2021 Medical Plan Schedule of Benefits

Medical	Plus Option		Basic Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible One Person Two Person Family	$500 $1,000 $1,500	$1,000 $2,000 $3,000	$1,300 $2,600 $3,900	$2,600 $5,200 $7,800
Maximum Out-of-Pocket One Person Two Person Family	$2,200 $4,400 $6,600	No Maximum Amount No Maximum Amount No Maximum Amount	$3,400 $6,800 $10,200	No Maximum Amount No Maximum Amount No Maximum Amount
Coinsurance - EE/ER	20% / 80%	50% / 50%	20% / 80%	50% / 50%
Physician Copay Primary Care Physician Specialist w/ PCP referral Specialist w/o PCP referral	$15 $25 $50	50% after deductible	$20 $35 $75	50% after deductible
Ambulance Service	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Chiropractic Care	20% after deductible; limited to 25 visits per calendar year	20% after deductible; limited to 25 visits per calendar year	20% after deductible; limited to 25 visits per calendar year	20% after deductible; limited to 25 visits per calendar year
Hospital Services Inpatient Outpatient	20% after deductible 20% after deductible	50% after deductible & $500 copay per admission 50% after deductible	20% after deductible 20% after deductible	50% after deductible & $500 copay per admission 50% after deductible
Emergency Room	20% after deductible and $200 co-pay	20% after deductible and $200 co-pay	20% after deductible and $200 co-pay	20% after deductible and $200 co-pay
Urgent Care	$15 co-pay	50% after deductible	$20 co-pay	50% after deductible
Maternity Physician Hospital	$200 copay and 20% after deductible	50% after deductible 50% after deductible	$200 copay and 20% after deductible	50% after deductible 50% after deductible
Mental Health/Substance Abuse Inpatient Outpatient	20% after deductible $15 copay	50% after deductible 50% after deductible	20% after deductible $20 copay	50% after deductible 50% after deductible
Preventive Care Well Adult Care Well Child Care	100% 100%	No benefits No benefits	100% 100%	No benefits No benefits
Therapeutic Service (Occupational, Speech, and Physical Therapy)	20% after deductible; limited to 30 visits per calendar year	50% after deductible; limited to 30 visits per calendar year	20% after deductible ; limited to 30 visits per calendar year	50% after deductible; limited to 30 visits per calendar year
Prescription Drug Copay	30 day supply	Mail Order / 90-day @ retail	30 day supply	Mail Order / 90-day @ retail
Tier 1 Drug	$5.00 copay	$10.00 copay	$5.00 copay	$10.00 copay
Tier 2 Drug	$25.00 copay	$50.00 copay	$25.00 copay	$50.00 copay
Tier 3 Drug	$50.00 copay	$125.00 copay	$50.00 copay	$125.00 copay
Tier 4 Drug	$75.00 copay	N/A	$75.00 copay	N/A

Plus SAV4HEALTH Premium				Basic SAV4HEALTH Premium			
Weekly		Bi-Weekly		Weekly		Bi-Weekly	
Employee Only	$18.01	Employee Only	$36.02	Employee Only	$11.22	Employee Only	$22.45
Employee +1	$62.49	Employee +1	$124.98	Employee +1	$42.57	Employee +1	$85.14
Family	$114.38	Family	$228.77	Family	$79.39	Family	$158.78

Plus STANDARD Premium				Basic STANDARD Premium			
Weekly		Bi-Weekly		Weekly		Bi-Weekly	
Employee Only	$37.24	Employee Only	$74.48	Employee Only	$30.46	Employee Only	$60.91
Employee +1	$81.72	Employee +1	$163.44	Employee +1	$61.80	Employee +1	$123.61
Family	$133.61	Family	$267.23	Family	$98.62	Family	$197.25

Prescription Drug Coverage – Express Scripts

Prescription Drug Copay	30-day supply	90-day supply thru Mail Order or CVS retail	30-day supply	90-day supply thru Mail Order or CVS retail
Tier 1 Drug	$5.00 copay	$10.00 copay	$5.00 copay	$10.00 copay
Tier 2 Drug	$25.00 copay	$50.00 copay	$25.00 copay	$50.00 copay
Tier 3 Drug	$50.00 copay	$125.00 copay	$50.00 copay	$125.00 copay
Tier 4 Drug	$75.00 copay	N/A	$75.00 copay	N/A

2021 MetLife Vision

A Vision Plan is available through MetLife. The City does not contribute to the vision plan.

