/26 Week (12 Months)	22 Week (10 Months)	39 Week (9 Months)	Retiree (12 Months)
Basic Life Insurance	$1.630	$1.956	$2.173	$3.370
Child Life Insurance	$1.700	$2.040	$2.267	$1.700

Active Employee (Class 1) Supplemental Life Insurance Rates

EE Age	Monthly Deduction (12 months)	22 Week Deduction (10 months)	39 Week Deduction (9 months)
15-34	$0.1500	$0.1800	$0.2000
35-39	$0.1900	$0.2280	$0.2533
40-44	$0.2600	$0.3120	$0.3467
45-49	$0.4000	$0.4800	$0.5333
50-54	$0.5700	$0.6840	$0.7600
55-59	$0.8300	$0.9960	$1.1067
60-64	$1.3300	$1.5960	$1.7733
65-69	$2.5300	$3.0360	$3.3733
70-74	$3.3300	$3.9960	$4.4400

Deduction per $1,000 elected based on age bracket; includes $0.05/$1,000 AD&D
Coverage/volume amounts reduce by 35% at age 65 and by 60% at 70 (On Birthdays)
Employee moves into new age bracket at Plan Anniversary (October 1).
Supplemental Coverage ends at age 75.

Basic and Supplemental (Optional) Life Insurance

Spouse Supplemental Life Insurance Rates

EE Age	Monthly Deduction (12 months)	22 Week Deduction (10 months)	39 Week Deduction (9 months)
15-34	$0.1000	$0.1200	$0.1333
35-39	$0.1400	$0.1680	$0.1867
40-44	$0.2100	$0.2520	$0.2800
45-49	$0.3500	$0.4200	$0.4667
50-54	$0.5200	$0.6240	$0.6933
55-59	$0.7800	$0.9360	$1.0400
60-64	$1.2800	$1.5360	$1.7067
65-69	$2.4800	$2.9760	$3.3067
70-74	$3.2800	$3.9360	$4.3733

Deduction per 1,000 elected based on age bracket
Spouse coverage premium is based on EE age; terms at Spouse's age 70
Spouse insurance is 50% of EE election up to a maximum of $25,000

Retirees & Spouses (Class 2 & 3)

Age	Monthly Deduction
15-34	$0.1000
35-39	$0.1400
40-44	$0.2100
45-49	$0.3500
50-54	$0.5200
55-59	$0.7800
60-64	$1.2800
65-69	$2.4800
70-74	$3.2800

Monthly Deduction

16,250	25,000	50,000	100,000	150,000	200,000
$1.63	$2.50	$5.00	$10.00	$15.00	$20.00
$2.28	$3.50	$7.00	$14.00	$21.00	$28.00
$3.41	$5.25	$10.50	$21.00	$31.50	$42.00
$5.69	$8.75	$17.50	$35.00	$52.50	$70.00
$8.45	$13.00	$26.00	$52.00	$78.00	$104.00
$12.68	$19.50	$39.00	$78.00	$117.00	$156.00
$20.80	$32.00	$64.00	$128.00	$192.00	$256.00
$40.30	$62.00	$124.00	$248.00	$372.00	$496.00
$53.30	$82.00	$164.00	$328.00	$492.00	$656.00

How do I determine what the optional life insurance cost will be?
Select the correct rate for your age and pay schedule. Then, multiply by the volume of Life Insurance divided by 1,000.

Example:

1.) I am a 32 year employee and I wish to elect $100,000 of life insurance for myself. I receive 52 paychecks a year (12 monthly deductions). I would also like to take out a $25,000 policy for my spouse and policies for my two children.

Employee	$0.15 * ($100,000 / $1,000)	= $	15.00
Spouse	$0.10 * ($25,000 / $1,000)	= $	2.50
Children (2)	$1.70	= $	1.70
Total Premium		$	19.20

City of Springfield Benefits Vendors

Aflac	Customer Svc Kelly Assis	800-992-3522 203-871-0020	https://www.aflac.com/ Kelly_Assis@us.aflac.com
Cigna - Dental & Vision Insurance	Plan Support	800-244-6224	www.mycigna.com
Employee Assistance Program - ESI Group	Plan Support	800-535-4841	www.theEAP.com
Group Insurance Commission (GIC)	Plan Support	617-727-2310	https://www.mass.gov/orgs/group-insurance-commission
Guardian Life Insurance	Plan Support Mark Boardman	888-600-1600 413-357-9900	www.guardiananytime.com
Smart Plan Deferred Compensation	Plan Support Heather Kane Dan Moroney	877-457-1900 781-296-9948 413-335-0542	www.mass-smart.com heather.kane@empower-retirement.com dan.moroney@empower-retirement.com
Springfield Parking Authority (SPA)	Main Office	413-787-6118	http://springfieldparkingauthority.com/
TakeCare by Wageworks (FSA)	Plan Support	800-950-0105	https://www.myflexonline.com/Login/Welcome.aspx
Trustmark	Michael Jenks	800-445-4493 ext.31	mfj@pwb-mmip.com
City of Springfield *Benefits Department* 36 Court St., Room 18 Springfield, MA 01103	Office Hotline Fax	413-787-6055 413-787-6010	https://www.springfield-ma.gov/hr/ benefits@springfieldcityhall.com

GIC Health Insurance Vendors

Fallon Health	866-344-4442	www.fallonhealth.org/gic
Harvard Pilgrim Health Care	800-542-1499	www.harvardpilgrim.org/gic
Health New England (HNE)	800-842-4464	www.hne.com/gic
AllWays Health Partners	866-567-9175	https://allwayshealthpartners.org/gic-members
Tufts Health Plan	800-870-9488	www.tuftshealthplan.com/gic
UniCare State Indemnity Plan	800-442-9300	www.unicarestateplan.com

Prescription Drug Coverage (R_x)

Express Scripts (ESI)	Non-Medicare	855-283-7679	www.express-scripts.com
SilverScript	Medicare	877-876-7214	www.gic.silverscript.com

Behavioral Health/Substance Abuse and EAP for GIC Eligible Employees

Beacon Health Options	855-750-8980	www.beaconhealthoptions.com/gic

Additional Resources

City of Springfield Retirement *70 Tapley Street, Springfield MA*	413-787-6090	www.springfieldretirement.com
Mass. Teacher's Retirement System (MTRS) *One Monarch Place, Suite 510*	413-784-1711	www.mass.gov/mtrs
Medicare	800-633-4227	www.medicare.gov
Social Security Administration	800-772-1213	www.ssa.gov