2024
EMPLOYEE**BENEFITS**

MILTON
EST 2006

CONTENTS

WELCOME

The City of Milton evaluates our benefit program each year to make sure that we accomplish several goals:

- Promote health and wellness among The City of Milton employees and their dependents.
- Provide employees with affordable access to health benefits and competitive benefits programs.
- Provide resources to support employees and their dependents as they make important decisions about their health and health care.

This booklet will answer some of the questions you have about your employee benefits at The City of Milton. This document is a high level summary of the major points of our benefit plans and is for informational purposes only. It does not cover all provisions, limitations, and exclusions. The official plan documents, policies, and certificates of insurance govern in all cases and are available for your review at any time. Guidance and interpretations relating to healthcare are being released on a regular basis. The City of Milton is not providing legal advice. Please contact Human Resources if you have any questions.

MILTON
ESTABLISHED 2006

Dear City of Milton Employees,

We are pleased to present your 2024 benefits package. We understand that your health and well-being are very important to you, your family, and the City's success. We are committed to providing our employees and their eligible dependents with a comprehensive benefits package including medical, dental, vision, life, and disability insurance. We strive to ensure that your benefit program is not only high quality, but also affordable in this world of increasing healthcare costs.

Our renewal with Cigna went very well this year with the City receiving only minor increases. In 2024, we will continue to offer a POS Plan and a High Deductible Health Plan (HDHP) for medical options. The High Deductible option gives you a way, through a Health Savings Account (HSA), to set aside pre-tax dollars to pay for expenses in the HDHP. In addition, the City will contribute an annual amount of $750, $ l, 125, or $1,500, based on your level of coverage to your HSA, to help pay for your eligible expenses. If enrolled in the POS Plan, you will receive a $500 contribution from the City in the form of a Health Reimbursement Account (HRA) to help pay for expenses. You may also enroll in the Flexible Spending Account (FSA), offered through our provider Basic. The annual contribution limit for the FSA is projected to increase from $3,050 to $3,200 for health related expenses and $5,000 for dependent care. Your plan selections will remain in effect through December 31, 2024.

There will continue to be one dental plan offered through Cigna. The deductible and annual maximums have not changed for the dental plan. The vision plan remains with VSP, and there are no changes to the benefit levels or network.

We are proud to continue to offer competitive rates for benefits. All rate changes are detailed in this book.

This benefits booklet is designed as a resource to help you review your benefit choices, and serves as a summary of the various programs offered to you as an employee of the City of Milton. Additionally, you may contact our insurance broker's office, Relation, for any questions or concerns that you may have. All contact information is listed on the back cover of this booklet.

Sincerely,

Steve Krokoff, City Manager

2006 Heritage Walk Milton, GA 30004 P: 678.242.2500 | F: 678.242.2499 info@cityofmiltonga.us | www.cityofmiltonga.us

BENEFITS ELIGIBILITY

The City of Milton provides a comprehensive employee benefit program to all full-time employees. Employees are eligible for coverage on the first day of the month following date of hire for medical, dental, vision, life, disability and FSA benefits.

Enroll The Following Dependents In Our Benefits:

- Your legal spouse
- Dependent children up to age 26. Dependent children include natural children, legally adopted children, stepchildren, children for whom the employee has been appointed legal guardian
- Unmarried children if totally disabled and claimed as a dependent on your federal income tax return

SPOUSAL SURCHARGE

Employees who choose to cover their spouse on the City of Milton medical plan, and whose spouse has access to "minimum essential", employer sponsored coverage that also meets the "minimum value" and "affordability" thresholds of the Affordable Care Act, will be subject to an additional $10 per pay period. Complete the Spousal Surcharge Affidavit and return to Human Resources.

OPT-OUT BENEFIT

Employees who waive out of City of Milton's medical plan, as a result of having coverage elsewhere, will receive an annual benefit of $1,800. Employees who waive out of both the offered medical and dental plans, will receive an annual benefit of $2,400.

The opt-out benefit will be distributed quarterly via check as taxable income. The employee must provide "reasonable evidence" that the employee and all members of the employee's tax family (dependents on his/her tax return) have or are expected to have minimum essential coverage (MEC) for the relevant period (the plan year for which the opt-out payment is offered).

BENEFITS CHANGES

Most benefit deductions are withheld from your paycheck on a pre-tax basis; therefore, your ability to make changes to these benefits is restricted by the IRS. Once enrolled, most elections cannot be changed until the next annual Open Enrollment period unless you have a Qualifying Life Event. Open Enrollment generally occurs in November, with changes effective from January 1 to December 31 of the following year.

COMMON LIFE STATUS CHANGES:

- Marriage, divorce, legal separation, birth or adoption
- Death of policy holder or family member
- Change in work status that affects benefits
- Permanent relocation or change in citizenship
- Change in eligibility due to Medicaid or Medicare
- Change in coverage due to spouse's open enrollment

How To Make Benefit Changes.

Employees must notify and provide proof to Human Resources within 30 days of the qualifying life event date. A completed enrollment form must be submited.

TERMINATION OF BENEFITS

Medical, dental, and vision benefits terminate on the last day of the month of your termination date. Life and disability benefits end on your last day of employment.

COBRA Benefits.

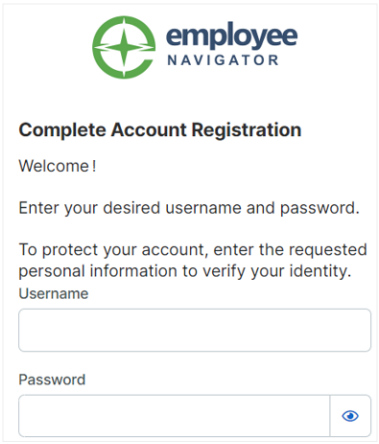
COBRA allows benefit eligible employees to continue their group medical, dental and/or vision benefits for limited periods of time under certain circumstances. It is your responsibility to notify HR within 30 days of a qualifying life event so that COBRA enrollment information can be sent to you. Please refer to the COBRA notice on page 23 for more information.

BENEFITS ELIGIBILITY

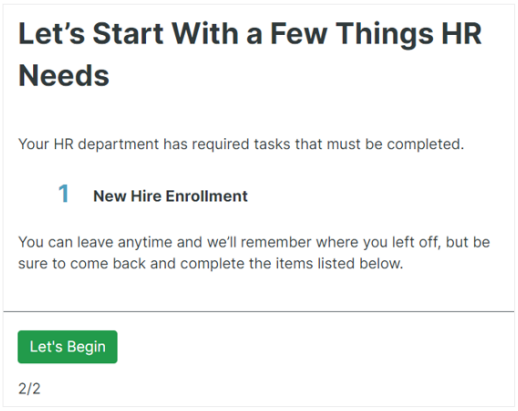
Employee benefits enrollment will occur through Employee Navigator (EN), a web-based tool that allows you to make benefit elections online. It is available 24 hours a day, 7 days a week and should be used as a benefits resource throughout the year. Employees can update demographic information, report qualifying life events, and make eligible benefit changes.

You are required to complete the enrollment process even if you are declining benefits. Enrollment must be completed immediately, or you may not be able to enroll until our next Open Enrollment.

1. You will receive an email directly from Employee Navigator to register your account. The email comes from **noreply@employeenavigator.com**. Click on the link and follow the instructions to setup your username and password. Agree to the Terms and Privacy Policy.

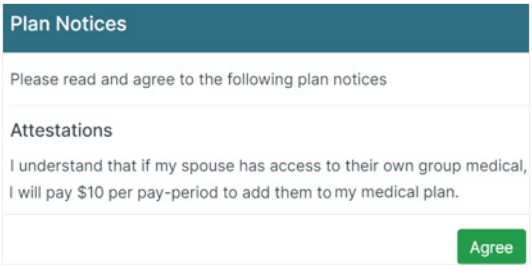


2. Click 'Let's Begin' to complete any assigned onboarding tasks then click 'Start' to begin your enrollment. You may save your enrollment and come back to complete it at a later time, if necessary.



