



Medical, Dental and Vision Plan Frequently Asked Questions

General Questions:

1. What qualifying events allow me to make changes to my medical, dental or vision coverage?

- The marriage or divorce of an employee. Employees **must** remove an ex-spouse from the plan at the end of the month in which the divorce is final.
- The birth or adoption of a child by the employee. (Turn in the form within the 30 day time limit; send the Birth Certificate and SSN after you receive it.)
- Obtaining permanent custody of a child.
- The death of an employee's spouse or dependent.
- A change in employment status of the employee, spouse, or child if it affects their benefits.
- An unpaid leave of absence of the employee or spouse.
- A significant change in a spouse or child's employer-provided health care coverage.
- A dependent child no longer eligible for coverage.
- Changes may be made during Open Enrollment without a qualifying event.

2. How do I make the change when a qualifying event occurs?

Fill out and turn in a [Benefits Change Form](#) and your back up documentation to the Benefits and Wellness Office within 30 days of the event. The form must be received by Benefits and Wellness within 30 days or no changes will be made. Mail the form to MC 722, fax to (719) 385-5160, or scan and email the form to CityBenefitsHelp@springsgov.com. If you have any questions, please call Benefits and Wellness (719) 385-5125 or send an email to CityBenefitsHelp@springsgov.com right away when there is a change to ensure the 30 day deadline is easily met.

3. How long can my child remain on the plans?

Due to the Healthcare Reform Act, adult children up to age 26 may remain on medical, dental, vision, EAP and/or life insurance through the end of the month in which they turn 26.

4. If my employment with the City is terminated, when do my benefits end?

Your benefits will remain in effect through the last day of the month in which you worked.

5. How do I receive COBRA benefits?

You will receive information from Ameriben on how to enroll in COBRA after your benefits term. You should receive the COBRA information from Ameriben by the 15th of the month following the month in which your benefits terminated. If you do not receive the paperwork within that timeframe, please call Ameriben directly at (866) 955-1482. If you return the paperwork and make the payment within the COBRA deadlines, your benefits will be retroactive back to the first of the month following the termination of your benefits.

Medical Questions:

1. Where can I find a list of in-network providers?

You can find in-network providers for the medical plan at www.mymednet.com.

2. Do I have to choose a primary care doctor or need a referral to see a specialist?

No. Our medical plans do not require you to choose a primary care doctor or a referral to see a specialist.

3. Is there a deductible on our medical plan?

Yes.

Premier: The deductible is \$300 per year for an individual and \$900 for a family.

Advantage Plan: The deductible is \$1,500 per year for an individual and \$3,000 for a family.

4. What are the co-pays for those on the medical plan?

The Premier Plan:

- There is a \$30 co-pay for the following in-network doctors: general/family practice, internal medicine, ob/gyn, pediatric, out-patient mental health, physician assistants and nurse practitioners.
- All others are considered specialists and the in-network co-pay is \$40. (In-patient mental health is subject to deductible and co-insurance.)
- \$150 co-pay for a visit to the emergency room.
- \$100 co-pay for an ambulance ride.
- \$150 co-pay for outpatient surgery performed in an ambulatory surgical facility.
- No co-pay for preventative care.
- \$15 co-pay at the City Employee Medical Clinic.

The Advantage Plan:

- There is not a co-pay, however, you are responsible for 100% until you've met your deductible for:
 - The following doctors: general/family practice, internal medicine, ob/gyn, pediatric, out-patient mental health, physician assistants and nurse practitioners.
 - Specialists
 - In-patient mental health
 - Visit to the emergency room
 - Ambulance ride
 - Outpatient surgery performed in an ambulatory surgical facility
- No co-pay for preventative care.
- \$15 co-pay at the City Employee Medical Clinic.

5. Is prescription coverage included on our medical plan?

Yes, prescription coverage is part of the medical plan. Members enrolled in either of the City's medical plans are subject to co-pays. The City Employee Pharmacy is located in the lower level of the City Administration Building. The pharmacy can be reached by calling (719) 385-2261.

Dental Questions:

1. Where can I find a list of in-network providers?

You can find in-network providers for the dental plan at www.deltadentalco.com. Once there, click on the dentist in the middle of the page that says “Find a Dentist.” To find dentists in the Hi-option plan, click the Delta Dental Premier option. To find dentists in the Standard Option, click the Delta Dental PPO option.

2. What is the difference between a Delta Premier (Hi-Option) dentist and a Delta PPO (Standard Option) dentist?

A Premier dentist charges higher fees and you have better coverage for routine dentistry. A Standard dentist charges discounted rates, but routine dentistry is paid at a lesser percentage than it would be if you are on the Hi-Option plan. Also, if your dentist is a Premier dentist and you are on the Standard Option plan, the dentist is considered out-of-network and claims will be paid at out-of-network rates. However, if you are on the Hi-Option plan and go to a Standard dentist, you get the best of both worlds. Your claims would be paid at a higher rate and you would receive a deeper discount.

3. What is the deductible and annual maximum benefit for the dental?

Both the Hi-Option and Standard Option plans have a \$50 deductible and the annual maximum benefit is \$1500 per individual.

4. How do I file a Claim?

Simply let your dentist know that you have Delta Dental coverage. They will need to know the plan number and will need to file the claim with your six digit employee ID number preceded by three zeros **INSTEAD** of your Social Security number. The plan number for the Hi-Option Plan is #1512; for the Standard Option Plan, it is #1844.

Vision Questions:

1. Where can I find a list of in-network providers?

You can find in-network providers for the vision plan at www.vsp.com.

2. Is there a deductible for vision?

No, there is no deductible for vision.

3. Can I get both glasses and contacts if I’m on the vision plan?

You can get both glasses and contacts, but you cannot get them both during the same plan year.

4. What is considered the plan year?

The plan year runs from January 1 – December 31 each year. So if you get glasses in December, you would be able to get contacts in January.

5. Is Lasik surgery covered on the Vision plan?

No. Lasik surgery isn’t covered, but you can receive a discount if you go to a VSP provider for the surgery. Also, check the Employee Marketplace on the City’s Intranet to see if there are any discounts available.

Have more questions?

Contact CityBenefitsHelp@springsgov.com or call (719)385-5161.