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2024 Benefit DIGEST

CITY OF LEXINGTON

We are pleased to provide you with the 2024 Benefit Digest. This digest is intended to provide a summary of the benefit programs available to all benefit eligible retirees. It is only an overview and you must review specific plan brochures and plan documents for full program details, limitations and exclusions.

This digest provides benefit information available July 1, 2024.

If you have comments, questions, or other inquiries, please contact Human Resources at 336-248-3955.

Monthly Contributions Effective July 1, 2024

Contributions are your share of premium cost and are made on an after-tax basis. UMR will adjust the monthly premium drafted to reflect premium changes for the medical and/or dental coverage and the new vision coverage if elected.

MEDICAL	
Retiree	$145.00
Retiree/Spouse	$1,071.62
Retiree/Child	$582.32
Retiree/Children	$870.66
Family	$1,781.16

The City contributes approximately 82% toward the monthly cost of coverage for eligible retirees. The retiree may elect to carry dependents on the City's plan and pay 100% of the cost of coverage.

DENTAL	
Retiree	$17.30
Retiree/Spouse	$59.42
Retiree/Child	$37.20
Retiree/Children	$50.28
Family	$91.68

The City contributes approximately 55% toward the monthly cost of coverage for eligible retirees. The retiree may elect to carry dependents on the City's plan and pay 100% of the cost of coverage.

VISION	
Retiree	$2.00
Retiree/Spouse	$4.00
Retiree/Child	$4.00
Retiree/Children	$6.00
Family	$8.00

The City contributes approximately 30% toward the monthly cost of coverage for eligible retirees. The retiree may elect to carry dependents on the City's plan and pay 100% of the cost of coverage.

Medical Plan and Pharmacy Plan

www.umr.com | 800-826-9781 **www.optumrx.com | 800-356-3477**

Your medical coverage through UMR is an "open access" PPO plan, which means that you do not need to select a primary care doctor nor will you need a referral to visit a specialist. As long as you remain in the network, your benefits will be covered at the higher in-network benefit amount. Your pharmacy coverage is through OptumRx.

	IN-NETWORK
Contract Year	July 1 – June 30
Office Visit	PCP/SPC: $25/$50 Copay Telemedicine (Teladoc): $10 Copay
Prescription Drugs	$10 Copay Generic 20% up to $100 each Preferred Brand 20% up to $200 each Non-preferred Brand Mail Order: 2x Copay for 3-month supply
Emergency Room	$150 Copay 1st visit, then 20% after deductible
Urgent Care	$50 Copay
Annual Deductible	$750/$2,250
Out-of-Pocket Maximum	$5,500 / $11,000
Inpatient Care	20% after deductible
Outpatient Care	20% after deductible

Preventive care is covered at 100%. Preventive care is based on the US Preventive Taskforce recommended services and Preventive Services for Women as required by Healthcare Reform.

Dental Plan

www.umr.com | 800-826-9781

Your dental plan is provided by UMR and allows you to use the dentist of your choice.

LEVEL OF COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Benefit Period	July 1 – June 30	
Single/Family Deductible	$50/$150	
Benefit Max	$2,000	
Orthodontia Lifetime Max	$1,500	
Preventive Care	Covered at 100% of allowed amount	
Basic Care	20% of allowed amount after deductible	
Major Care	50% of allowed amount after deductible	
Orthodontia Care	50% of allowed amount after deductible (children only ages 6-18)	

Timely and late entrants will be subject to a 6-month benefit waiting period for basic services and a 12-month wait for all major and orthodontic services. Please note: This applies to employees and dependents.

Note: The description in this document is intended to provide a general overview of your health & welfare benefit plans. For a complete description, please consult your policy.

Vision Plan

www.eyemed.com | 866-939-3633

Your vision plan is provided by EyeMed using the Insight Network. Using an in-network provider will lower your cost. Go to https://eyedoclocator.eyemedvisioncare.com to find an in-network provider.

	IN-NETWORK	OUT-OF-NETWORK
Eye Exam (Once every 12 months)	$10 Copay	Up to $40 Allowance
Retinal Imaging	Up to $39	Not Covered
Lenses (Once every 12 months)		
Single Vision	$10 Copay	$30 allowance
Bifocal	$10 Copay	$50 allowance
Trifocal	$10 Copay	$70 allowance
Progressive – Standard	$65 Copay	$50 allowance
Progressive – Premium Tier I, II, III	$95, $105, or $120 Copay	$50 allowance
Progressive – Premium Tier IV	$225 Copay	$50 allowance
Frames (Once every 12 months)	Up to $180 allowance (20% off remaining balance)	Up to $126 allowance
Contact Lenses (Once every 12 months)	Conventional: Up to $180 (15% off remaining balance) Disposable: Up to $180	Up to $126 allowance
Contact Lenses	Fit and Follow-Up – Standard Up to $40 Fit and Follow-Up – Premium 10% off retail price	N/A

Plan allows member to receive either contacts and frame, or frames and lenses