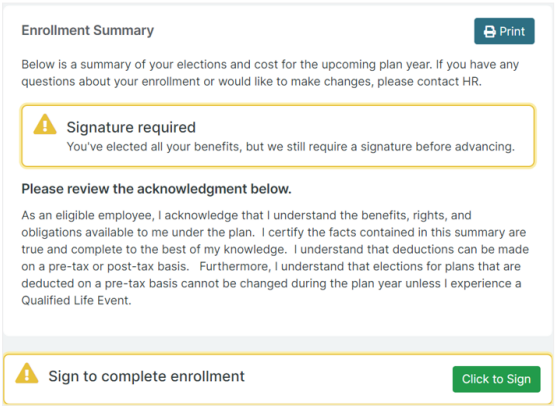
3. Check and update your personal information and add your dependents. You will need their Social Security numbers and dates of birth.

4. Read and sign the mandatory spousal attestation.

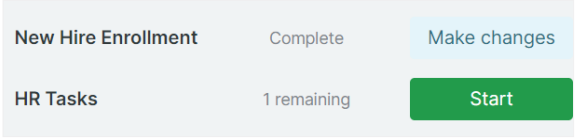


5. Make your benefit elections by following the prompts. Once you have completed all the available benefit elections, you will review a summary screen of your enrollment. Review your elections and make any changes.

6. Print or download a copy for your records then click the green button to electronically sign and complete your enrollment.



7. Employees must complete the Tobacco Attestation form after enrollment. Click "start" under HR Tasks to complete the form and upload a signed copy.



MEDICAL

The City of Milton offers full-time employees two health plan options through Cigna, a Point of Service (POS) plan and a High-Deductible Health Plan (HDHP) with a Health Savings Account (HSA).

CIGNA POS MEDICAL PLAN

The Cigna POS Medical Plan works like a traditional health plan. You will pay copays for some services, such as PCP/Specialist office visits, prescriptions, emergency room and urgent care visits, etc. Hospitalizations or major diagnostic services are subject to the deductible being met first, and then those services are covered at 100%. Once you reach the out-of-pocket maximum, your plan will pay for covered healthcare costs at 100%.

CIGNA HSA MEDICAL PLAN

The HSA Medical Plan is not a copay driven plan. You will pay lower monthly premiums, but you are responsible for paying the negotiated rate between Cigna and the provider/facility until you meet the plan deductible. You are then responsible for 10% coinsurance until you meet the out-of-pocket maximum, at which point your plan will pay for covered healthcare costs at 100%.

Employees that enroll in the HSA Medical Plan are eligible to open a Health Savings Account (HSA) with HealthEquity, which allows you to pay and save for your healthcare using tax free money. As an added benefit, the City will contribute to your HSA.

Availability Of Summary Health Information.

A Summary of Benefits and Coverage (SBC) summarizes important information about coverages in a standard format. The SBC is available on the online enrollment portal and through the carrier's member portal.

CIGNA OPEN ACCESS NETWORK

Both the POS and HDHP plans are Open Access Plans, which means you are not required to choose a Primary Care Provider (PCP) or get referrals to see a Specialist, and in-network preventive care is covered at 100%.

In-Network vs. Out-Of-Network.

Choose a doctor who participates in your plan's network and receive in-network coverage, pay lower out-of-pocket costs, and have less paperwork. In-network providers have agreed to charge lower fees and your plan covers a larger share of the charges.

If an out-of-network provider is used, the amount you pay will be higher. These providers do not have an agreement with Cigna and may bill you for any amount over the maximum allowable fee in addition to any copayment, deductible and coinsurance. Amounts paid over the maximum allowable fee will not apply to your deductible or out-of-pocket limit.

Some out-of-network providers work with in-network hospitals. Cigna will apply the in-network provider copay, deductible and coinsurance to covered expenses received by out-of-network providers. You may have to pay any amount over the maximum allowable fee. You should check if all providers working with in-network hospitals are in-network providers. If you are admitted to the hospital from an out-of-network emergency room, call Cigna to review or seek approval for further care as soon as possible. Otherwise, you may be unaware of additional charges that are your responsibility.

PLAN SUMMARIES	POS PLAN	HDHP PLAN
NETWORK NAME: CIGNA OPEN ACCESS		
In-Network Coverage		
Calendar Year Deductible (Individual / Family) Accrue separately for in and out of network.	$2,500 / $7,500	$3,000 / $6,000 $3,200 (individual within a family)
Out-of-Pocket Maximum (Individual / Family) Includes deductible, coinsurance, and copays.	$6,600 / $13,200	$4,000 / $8,000
Coinsurance (CCD Provider / Other Provider)	100%	90%
Common Benefits – Member Costs		
Preventive Care	No charge, Plan pays 100%	$0; deductible waived
PCP (CCD Provider C / Other Provider)	$25 copay C / $35 copay	10% after deductible
Virtual Visit	$35 copay	10% after deductible
Specialist (CCD Provider C / Other Provider)	$40 copay C / $50 copay	10% after deductible
Urgent Care	$60 copay	10% after deductible
Emergency Room (waived if admitted)	$200 copay	10% after deductible
Inpatient Hospital Services	$0 after deductible	10% after deductible
Outpatient Hospital Services	$0 after deductible	10% after deductible
Therapy Services	$35 copay	10% after deductible
Mental Health / Substance Abuse	$0 after deductible	10% after deductible
Prescription Drug Benefits (Pharmacy Network = *Focused 90*, Pharmacy Formulary / PDL = *Performance 3 Tier*)		
Rx Deductible (Individual / Family)	$150 / $300 (does not apply to Tier 1)	Copays are paid after the medical deductible is met
30-Day Retail: Tier 1 / Tier 2 / Tier 3	$10 / $40 / $75 copay	$15 / $35 / $60 copay
90-Day Retail/Home Delivery: Tier 1 / Tier 2 / Tier 3	$30 / $120 / $225 copay	$45 / $105 / $180 copay
Out-of-Network Coverage		
Calendar Year Deductible (Individual / Family) Accrue separately for in and out of network.	$5,000 / $15,000	$6,000 / $12,000
Out-of-Pocket Maximum (Individual / Family) Includes deductible, coinsurance, and copays.	$19,800 / $39,600	$12,000 / $24,000
Coinsurance (CCD Provider / Other Provider)	70%	70%

This summary should not be considered a full explanation of benefits. The official plan documents, policies, and certificates of insurance govern in all cases.

PRESCRIPTION DRUGS

Cigna provides up-to-date drug lists online so you can see which medications your plan covers. Go to **Cigna.com/PDL** and scroll down until you see a pdf of the Cigna Performance 4-Tier Prescription Drug List. Medications are listed by the condition they treat, then alphabetically within tiers.

PREVENTIVE MEDICATIONS

Preventive medications are used for the prevention of conditions such as high blood pressure, high cholesterol, diabetes, asthma, and more. A prescription is required to process preventive medication claims under your pharmacy plan (including over the counter medications).

Prescription Tips.

- **Free Prescriptions:** Some grocery stores offer a list of antibiotics, high blood pressure and diabetes medications at no cost (restrictions may apply).
- **GoodRx:** GoodRx is a website that helps you find the least expensive prescriptions by giving you pricing information and more cost-effective alternatives. Visit **www.goodrx.com** or download the app!

30-DAY SPECIALTY MEDICATIONS

Specialty medications are used to treat rare and chronic conditions. Cigna specialty medications are limited to a 30-day supply at retail and Cigna HomeDelivery Pharmacy in order to help contain your costs.

CIGNA HOME DELIVERY PHARMACY

Cigna home delivery is for individuals who take prescription medications on a regular basis, such as those used for diabetes, asthma, birth control and more.

- Easy refills plus a reminder service to refill or take your medication available at **Cigna.com/CoachRx.**
- Cigna's free QuickFill service will call or email you when its time to refill your prescriptions.
- Talk to Cigna pharmacists 24/7 at **(800) 285-4812.**

TOBACCO POLICY

The City of Milton recognizes the health risks of tobacco use. Employees who are tobacco free or become tobacco free are rewarded with a discount on Medical benefit premiums. All employees MUST complete an affidavit indicating whether or not you use tobacco products. If you don't already live tobacco free, we encourage you to do so. **If you use tobacco products, you pay an additional $25 per-paycheck for medical benefits.**

TOBACCO CESSATION REIMBURSEMENT

To support employees in their goals to end tobacco use, the City of Milton offers a tobacco cessation reimbursement program. This program reimburses employees tobacco cessation products only.

TOBACCO CESSATION PROGRAMS

Employees who currently use tobacco can refer to several tobacco cessation resources to help you on your journey to quitting. Counseling and support can double your chances of successfully quitting tobacco products. One of the best resources for finding cessation programs designed to meet your total health needs is your Primary Care Pysician. Your PCP can discuss over-the-counter and prescription medications.

