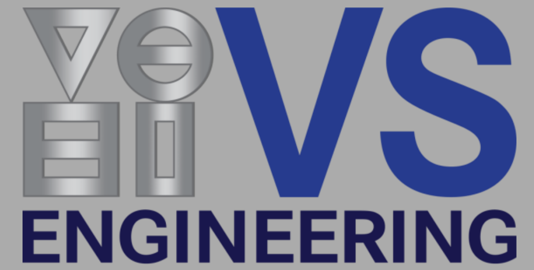
VS ANNUAL OPEN ENROLLMENT
JULY 17, 2020 9-11AM

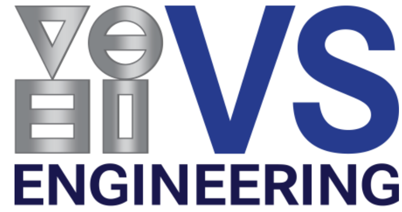


Welcome!

We will be starting momentarily…

PLEASE MUTE!

Thank you.



- **Welcome & Introductions** - *Sanjay*
- **Review of Plan Offerings** – *David Resley, J.D. Resley Associates, Inc.*
- **Introduction of BPC** – *David Resley, J.D. Resley Associates, Inc.*
- **Review of Costs** – *Drew*
- **Next Steps & Forms** – *Ameetrice*

Agenda

J.D. RESLEY ASSOCIATES, INC.

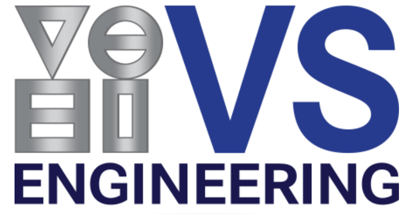
8900 KEYSTONE CROSSING, SUITE 560
INDIANAPOLIS, IN 46240

J. DAVID RESLEY, CLU
resley@jdresley.com

317-844-1049 (o)
317-509-2844 (c)

BETSY WENTWORTH
betsy@jdresley.com

317-844-1049 (o)



- New - Blue Access HSA w/Rx Option C2
- Blue Access PPO w/HRA
- New - Blue Access PPO HSA w/Option E5 w/HRA

Anthem Plans Offered

Your summary of benefits

Anthem

Anthem® BlueCross and BlueShield　　Effective Date: 08.01.2020

VS Engineering

Your Plan: Anthem Blue Access PPO HSAs (with Copay) Option E4 with Rx Option C2

Your Network: Blue Access

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$5,000 person / $10,000 family	$15,000 person / $30,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$6,900 person / $13,800 family	$20,700 person / $41,400 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *When Allergy injections are billed separately by network providers, the member is responsible for $10 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for $10 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit after deductible is met	30% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit after deductible is met	30% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	$30 copay per visit after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	$50 copay per visit after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$10 copay per prescription after deductible is met (retail) and $25 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$35 copay per prescription after deductible is met (retail) and $105 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$75 copay per prescription after deductible is met (retail) and $225 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Anthem

Your summary of benefits

Anthem® BlueCross and BlueShield Effective: 8/1/2020

Your Plan: VS Engineering Anthem Blue Access PPO

Your Network: Blue Access

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$5,000 person / $10,000 family	$10,000 person / $20,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$7,350 person / $14,700 family	$20,000 person / $40,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Specialist Care Visit	$60 copay per visit deductible does not apply	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.		
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	$35 copay per pregnancy deductible does not apply	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
On-line Visit	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	40% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible does not	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Anthem

Your summary of benefits

Anthem® BlueCross and BlueShield Effective Date: 08.01.2020

VS Engineering

Your Plan: Anthem Blue Access PPO HSAs Option E5

Your Network: Blue Access

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$6,350 person / $12,700 family	$19,050 person / $38,100 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$6,350 person / $12,700 family	$22,225 person / $44,450 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

VS ENGINEERING

VS Engineering, Inc.
EMPLOYEE ELECTION FORM
EFFECTIVE AUGUST 1, 2020

NOTE: EMPLOYEE CONTRIBUTIONS/PAYROLL DEDUCTIONS FOR MEDICAL, VISION, DENTAL, HSA & FSA ARE PRE-TAX IF ENROLLED IN IRS SECTION 125 CAFETERIA PLAN.

NOTE: THIS FORM IS FOR INTERNAL PURPOSES ONLY. YOU MUST COMPLETE AN ENROLLMENT FORM FROM THE INSURANCE CARRIER FOR ACTIVATION OF YOUR COVERAGE.
BENEFITS ARE NOT EFFECTIVE UNTIL EMPLOYEE ELECTS AND SIGNS PROPER ENROLLMENT FORMS.