Vision Benefits	In-Network	Out-of-Network
Exam Vision Exam Including a Contact Lens Exam	100% after $10 copay	$45 allowance
Retinal Imaging This screening is used to take pictures of the inside of the eye particularly the retina to look for possible changes.	Up to $39 copay	Applied to the exam allowance
Lenses Single Vision Bifocal Trifocal Lenticular	$20 copay $20 copay $20 copay $20 copay	$30 allowance $50 allowance $65 allowance $100 allowance
Standard Lens Enhancements Ultraviolet coating Polycarbonate (child up to age 18)	Covered in Full Covered in Full	Applied to the allowance for the applicable corrective lens
Additional Lens Enhancements Progressive Standard Progressive Premium Progressive Custom Polycarbonate (adult)	Up to $55 copay Up to $95-$105 copay Up to $150-$175 copay Single Vision up to $31 copay Multifocal up to $35 copay	Applied to the allowance for the applicable corrective lens
Frames – at all participating locations except Costco Costco	$120 allowance 20% discount off balance $65 allowance	$55 allowance
Contact Lenses Elective Medically Necessary	$120 retail allowance Covered in full after eyewear copay	$105 allowance $210 allowance
Value Added Features Additional Savings on Glasses and Sunglasses Laser Vision Correction	Get 20% off the cost of additional pairs of Rx glasses non-Rx sunglasses, including lens enhancements. At times, other promotional offers may also be available. Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK, and Custom LASIK. Offer is only available at MetLife participating locations.	
Frequency Exams Lenses or Contacts Frames	One per 12 months One per 12 months One per 12 months	
Premium	**Weekly**	**Bi-Weekly**
Individual	$1.29	$2.59
EE+1	$2.33	$4.67
Family	$3.37	$6.73

2021 MetLife Dental

A Dental Plan is available through MetLife. The City does not contribute to the cost of dental insurance.

Basic Option Summary	Plus Option Summary
TYPE A Services covered at 100% (Deductible Waived)	TYPE A Services covered at 100% (Deductible Waived)
Exams Fluoride Treatments Sealants	Exams Fluoride Treatments Sealants
X-Rays Palliative Treatments	X-Rays Palliative Treatments
Cleanings Space Maintainers	Cleanings Space Maintainers
Labs and Other Tests	Labs and Other Tests
TYPE B Service covered at 60%	TYPE B Services covered at 80%
Amalgam and Resin Composite Fillings	Amalgam and Resin Composite Fillings
Pulpotomy	Pulpotomy, Pulp Capping and Pulp Therapy
Pulp Capping	Root Canal
Pulp Therapy	Simple Extractions; Surgical Extractions; Other Oral Surgery
Oral Surgery - Simple Extractions	General Services
Repairs of Crowns, Inlays, On lays, Bridges and Dentures	Periodontal Surgery – including soft and connective tissue grafts
General Services	Scaling and Root Planing
	Periodontics – non surgical
	General Anesthesia
	Consultations
	Repairs of Crowns, Inlays, On lays, Bridges, and Dentures
	Apexification and Recalcification
	Periodontal maintenance
TYPE C Services covered at 25%	TYPE C Services covered at 50%
Inlays, On lays; Crowns; Dentures	Inlays, On lays; Crowns; Dentures
Denture – Rebases/Relines; Adjustments; Fixed Bridges	Denture – Rebases/Relines
Prefabricated Crowns; Crown Buildups and Post Core	Denture Adjustments
Oral Surgery – Surgical Extractions	Fixed Bridges
Consultations	Tissue Conditioning
Root Canal	Prefabricated Crowns
Periodontal Surgery; Periodontics – Non-Surgical	Crown Buildups and Post Core
Scaling and Root Planing	Recementations
Tissue Conditioning	
General Anesthesia	
Occlusal Adjustments	
Orthodontic To age 19 or 23 if full-time student covered at 50%	Orthodontics Not Covered
Diagnostic, Active Retention Treatment	N/A
Deductibles and Maximums	Deductibles and Maximums
Annual Deductibles: $50 per person	Annual Deductibles: $50 per person
$150 per family aggregate	$150 per family aggregate
Annual Maximum (per person) $1,000	Annual Maximum (per person) $1,000
Orthodontia Lifetime Maximum (per person) $1,000	
Out of Network services – negotiated fee schedule – Maximum Allowable Charge	Out of Network services are paid at Reasonable and Customary at the 90th percentile

Basic Option Premium				Plus Option Premium			
Weekly		Bi-Weekly		Weekly		Bi-Weekly	
Individual	$4.01	Individual	$8.02	Individual	$6.84	Individual	$13.68
EE+1	$7.40	EE+1	$14.80	EE+1	$11.72	EE+1	$23.45
Family	$13.50	Family	$27.01	Family	$17.18	Family	$34.37