As part of the preventive care benefit of your Cigna medical plan, you can get certain FDA approved prescription drugs and many over-the-counter (OTC) nicotine replacement products at no cost to you with a prescription from your physician. Cigna offers free online coaching for nicotine cessation at **myCigna.com**.

Resource List.

- **Georgia Tobacco Quitline:** call **(877) 270-7867** or visit **smokefree.gov**
- **CDC Tobacco Information and Prevention Source (TIPS)**: **cdc.gov/tobacco**
- **E-Cigarettes: e-cigarettes.surgeongeneral.gov**

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Employees enrolled in the Cigna POS medical plan are automatically enrolled in a Health Reimbursement Arrangement (HRA) that is 100% funded by the City of Milton and used to provide employees with reimbursement for qualified medical or prescription expenses incurred by the employee. The HRA is administered by BASIC. For more information, call **(800) 372-3539** or visit **basiconline.com**.

USING YOUR HRA

The City of Milton will fund your HRA in the amount of $500 annually. It can be used to offset the cost of your medical deductible, prescription deductible and medical and pharmacy copays. The HRA does not cover dependents, only employees.

Employees may use their debit card to pay for expenses. The card is programed to identify if the vendor is a medical provider and if the codes are medical in nature. If in the event the card is not able to recognize the charges, you can submit a manual claim for processing.

Deadline For Filing 2023 Claims.

Services must be incurred by December 31, 2023 in order to qualify for reimbursement for the 2023 plan year. File your claims as soon as possible to avoid a delay in processing. The HRA plan has a 90-day runout period for 2023 claims – Basic must receive claims by midnight on March 31, 2024 to qualify for reimbursement.

Claims received after midnight on March 31, 2024 for services incurred in 2023 will be denied. Any balance left in your HRA after the grace period will be forfeited.

BASIC MOBILE APP AND MEMBER PORTAL

BASIC Member Portal.

Create an account on BASIC's Consumer Driven Accounts to manage your HRA.

1. Visit **cda.basiconline.com**.
2. Find 'First time here' under the section that applies to you and select sign up. Follow the instructions.

   NOTE: It is important to use the email address your employer has on file for you. If your email is not recognized, call **(800) 372-3539** for assistance.
3. Once you have signed up, use the sign in function to access your account(s) going forward.

BASIC Benefits App.

The BASIC benefits app allows you to track and manage your account, anywhere at any time. Search for "BASIC benefits" and locate the blue app icon. Use your member portal login credentials to sign in.

HOW TO RECEIVE REIMBURSEMENT

BASIC Card.

The BASIC Card is the preferred and most convenient method to access HRA funds. It automatically pays for and substantiates most eligible expenses at the point of purchase, eliminating the need to submit requests for reimbursement and wait for payment.

Online.

If you pay for an eligible expense out-of-pocket, submit a request for reimbursement online.

1. Sign into your account at **cda.basiconline.com**.
2. On the Overview page select the green box 'Request a Reimbursement'.
3. Enter the requested information about the expense and attach the Explanation of Benefits (EOB).
4. Click 'Next' to review your request, and then 'Submit' reimbursement request. The reimbursement will be deposited into your MyCash account.

Picture to Pay & Pay the Provider.

Both features allow you to pay your provider directly from your benefit account. Do not use this option if you have already paid the bill or your provider.

- **Picture to Pay.** In the BASIC app, click the menu option called Picture to Pay, and a camera will pop up. Take a picture of the invoice, enter the amount you would like to pay the provider and submit.
- **Pay the Provider.** In the online portal, from either the Overview page or the Benefit Accounts page, click 'Pay the Provider', and enter the requested information regarding the expense. Attach your bill then review and submit.

HEALTH SAVINGS ACCOUNT (HSA)

The City of Milton offers employees enrolled in the HDHP medical plan with the option to contribute pre-tax dollars to a Health Savings Account (HSA) to help with out-of-pocket health expenses for you and your qualified dependents. The HSA is administered by HealthEquity. For questions or additional information regarding your Health Savings Account, please call HealthEquity at **(866) 346-5800** or visit **healthequity.com**.

USING YOUR HSA

Refer to your medical benefits summary to determine your annual deductible, coinsurance and copayment amounts, as well as how much of the amount you pay from your HSA will be applied to your deductible. Once you use up the funds in your HSA, you are responsible for deductibles and coinsurance until you reach your out-of-pocket maximum.

You may change your contribution at any time during the plan year as long as you don't exceed the 2024 annual limits set by the IRS.

Your HSA Has Triple Tax Advantages.

1. Contributions are through pre-tax payroll deductions, which lowers your taxable income – you pay taxes on less money.
2. HSAs grow (interest/ investment earnings) tax-free.
3. Withdrawals are tax-free, as long as you use them to pay for eligible health care expenses.

What You Will Receive From HealthEquity.

Employees that enroll in the HDHP medical plan will be mailed a debit card in an unmarked envelope and a Certificate of Coverage detailing your plan benefits.

Employees enrolling in a Health Equity HSA for the first time will also receive a welcome kit 7-10 business days after your enrollment is received, and must visit healthequity.com to authorize the opening of a Health Savings Account on their behalf.

Requirements To Open An HSA.

- You must be covered by a qualified HDHP
- You cannot be covered by any other health insurance
- You cannot be enrolled in Medicare, Tricare or have received any VA health benefits in last three months
- You cannot be claimed as a dependent

2024 ANNUAL HSA CONTRIBUTION LIMITS

The 2024 maximum IRS contribution limits, including employer contributions, are as follows: $4,150 for single coverage, or $8,300 for family coverage. For those age 55 or older, an additional $1,000 catch-up contribution.

Employer HSA Contributions.

The City of Milton makes contributions to employees' Health Savings Accounts.

- Employee Only: $750
- Employee + Spouse or Child(ren): $1,125
- Family: $1,500

HSA Eligible Expenses.

Pay for qualified medical, prescription drug, dental and vision expenses for yourself and your eligible dependents, regardless of their enrollment in the medical plan. A complete list of eligible expenses can be found in Publication 502 on **irs.gov**. Examples include:

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs/teeth
- Chiropractor
- Contact lenses
- Dental treatment
- Diagnostic devices
- Doctor's office visits
- Addiction treatment
- Drugs, prescription
- Eyeglasses & exams
- Eye surgery
- Fertility enhancements
- Hearing aids
- Hospital services
- Laboratory fees
- Long-term Care
- Nursing home
- Physical therapy
- Psychiatric care
- Psychologist
- Speech therapy
- Vasectomy
- Weight-loss programs
- Wheelchair
- Wig
- X-rays

FREQUENTLY ASKED QUESTIONS ABOUT HDHPS AND HSAS

What Is A High Deductible Healthcare Plan (HDHP)?

A HDHP has lower monthly premiums and pays no benefit until the deductible is met. Once the annual out-of-pocket is met, in-network expenses are paid at coinsurance level. Preventive care is covered at 100%.

What Is Health Care Consumerism?

The concept behind health care consumerism is that money saved by living a healthy lifestyle should remain yours instead of going to an insurance company for services you may never use. Health Savings Accounts (HSAs) provide an incentive to save real money— find the lowest cost pharmacy, use over-the-counter treatments when possible, and do things that promote good health like exercise and quitting tobacco.

How Do I Make Deposits To My HSA?

Deposits are made through pre-tax payroll deductions or an initial lump sum deposit at enrollment. You may change your HSA payroll deductions at any time during the plan year.

What's Covered By My HSA?

Medical expenses that you can deduct on your income taxes (Section 213D expenses).

Who Verifies That My HSA Was Used For Qualified Expenses?

Save your receipts. In the event of an IRS audit, you are responsible for providing documentation.

What If I Never Withdraw Funds, Change Jobs, Or Retire?

Money in your HSA accumulates interest and is not forfeited at the end of the year — balances will rollover. HSA funds are portable if you change employers or retire. Funds can be withdrawn for any reason, without penalty once you reach age 65.

Can I Pay For Services That Cost More Than My HSA Balance?

No. Your balance must be sufficient to cover the expense before funds are withdrawn by using your debit card or before submitting the expense for reimbursement.

MEDICAL RESOURCES

CIGNA MEMBER RESOURCES

Your myCigna.com online account and the myCigna app helps you manage your benefits and makes it easy for you to personalize, organize and access your health information on the go.