EMPLOYEE NAME: ____________________

CHECK ELECTION HERE	MEDICAL, RX COVERAGE	ANTHEM NEW HSA E4C (C2) EMPLOYEE COST PER PAY PERIOD
☐	SINGLE	$45.93
☐	EMPLOYEE + SPOUSE	$182.20
☐	EMPLOYEE + CHILD(REN)	$164.84
☐	FAMILY	$269.65

CHECK ELECTION HERE	MEDICAL, RX COVERAGE	ANTHEM PPO 25 Rx E2 w/HRA EMPLOYEE COST PER PAY PERIOD
☐	SINGLE	$65.88
☐	EMPLOYEE + SPOUSE	$279.69
☐	EMPLOYEE + CHILD(REN)	$250.34
☐	FAMILY	$405.14

CHECK ELECTION HERE	MEDICAL, RX COVERAGE	ANTHEM NEW HSA E5 w/HRA EMPLOYEE COST PER PAY PERIOD
☐	SINGLE	$75.76
☐	EMPLOYEE + SPOUSE	$318.19
☐	EMPLOYEE + CHILD(REN)	$287.89
☐	FAMILY	$465.91

CHECK ELECTION HERE TO WAIVE	WAIVE ALL MEDICAL COVERAGE
☐	$0.00

UNITED HEALTHCARE	CHECK ELECTION HERE	DENTAL INSURANCE EMPLOYEE COST PER PAY PERIOD	CHECK ELECTION HERE	VISION INSURANCE EMPLOYEE COST PER PAY PERIOD
SINGLE	☐	$3.00	☐	$0.01
EMPLOYEE + SPOUSE	☐	$12.01	☐	$0.02
EMPLOYEE + CHILD(REN)	☐	$13.96	☐	$0.02
FAMILY	☐	$21.03	☐	$0.03
WAIVE COVERAGE	☐	$0.00	☐	$0.00

BASIC LIFE & AD&D 100% PAID BY VS ENGINEERING	LINCOLN FINANCIAL GROUP $50,000 LIFE & AD&D BENEFIT PLEASE ENSURE YOUR BENEFICIARY FORM IS UP TO DATE

LONG-TERM DISABILITY 100% PAID BY VS ENGINEERING	LINCOLN FINANCIAL GROUP 60% OF BASE SALARY TO A MONTHLY MAXIMUM OF $10,000

CHECK BENEFIT ELECTION HERE	VOLUNTARY STD 100% EMPLOYEE PAID COVERAGE	LINCOLN FINANCIAL GROUP VOLUNTARY SHORT-TERM DISABILITY 60% OF BASE SALARY TO A WEEKLY MAXIMUM OF $1,000 BENEFITS BEGIN ON 8TH DAY OF DISABILITY
☐	NO CHANGE TO CURRENT VOLUNTARY STD ELECTION. PAYROLL DEDUCTIONS WILL CONTINUE POST-TAX	
☐	I WISH TO ENROLL, ENROLLMENT AND EVIDENCE OF INSURABILITY FORM(S) ATTACHED. PAYROLL DEDUCTIONS WILL BE POST-TAX	
☐	WAIVE VOLUNTARY STD COVERAGE	

CHECK BENEFIT ELECTION HERE	VOLUNTARY LIFE/AD&D 100% EMPLOYEE PAID COVERAGE	LINCOLN FINANCIAL GROUP VOLUNTARY LIFE / AD&D EMPLOYEE: $10,000 INCREMENTS UP TO $500,000 / GUARANTEED $100,000 SPOUSE: $5,000 INCREMENTS UP TO $250,000 / GUARANTEED $25,000 CHILD: $1,000 TO $10,000 / GUARANTEED UP TO $10,000 *EMPLOYEE ELECTION REQUIRED TO ELECT DEPENDENT COVERAGE*
☐	NO CHANGE TO CURRENT VOLUNTARY LIFE/AD&D ELECTION. PAYROLL DEDUCTIONS WILL CONTINUE POST-TAX	
☐	I WISH TO ENROLL, ENROLLMENT AND EVIDENCE OF INSURABILITY FORM(S) ATTACHED. PAYROLL DEDUCTIONS WILL BE POST-TAX	
☐	WAIVE VOLUNTARY LIFE/AD&D COVERAGE	

FLEXIBLE SPENDING ACCOUNT (FSA) 100% EMPLOYEE PAID COVERAGE	OPEN ENROLLMENT FOR THIS PLAN WILL COMMENCE DECEMBER 2018 FOR JANUARY 1, 2019 EFFECTIVE DATE

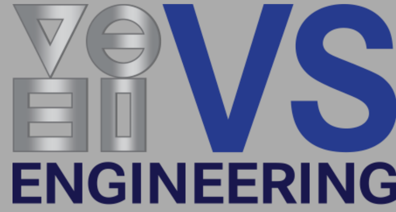
HEALTH SAVINGS ACCOUNT (HSA) 100% EMPLOYEE PAID COVERAGE	OPTUM HEALTH SAVINGS ACCOUNT AVAILABLE TO EMPLOYEES ENROLLED IN A DEDUCTIBLE HEALTH PLAN BDQM/Rx282

I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deduction from my earnings. I understand that if I decline any of the above coverage, I cannot later change my mind during the plan year and elect this coverage unless I experience a qualified life event/change.

EMPLOYEE SIGNATURE: ____________________ DATE: ____________

Ameetrice Smalls will email form today

Employee Election Form



Forms are due to:
Ameetrice Smalls
by
Wednesday
July 22, 2020
at 5pm

QUESTIONS?

Ameetrice Smalls
asmalls@vsengineering.com
317-293-3542 ext. 149

David Resley, CLU, J.D. Associates, Inc.
resley@jdresley.com
317-844-1049 (o)
317-509-2844 (c)