Website And Mobile App Features.

- View, print or fax your Cigna ID card
- Find in-network doctors and medical services
- See cost estimates for procedures and compare quality-of-care information for doctors and hospitals
- Find retail pharmacies / compare medication costs
- Review coverage and manage and track claims

Register For Your Cigna Member Account.

1. Go to **myCigna.com** and select “Register Now”
2. Enter the requested personal details and confirm your identity with secure information
3. Create a user ID and password
4. Review and submit

CIGNA CARE MANAGEMENT

Cigna offers a comprehensive care management solution for members.

- **Precertification.** Precertification helps you know in advance whether a procedure, treatment or service will be covered under the medical plan and makes sure you get the right care in the right setting
- **Dedicated Care Managers.** Care managers work with members, their families and their doctors. Our approach integrates medical, behavioral, pharmacy, disability, and disease management, all while helping customers maximize their benefits.
- **Outstanding customer support.** Care management is delivered through a multidisciplinary team including a nurse, social worker, medical director, pharmacist and behavioral professional. The right people and resources can help improve your health.
- **Specialty Care Management.** Cigna’s Specialty Care Management programs are designed to help members with complex health issues and feature care managers who are nurses with expertise and training in condition management.

CIGNA DIGITAL ID CARD

Digital ID Cards Go Everywhere You Do.

Cigna members have immediate and secure access to your digital ID cards and proof of coverage anytime you need them, right from myCigna.com or the mobile app.

How To Use Your Digital ID Card.

Download your card to save, share, print, or email to dependents or providers as needed.

1. Log in to **myCigna.com**® or the myCigna® App
2. Click or tap “ID Cards”
3. View cards for yourself and any dependents
4. Save or print ID card(s) to share with your doctor

HEALTHY REWARDS®

Get discounts on wellness programs and services, including weight management, nutrition, nicotine cessation, vision and hearing care. Call **(800) 258-3312** or visit **Cigna.com/rewards** (password: savings).

Active&Fit Direct Program.

Members and their dependents over the age of 18 are eligible to join the Active & Fit gym membership network through the Cigna Healthy Rewards program. Memberships are $28 per month (plus a $28 enrollment fee) and allows you access to multiple local gyms and standard fitness centers in the Active & Fit network, plus digital workout videos. Access premium exercise studios with 20-70% discounts.

Login to **myCigna.com**, choose ‘Wellness’ then click ‘Healthy Rewards-Discount Programs.’

CIGNA VIRTUAL CARE (TELEHEALTH)

Register for a myCigna account to connect with quality board-certified doctors, pediatricians, licensed counselors and psychiatrists. Members can get minor medical virtual care 24/7/365 from anywhere via video or phone or schedule a behavioral/mental health virtual care appointment online in minutes.

Virtual Medical Care.

Board-certified doctors/pediatricians can diagnose, treat and prescribe medications for minor medical conditions. To connect with an MDLIVE virtual provider, visit myCigna.com and click on the 'Talk to a doctor' callout. Medical conditions include:

- Allergies
- Asthma
- Bronchitis
- Cold / flu
- Diarrhea
- Earaches
- Fever
- Headaches
- Joint aches
- Nausea
- Pink eye
- Rashes
- Shingles
- Sinus infections
- Skin infections
- Sore throats

Virtual Behavioral Health Care.

Licensed counselors and psychiatrists can diagnose, treat and prescribe medications for certain nonemergency conditions. To locate a Behavioral Health provider, visit **myCigna.com**, go to 'Find Care & Costs' and enter 'Virtual counselor' under 'Doctor by Type,' or call the number on the back of your Cigna ID card. Behavioral Health conditions can include:

- Addictions
- Depression
- Grief/Loss
- Stress
- Trauma/PTSD
- Eating disorders
- Panic disorders
- Bipolar disorders
- Parenting issues
- Relationship issues

Schedule An Appointment.

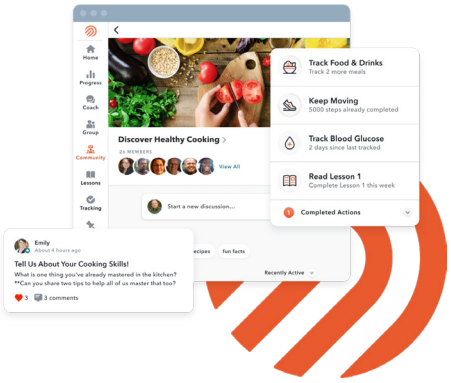
To access MDLIVE, login into **myCigna.com** and click 'Talk to a doctor' or call MDLIVE at **(888) 726-3171**.

OMADA- DIABETES PREVENTION PROGRAM

Omada is a digital lifestyle program that inspires healthy habits though technology and support programs. The goal is to help you accomplish the changes that matter most in the areas of eating, activity, stress, and sleep. Omada features include:

- Interactive program to guide your journey
- Wireless smart scale to monitor your progress
- Weekly online lessons to empower you
- Professional Omada health coach for added support
- Small online peer group to keep you engaged

Omada is available at no additional cost if you or your covered adult dependents are enrolled in one of the Cigna medical plans, are at risk for diabetes or heart disease, and are accepted into the program.



IDENTITYFORCE THROUGH CIGNA

IdentityForce offered through Cigna is included in your Cigna medical coverage at no additional cost for you and children living in your household up to age 26.

IdentityForce proactively monitors the Dark Web, credit reports, and real-time fraud issues, and will help fix compromises to your personal information, ensuring your identity is restored.

IdentityForce Plan Features.

- Bank and credit card activity alerts
- Data breach notifications / Fraud monitoring
- Smart SSN Tracker (SSN monitoring)
- Medical ID fraud protection
- Credit freeze and lock assistance
- Stolen funds replacement
- Pre-existing Identity Theft Restoration

To enroll, visit **cigna.identityforce.com/starthere** or call **(833) 580-2523.** Members who have provided their email on **myCigna.com** will receive a registration link.

BEHAVIORAL HEALTH

Your mental heath is an important part of overall health. There are many resources for help at your fingertips.

GINGER

Integrated mental healthcare services are available to Cigna members through the Ginger Emotional Support App. Members receive 30 days of unlimited behavioral health coaching. Cigna Members receive the following services with the Ginger App:

- **Text-based emotional support coaching.** Ginger coaches are available anytime, 24/7/365.
- **Skill-building activities.** Activity cards are clinically-validated exercises that help you practice life skills. The personalized, interactive content is accessible anytime in the app and supports the work members may do during sessions with a coach.
- **Check-ins and progress.** A check-in is where you answer a few multiple choice questions about how you've been feeling. Members can track progress over time and adjust the care plan summary of their results in their personal dashboard. The member care team can use the dashboard to track progress and adjust the care plan.

TALKSPACE

Talkspace is a digital space for private and convenient mental health support for Cigna members. Choose a dedicated therapist and/or prescriber from a list of licensed providers and receive support day and night from the convenience of your device.

Talkspace's clinical network features thousands of licensed, insured, and verified clinical professionals with specialties including:

- Anxiety
- Chronic Issues
- Depression
- Eating Disorders
- Grief
- Healthy Living
- Identity Struggles
- Relationships
- Trauma
- Sleep
- Stress
- Substance Use

Contact Talkspace.

Visit **talkspace.com/cigna** and complete the Quick Match™ survey to receive your personalized provider matches. Choose a provider to begin your journey.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

City of Milton cares about the health and well-being of its employees and their family members, and recognizes that a variety of issues can disrupt their personal and work lives. The City provides access to two Employee Assistance Programs (EAP) that offers support, guidance and resources to help you and your family resolve personal issues.

UNUM EAP

Your Unum EAP is designed to help you lead a happier and more productive life at home and at work. Unum's EAP services are available to all eligible partners and employees, their spouses or domestic partners, dependent children, parents and parents-in-law. To access Unum's EAP services call **(800) 854-1446** or visit **unum.com/lifebalance.**

Licensed Professional Counselor

Call for confidential access to a Licensed Professional Counselor. You can get up to three visits at no additional cost to you for the following issues, and more:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems

Work/Life Balance.

Our Work/Life Specialists can help by answering your questions and can help you find resources in your community about:

- Child care and elder care
- Financial services, debt management, credit issues
- Identity theft
- Legal questions
- Reducing your medical/dental bills

FEI EAP

Our EAP is a company paid benefit that provides a variety of services designed to support the overall wellbeing of you and your household members. When problems and stressors in life start to interfere with your family, your job, and your peace of mind, the EAP can help.

The EAP provides up to six sessions per issue of short-term counseling, up to six sessions per year of life coaching, financial and legal consultation, referrals for elder and childcare, Personal Assistant services, and Medical Advocacy. These services are confidential, and available to you and your family members at no cost to you.

For more information or to access services, contact the EAP by phone at **(800) 824-4327** or though the Member Portal at **myassistanceprogram.com/fei code: milton**. The Member Portal has additional resources, including personal assessments, online courses, resource locators, and a discount marketplace.

HOW TO SAVE MONEY WITH CIGNA

With healthcare costs continuing to rise, it's more important than ever to be conscious of how much you are paying for the care you receive. Becoming an educated healthcare consumer is a great way to help you manage your out-of-pocket healthcare expenses.

Cigna has the tools and support you need to help you find a quality in-network doctor near you, including 24/7 live customer service, plus a host of valuable resources to help you manage and track claims, and compare cost and quality information. Cigna tools are accessible through **myCigna.com** or with the free myCigna mobile App.

STAY ON TOP OF PREVENTIVE CARE

What Is Preventive Care?

Preventive care is a group of services recommended when you don't have any symptoms and haven't been diagnosed with a related health issue. It includes your periodic wellness exam (check-up) and specific tests, certain health screenings, and most immunizations. You and your health care provider will decide what preventive services are right for you, based on your age, gender, personal health history, and current health.

Why Do I Need Preventive Care?

Preventive care can help you detect problems at early stages when they may be easier to treat, and can help you prevent certain illnesses and health conditions from happening. Getting your preventive care at the right time can help you take control of your health.

Which Preventive Services Are Covered?

Many plans cover preventive care at no additional cost to you when you use a health care provider in your plan's network. Use the provider directory on myCigna.com for a list of in-network health care providers and facilities.

FIND THE BEST PROVIDERS

Doctors With The Cigna Care Designation.

To be awarded the Cigna Care Designation, doctors in 21 different medical specialties are assessed for quality and cost efficiency, since quality care doesn't have to mean higher costs. Use the myCigna online directory to find top-performing doctors shown with the Cigna Care Designation symbol .

Hospitals With A Center of Excellence Designation.

In-network hospitals that demonstrate better health outcomes at lower costs for specific conditions earn our top rating of Cigna Centers of Excellence .

STAY IN-NETWORK

Costs will be lower if you choose to see doctors, hospitals and facilities in Cigna's network. When you are scheduled for surgery, ensure that the surgeon, anesthetist, and facility are all In-Network. Before you visit any provider or facility, we recommend you call ahead to be sure they are in your plan's network, as well as confirm their address, office hours, and that they are accepting new patients. myCigna and Cigna One Guide can help you stay in-network, maximize savings, and avoid any surprises.

Search For An In-Network Provider.

Cigna's provider directory shows you results based on your health plan network and your location.

1. Log in to **myCigna.com** and select the 'Find Care & Costs' Tab
2. Find care and cost estimates in your area by 'Primary Care, Doctor by Type, Doctor by Name, Reason for Visit or Locations'
3. Select 'Doctor by Type' and enter a specialty or type of doctor

THE VALUE OF IN-NETWORK LABS

Save Money By Using An In-Network Lab.

Cigna's network includes national labs like LabCorp or Quest as well as regional and local labs. Find in-network labs in your area by using the Cigna directory.

In-network labs can provide general and specialty laboratory and pathology testing in locations that are convenient and cost-effective. You have a choice when it's time for lab tests, like blood work. Labs in Cigna's network give you quality service at a lower cost. If you need lab tests, tell your doctor you want to stay in-network. Even if samples are taken in the doctor's office, you can ask for them to be sent to an in-network lab.

FIND THE MOST COST EFFECTIVE RX

When you fill a prescription at an in-network pharmacy, what you pay depends on your cost-share for the medication and your annual deductible. If you're enrolled in a Health Reimbursement Account (HRA) or Health Savings Account (HSA) plan through Cigna, you may be able to use your funds to help pay for your eligible out-of-pocket expenses.

Ways To Spend Less On Medication.

- **Buy generic.** You usually have a choice between a brand name medication and its generic equivalent. Generics offer the same strength and active ingredients as the brand name medication but often cost much less. Check options with your provider.
- **Compare drug costs at different pharmacies.**
  1. Login to myCigna.com
  2. Select the 'Prescriptions' Tab then click 'Price a Medication'
  3. Enter/select a drug name, form/dosage, quantity, frequency and duration
  4. Get cost estimates
- **90-Day Prescriptions.** Ask your doctor about getting a 90-day (three-month) supply of your prescription. 90-day prescriptions may be filled using Cigna Home Delivery Pharmacy or select in-network retail pharmacies. To start using home delivery:
  1. Login to **myCigna.com** or the myCigna App
  2. Select the 'Prescriptions' tab then select 'My Medications' from the dropdown menu
  3. Click the button next to your medication name to move your prescription(s)

LOOK FOR THE BEST OUTPATIENT FACILITIES

Diagnostics such as MRI, CT and PET scans can cost much less at some facilities. Make a more informed choice about where you receive services. Call Cigna at **(866) 494-2111** and get cost comparisons for hundreds of procedures.

The myCigna provider directory can show you the costs of services within your location.

1. Login to **myCigna.com** and select the 'Find Care & Costs' Tab
2. Find care and cost estimates in your area by selecting one of these options: 'PrimaryCare, Doctor by Type, Doctor by Name, Reason for Visit or Locations'

ACCESS CARE IN THE RIGHT SETTINGS

Deciding whether to see a doctor, go to urgent care, or use another option can be difficult. When your life or health is in serious danger, there's only one option — the emergency room. When a situation isn't life-threatening but still needs immediate care, there are options that can be more convenient, appropriate, and less expensive.

- Go to an **Urgent Care Center** for conditions that should be looked at right away, but aren't as severe as emergencies. Doctors in an urgent care often do X-rays, labs, and stitches.
- Visit a **Retail Health Clinic** for medical professionals who provide basic medical care. These clinics are almost always located in retail stores, supermarkets and pharmacies.
- Use **Cigna Virtual Care** to get care for minor and acute conditions. Virtual visits with MDLIVE usually cost less than going to an urgent care clinic, and significantly less than an emergency room.

Cigna Health Information Line.

This service, staffed by nurses, helps you understand and make informed decisions about health issues you are experiencing, at no extra cost. It can help you choose the right care in the right setting at the right time, whether it's reviewing home treatment options, following up on a doctor's appointment, or finding the nearest urgent care center. For assistance, call the Cigna Health Information Line at **(800) 244-6224**.

DENTAL

The City of Milton provides full-time employees and their eligible dependents with a dental plan through Cigna.

Routine dental care does more than brighten your smile. Research shows that receiving regular dental care can help detect minor problems before they become major and expensive to treat. Routine dental exams can help catch serious health problems, such as diabetes, leukemia, heart disease and kidney disease. In fact, some diseases produce oral signs and symptoms. A healthier mouth may help you have a healthier life.

TOTAL CIGNA DENTAL PPO NETWORK

The Total Cigna Dental PPO (DPPO) network makes it easy to protect your health and your smile with the right dental care at the right price. You can visit any dentist with this plan. Members receive two routine cleanings and exams per year at no charge.

In-Network Dental Care.

Selecting a dental provider in Cigna's Total DPPO Network will save you money. Your plan covers in-network preventive services at 100%. While there is no deductible for preventive services, these do count towards your annual maximum benefit. To find an in-network Cigna dental provider, call **(866) 494-2111** or visit **myCigna.com**.

Out-Of-Network Dental Care.

Cigna pays all out-of-network claims based on the 90th UCR – they will look at what 9 out 10 dentists in your area are charging, and pay claims based on that amount. If you see an out-of-network dentist, you are responsible for paying all charges that Cigna does not cover.

DENTAL PLAN SUMMARY		
NETWORK: TOTAL CIGNA DPPO	**IN-NETWORK**	**OUT-OF-NETWORK**
Reimbursement Level	Based on contracted fees	90th UCR
Calendar Year Deductible (family / individual)	$50 / $150	$50 / $150
Maximum Annual Benefit (per individual per year)	$1,500	$1,500
Class I: Preventive and Diagnostic Care Exams, Cleanings, X-rays, Fluoride Application, Sealants, Space Maintainers, Emergency Pain Relief	100%; no deductible	80%; no deductible
Class II: Basic Restorative Care Fillings, Oral Surgery, Surgical Extraction - Impacted Teeth, Anesthetics, Periodontics, Root Canal Therapy/Endodontics, Relines, Rebases, and Adjustments, Brush Biopsy	80% after deductible	60% after deductible
Class III: Major Restorative Care Bridges, Dentures, Inlays, Onlays, Crowns, Surgical Extractions, Repairs - Bridges, Dentures, Inlays, Crowns	50% after deductible	50% after deductible
Class IV: Orthodontia (eligible adults and children)	50%; no deductible	50%; no deductible
Orthodontia Lifetime Maximum	$1,500	$1,500
Class IX: Implants	50% after deductible	50% after deductible

This summary should not be considered a full explanation of benefits. The official plan documents, policies, and certificates of insurance govern in all cases.

VISION

The City of Milton provides full-time employees and their eligible dependents with a vision plan through VSP.

Comprehensive eye exams can help your doctor test your vision and spot the early stages of eye disease and other health conditions. As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VSP NETWORK

Save on eyewear and eye care when you see a VSP network doctor and take advantage of Exclusive Member Extras for additional savings. Visit **vsp.com/offers**.

VSP Providers.

It's easy to find a nearby in-network doctor or retail chain Maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations. Prefer to shop online? Use your vision benefits on Eyeconic®—the VSP preferred online retailer.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

VSP Value And Member Savings.

- **Glasses and Sunglasses.**
  - Extra $20 to spend on featured frame brands.
  - 30% savings on additional glasses/sunglasses, and lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or 20% savings from any VSP provider within 12 months of your last Exam.
- **Retinal Screening.** No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.
- **Laser Vision Correction.** Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

OUT-OF-NETWORK COVERAGE

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

VISION PLAN SUMMARY	
NETWORK: EYEMED VISION	**IN-NETWORK**
Eye Exam (once every 12 months)	$10 copay
Primary Eyecare (medical/urgent eyecare)	$20 copay
Prescription Glasses (once every 12 months)	
Frames	$30 copay; up to $130 allowance , then 20% off balance $70 Walmart®/Costco® frame allowance
Standard Lenses • Single Vision/Lined Bifocal/Lined Trifocal	$30 copay
Lens Enhancements • Std. Progressive, Tints/Photochromic Adaptive • Premium Progressive • Custom Progressive	 $0 $80 - $90 $120 - $160
Contact Lenses (in lieu of glasses) • Contact Lens Exam	$130 allowance (no copay) up to $60
Lasik Vision Correction	15% off retail price or 5% off of promotional price

This summary should not be considered a full explanation of benefits. The official plan documents, policies, and certificates of insurance govern in all cases.

FLEXIBLE SPENDING ACCOUNTS

The City of Milton offers employees the option to enroll in two types of Flexible Spending Accounts (FSA) administered by BASIC. Fund your FSA through pre-tax payroll deductions and pay for qualified health or dependent care expenses expenses using a debit card at the time of service or by submitting a receipt for reimbursement.

The annual contribution limit for the Health Care FSA is projected to increase from $3,050 to $3,200. The Dependent Care FSA maximum per the IRS will remain $5,000. Your plan selections will remain in effect through December 31, 2024.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HFSA)

A Healthcare FSA (HFSA) pays for qualified medical, dental, and vision expenses for you and your dependents.

- Only $610 in HFSA funds can be rolled over from 2023; all other funds in your HFSA will be forfeited.
- Access your full annual contribution at anytime during the plan year for expenses incurred during the year.
- You cannot change your annual contribution during the plan year unless you have a qualifying life event.

Healthcare FSA Eligible Expenses.

For a list of eligible expenses and exclusions, please visit **fsastore.com/fsa-eligibility-list**.

- Medical plan copays and deductible
- Prescription drug expenses
- Tobacco cessation programs
- Infertility treatment
- Psychology/psychoanalysis expenses
- Dental and orthodontia expenses

Unused Funds.

If you have HFSA funds remaining at the end of the plan year, consider using those funds in the following ways:

- Stock up on over-the-counter (OTC) drugs.
- Pay for expenses that you have put off , such as a dental cleaning or a medical screening/procedure.
- Buy a spare set of eyeglasses or contact lenses.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

A Dependent Care Flexible Spending Account (DCFSA) pays for qualified child care or elder care expenses.

About Your Dependent Care FSA.

- Your unused balances do not carry over and cannot be refunded (Use-it-or-lose-it).
- You ONLY have access to funds that have been withheld from your paycheck. If you submit receipts for a higher amount, you will be reimbursed as future payroll deductions are deposited into your account
- The deadline for submission of manual claims is 90 days after the end of the plan year.

Dependent Care FSA Eligible Expenses.

- Care at a licensed nursery school or daycare facility.
- Before/ after school care for children 12 and under.
- Day camp expenses, Nannies and Au Pairs.

Dependent Care FSA Ineligible Expenses.

- Services provided by a family member.
- Overnight camps.
- Babysitting costs when you or your spouse are not working or at school.
- Tuition expenses for school or late payment fees.

How To Plan Ahead.

Contributing too much money to your FSA may not benefit you if you have to spend money on unnecessary expenses or fail to spend the money at all. To allocate an appropriate amount to your FSA, you should:

- Look at your past expenses and determine what your average out-of-pocket medical expenses have been.
- Consider if the following year will bring any big life changes such as a marriage, divorce, or a new baby.
- Visit **fsastore.com/fsa-calculator** to determine how much money you should allocate to your FSA.

Important Rules Regarding FSAs.

- Accounts are separate and you cannot co-mingle funds.
- You must enroll in the FSA annually. Your election from last year will not automatically carry over to the new plan year.

LIFE AND AD&D

Life insurance provides a lump sum cash benefit to beneficiaries to help with immediate expenses and adjust to the loss of income related to the death of a wage earner. Accidental Death & Dismemberment (AD&D) insurance can help protect families from financial hardship by paying a benefit upon death or serious injury due to a covered accident.

BASIC LIFE AND AD&D

City of Milton provides all eligible full-time employees with company paid Basic Life and AD&D through Unum at no cost. Employees receive a Basic Life benefit of up to 3x annual earnings up to a maximum of $550,000, and AD&D benefits of 3x annual salary plus $50,000.

BASIC LIFE AND AD&D SUMMARY			
COVERAGE	**LIFE**	**AD&D**	**AGE REDUCTION**
Employee	3x annual salary, up to $550,000	3x annual salary plus $50,000	65% at 65 / 50% at 70

VOLUNTARY LIFE AND AD&D

The City of Milton provides eligible full-time employees with the opportunity to purchase additional Life and AD&D coverage through Unum. You must purchase employee coverage to be able to purchase dependent coverage. Dependents are covered up to age 19 or to age 26 if they are full time student.

Evidence Of Insurability.

Unum requires Evidence of Insurability (EOI) in order to purchase insurance above the Guaranteed Issue (GI) amount of $100,000. If you or your dependents have medical conditions that make it difficult to purchase life insurance on your own, you should consider applying for life insurance when you are hired. EOI involves completing a medical questionnaire and receiving carrier approval before your insurance takes effect.

A “Living” Benefit.

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to $250,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Waiver Of Premium.

Your cost may be waived if you are totally disabled for a period of time.

Portability.

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

VOLUNTARY LIFE AND AD&D SUMMARY			
COVERAGE	**INCREMENTS**	**BENEFIT**	**GUARANTEED ISSUE**
Employee	$1,000	5x annual salary up to a maximum of $500,000	$100,000
Spouse	$1,000	Up to 100% of employee benefit or $500,000	$25,000
Child(ren)	$1,000	$10,000	All amounts

DISABILITY

If an illness or injury should occur, you may need more than just health coverage. Group disability insurance can help pay part of your covered earnings when you can't work for a period of time due to a covered illness or injury.

SHORT-TERM DISABILITY (STD)

The City of Milton pays the full cost of Short-Term Disability insurance for all eligible full-time employees.

STD insurance provides income continuation for a short period of time if you are ever unable to work due to a non-work related accident or illness.

LONG-TERM DISABILITY (LTD)

The City of Milton pays the full cost of Long-Term Disability insurance for all eligible full-time employees.

LTD insurance provides income continuation in the event you will be out of work for a long period of time due to covered injury or illness.

DISABILITY SUMMARIES		
	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Benefit Percentage	66% of weekly earnings up to $2,500	60% of monthly income up to $7,500
Benefit Duration	Up to 16 weeks	Age 65 or SSNRA
Benefit Waiting Period	7 days after qualifying accident or illness	120 days after qualifying accident or illness

AFLAC

PERSONAL ACCIDENT INDEMNITY PLAN

Aflac's Personal Accident Indemnity Plan provides benefits for a covered person's death, dismemberment, or injury caused by a covered accident that occurs on or off the job. This policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date. The plan also provides the fixed dollar benefit that Aflac wilol pay for various types of emergency treatment directly related to an accident as described below:

- $120 once per 24-hour period when a covered person receives treatment by a physician or in a hospital emergency room for injuries sustained in a covered accident.
- $25 for one follow-up treatment per day, up to a max. of six treatments per covered accident, per covered person.
- $1,000 when a covered person is confined to a hospital for at least 24 hours for injuries sustained in a covered accident (payable once per confinement). If admitted directly to an intensive care unit, Aflac will pay $1,500.
- $200/day for which a covered person is charged for a room for hospital confinement of at least 18 hours for treatment of injuries sustained in a covered accident, payable for up to 365 days per covered accident, per covered person.
- Additional $400/day for each day a covered person is receiving the Accident Hospital Confinement Benefit and is confined to and charged for a room in an ICU (payable for up to 15 days per covered accident, per covered person).
- A fixed benefit is also payable for major diagnostic exams, physical therapy, rehabilitation unit services, medical appliances, prosthesis, blood or plasma, ambulance, and family lodging. Plan also includes a $60 wellness benefit per year per policy.

LUMP SUM CRITICAL ILLNESS AND CANCER PLAN

Aflac's Critical Illness policy provides specified health event coverage for critical illnesses, including cancer. The plan pays a $10,000 to $30,000 First Time Occurrence Benefit to employees and their spouse if enrolled.

- Covered specific Critical Illnesses include cancer, paralysis, Heart Attack, Stroke, Major Organ Transplant, and End Stage Renal Failure. Carcinoma in Situ and Coronary Artery Bypass Surgery are covered at 25% of the insured amount.
- Additional Occurrence and Re-Occurrence Benefits are also included.

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

An unplanned visit to the hospital could leave you with unexpected medical bills. Aflac pays you cash to help with the expenses not covered by health insurance, such as out-of-pocket expenses associated with doctor visits, hospitalizations, and mental health treatment, including counseling and urgent care, so you can worry less about making ends meet when you're left with unexpected medical bills.

The Hospital Basic Plan is guaranteed issue with no health questions. Please note that pregnancy is covered after the 10 month elimination period following the plan effective date of 1/1/2024.

Aflac Hospital Basic Plan.

- $2000.00 for any hospitalization admittance for 23 hours or more, payable once per calendar year.
- $100 a day up to 15 days for confinement in a rehabilitation facility. Limited to 30 days per calendar year.
- $100 for treatment in a hospital emergency room. Limited to 2 payments per calendar year.
- $100 for Hospital Short-Stay (stay of less than 23 hours of confinement). Limited to 2 payments per calendar year

BI-WEEKLY BENEFITS COSTS (26 PAY PERIODS) – NON-TOBACCO USER				
BENEFIT	**EMPLOYEE ONLY**	**EMPLOYEE + SPOUSE**	**EMPLOYEE + CHILD(REN)**	**FAMILY**
HDHP Medical[+]	$0.00	$48.48	$43.86	$69.25
POS Medical*[+]	$37.00	$77.70	$70.30	$110.99
Dental	$0.00	$9.76	$11.04	$14.09
Vision	$0.00	$1.50	$1.53	$2.46
Short-Term Disability	100% Employer Paid	*N/A*	*N/A*	*N/A*
Long-Term Disability	100% Employer Paid	*N/A*	*N/A*	*N/A*
Basic Life/AD&D	100% Employer Paid	*N/A*	*N/A*	*N/A*
Supplemental Life/AD&D	Refer to the Supplemental Life and AD&D rate chart below.			

BI-WEEKLY BENEFITS COSTS (26 PAY PERIODS) – TOBACCO USER				
BENEFIT	**EMPLOYEE ONLY**	**EMPLOYEE + SPOUSE**	**EMPLOYEE + CHILD(REN)**	**FAMILY**
HDHP Medical[+]	$25.00	$73.48	$68.86	$94.25
POS Medical*[+]	$62.00	$102.70	$95.30	$135.99

* Employees enrolled in the POS Medical Plan will receive $500 per calendar year in a Health Reimbursement Arrangement (HRA).

[+] Spousal Surcharge - Employees who choose to cover their spouse may be subject to an additional $10 per pay period. See page 3 for details.

EMPLOYER CONTRIBUTION IF DECLINING COVERAGE	
Declining Medical and Dental Coverage: $2,400	**Declining Medical Coverage Only:** $1,800

SUPPLEMENTAL LIFE MONTHLY RATES PER $1,000 IN COVERAGE										
EMPLOYEE AGE	**<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**
Non-Tobacco User Rate	$0.080	$0.090	$0.120	$0.160	$0.220	$0.360	$0.560	$0.910	$1.460	$2.570
Tobacco User Rate	$0.120	$0.140	$0.180	$0.260	$0.400	$0.640	$1.080	$1.520	$2.280	$3.910

SUPPLEMENTAL CHILD LIFE MONTHLY RATES					
BENEFIT	**$2,000**	**$4,000**	**$6,000**	**$8,000**	**$10,000**
Rate	$0.320	$0.640	$0.960	$1.280	$1.600

SUPPLEMENTAL AD&D MONTHLY RATES	
Rate Per $1,000	$0.020

Calculate Voluntary Life and AD&D Premiums.

1. **Monthly Life Benefit Cost:** find the rate for your age. Multiply the rate by the benefit amount you want. Divide that number by the rate increment ($1,000).
2. **Monthly AD&D Benefit Cost:** Repeat the steps above if your are electing AD&D coverage.
3. **Total Monthly Cost:** Add Life and AD&D costs together for your total monthly cost.
4. **Per Pay Period Cost:** multiply the total monthly cost by 12, then divide by the number of pay periods (26).

Example: Employee, age 42 and a non-tobacco user, wants $100,000 in Life and AD&D coverage.

1. **Monthly Life Benefit Cost:** ($0.220 x $100,000) / $1,000 = **$22**
2. **Monthly AD&D Benefit Cost:** $0.020 x $100,000 / $1,000 = **$2**
3. **Total Monthly Cost:** $22 + $2 = **$24**
4. **Per Pay Period Cost:** $24 x 12 / 26 = **$11.08**

REQUIRED NOTICES

COBRA CONTINUATION COVERAGE RIGHTS

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA can become available to you and other members of your family when group health coverage would otherwise end. For information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Employment ends for reason other than gross misconduct.
- Hours of employment are reduced

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse becomes entitled to Medicare benefits
- You become divorced/legally separated from your spouse
- Your spouse's employment ends for any reason other than his or her gross misconduct

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies
- The parent-employee's work hours are reduced
- The parent-employee becomes entitled to Medicare
- The parents become divorced or legally separated
- The parent-employee's employment ends for reasons other than gross misconduct;
- The child stops being eligible for coverage under the Plan as a "dependent child"

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The death of a covered employee
- Termination or a reduction in the hours of a covered employee's employment

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your HR Department.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA. Covered employees may elect COBRA on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Disability extension of 18-month period of COBRA: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA and must last at least until the end of the 18-month period of COBRA.

- The end of employment or reduction of hours
- Death of the employee
- Commencement of a proceeding in bankruptcy with respect to the employer
- The employee's becoming entitled to Medicare benefits

Second qualifying event extension of 18-month period of COBRA: If your family experiences another qualifying event during the 18 months of COBRA, the spouse and dependent children in your family can get up to 18 additional months of COBRA, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA if the employee or former employee dies; becomes entitled to Medicare benefits; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child.

This extension is only available if the second qualifying event would have caused the spouse/dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Instead of enrolling in COBRA, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA. Learn more about options at **healthcare.gov**.

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Part A or B, beginning on the earlier of:

- The month after your employment ends
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA and later enroll in Medicare Part A or B before the COBRA ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit **medicare.gov/medicare-and-you**.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **dol.gov/ebsa**.

Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For information about the Marketplace, visit **healthcare.gov**.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

HIPPA NOTICE OF PRIVACY PRACTICES REMINDER

Your employer would like to communicate the availability of its Notice of Privacy Practices. At any time, a copy may be obtained by contacting your HR Department.

HIPPA Special Enrollment Right.

Loss of Other Coverage: If you have declined or will decline enrollment for yourself and/or your dependents because of other in-force health plan coverage, you may be able to enroll yourself and/or your dependents in this plan in the future.

If you/your dependents lose eligibility for that other coverage, or if the employer stops contributing towards other group health plan coverage, it may trigger a special enrollment right.

You must request enrollment in this plan within 30 days after the other coverage ends. You will be required to submit proof of prior coverage, such as a coverage termination letter from an insurance company or employer.

New Dependent: If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependents. This triggers a special enrollment right. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. You will be required to submit proof of a newly eligible dependent, such as a marriage certificate or birth certificate.

Termination of Medicaid or CHIP Coverage: If you and/or your dependents are covered under a Medicaid plan or a state child health insurance plan (CHIP), and coverage under such a plan is terminated as a result of loss of eligibility, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right. To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date Medicaid or state-sponsored CHIP coverage ends.

Eligibility for Premium Assistance Under Medicaid or CHIP: If you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right. This is usually a program where the state provides employed individuals with premium payment assistance for their employer's group health plan, rather than direct enrollment in a state Medicaid program. To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

This law requires group health plans providing coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The law mandates that a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed
- prostheses
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient and is subject to the same annual deductibles and coinsurance provisions applicable to the mastectomy. For questions about coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your medical ID card.

MEDICARE PART D DISCLOSURE NOTICE

Notice about your Prescription Drug Coverage and Medicare: Please read this notice carefully and keep it where you can find it. This notice has information about our company's group health plan prescription drug coverage, and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. Our company's group health plan is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage will pay, and is considered "creditable coverage." Because our plan is considered creditable coverage, you can enroll and/or stay enrolled in our plan, and not pay a higher premium if you later decide to join a Medicare drug plan.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Individuals may enroll in a Medicare prescription drug plan when they first become eligible for Medicare, and each year from October 15th through December 7th, the annual Medicare Open Enrollment Period, with coverage effective on January 1st. Individuals leaving a group health plan during other times of the year may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you may not be able to get this coverage back. See below for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with your employer's group health plan and do not enroll in Medicare prescription drug coverage within 63 days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63+ days without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may always be at least 19% higher than the regular premium. You will have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare Open Enrollment Period to enroll.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail from Medicare every year. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places: Visit **medicare.gov**; Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help call **(800) 633-4227**. TTY users should call **(877) 486-2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **socialsecurity.gov**, or call **(800) 772-1213**; TTY **(800) 325-0778**.

Our company's group health plan is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage will pay, and is considered creditable coverage.

MICHELLE'S LAW

Michelle's Law generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year. See your plan documents for additional details or contact Human Resources for assistance.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(877) 543-7669** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **(866) 444-3272**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: **http://myalhipp.com**/
Phone: (855) 692-5447

ALASKA – Medicaid
The AK HIPP Program Website: **http://myakhipp.com/**
Phone: (866) 251-4861
Email: **CustomerService@MyAKHIPP.com**
Medicaid: **health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid
Website: **http://myarhipp.com/**
Phone: (855) 692-7447

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: **http://dhcs.ca.gov/hipp**
Phone: (916) 445-8322
Fax: (916) 440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: **healthfirstcolorado.com/**
Member Contact Center: (800) 221-3943 / State Relay 711
CHP+: **colorado.gov/pacific/hcpf/child-health-plan-plus**
CHP+ Customer Service: (800) 359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI): **colorado.gov/pacific/hcpf/health-insurance-buy-program**
HIBI Customer Service: (855) 692-6442

FLORIDA – Medicaid
Website: **flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: (877) 357-3268

GEORGIA – Medicaid
HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: (678) 564-1162, Press 1
CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults: **in.gov/fssa/hip/**
Phone: (877) 438-4479
All other Medicaid Website: **in.gov/medicaid/**
All other Medicaid Phone: (800) 457-4584

IOWA – Medicaid
Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: (800) 338-8366
Hawki Website: **http://dhs.iowa.gov/Hawki**
Phone: (800) 257-8563
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: (888) 346-9562

KANSAS – Medicaid
Website: **https://www.kancare.ks.gov/**
Phone: (800) 792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: (855) 459-6328
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**
Phone: (877) 524-4718
Kentucky Medicaid Website: **https://chfs.ky.gov**

LOUISIANA – Medicaid
Website: **medicaid.la.gov** or **ldh.la.gov/lahipp**
Medicaid Hotline: (888) 342-6207
LaHIPP: (855) 618-5488

MAINE – Medicaid
Website: **maine.gov/dhhs/ofi/applications-forms**
Phone: (800) 442-6003 / TTY: Maine relay 711
Private Health Insurance Premium
Website: **maine.gov/dhhs/ofi/applications-forms**
Phone: (800) 977-6740 / TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: **mass.gov/masshealth/pa**
Phone: (800) 862-4840 / TTY: (617) 886-8102

MINNESOTA – Medicaid
Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: (800) 657-3739

MISSOURI – Medicaid
Website: **dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: (573) 751-2005

MONTANA – Medicaid
Website: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: (800) 694-3084
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid
Website: **ACCESSNebraska.ne.gov**
Phone: (855) 632-7633
Lincoln: (402) 473-7000; Omaha: (402) 595-1178

NEVADA – Medicaid
Website: **https://dhcfp.nv.gov**
Phone: (800) 992-0900

NEW HAMPSHIRE – Medicaid
Website: **dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: (603) 271-5218
HIPP Program: (800) 852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: **state.nj.us/humanservices/dmahs/clients/medicaid/**
Medicaid Phone: (609) 631-2392
CHIP Website: **njfamilycare.org/index.html**
CHIP Phone: (800) 701-0710

NEW YORK – Medicaid
Website: **health.ny.gov/health_care/medicaid/**
Phone: (800) 541-2831

NORTH CAROLINA – Medicaid
Website: **https://medicaid.ncdhhs.gov/**
Phone: (919) 855-4100

NORTH DAKOTA – Medicaid
Website: **nd.gov/dhs/services/medicalserv/medicaid/**
Phone: (844) 854-4825

OKLAHOMA – Medicaid and CHIP
Website: **insureoklahoma.org**
Phone: (888) 365-3742

OREGON – Medicaid
Website: **http://healthcare.oregon.gov/Pages/index.aspx**
oregonhealthcare.gov/index-es.html
Phone: (800) 699-9075

PENNSYLVANIA – Medicaid
Website: **dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**
Phone: (800) 692-7462

RHODE ISLAND – Medicaid and CHIP
Website: **eohhs.ri.gov/**
Phone: (855) 697-4347, or (401) 462-0311
(Direct Rite Share Line)

SOUTH CAROLINA – Medicaid
Website: **scdhhs.gov**
Phone: (888) 549-0820

SOUTH DAKOTA – Medicaid
Website: **http://dss.sd.gov**
Phone: (888) 828-0059

TEXAS – Medicaid
Website: **http://gethipptexas.com/**
Phone: (800) 440-0493

UTAH – Medicaid and CHIP
Medicaid Website: **https://medicaid.utah.gov/**
CHIP Website: **http://health.utah.gov/chip**
Phone: (877) 543-7669

VERMONT– Medicaid
Website: **greenmountaincare.org/**
Phone: (800) 250-8427

VIRGINIA – Medicaid and CHIP
Website: **coverva.org/en/famis-select**
https://www.coverva.org/en/hipp
Phone: (800) 432-5924

WASHINGTON – Medicaid
Website: **hca.wa.gov/**
Phone: (800) 562-3022

WEST VIRGINIA – Medicaid
Website: **https://dhhr.wv.gov/bms/**
http://mywvhipp.com/
Medicaid Phone: (304) 558-1700
CHIP Phone: (855) 699-8447

WISCONSIN – Medicaid and CHIP
Website: **dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: (800) 362-3002

WYOMING – Medicaid
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**
Phone: (800) 251-1269

To see if other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
(877) 267-2323, Option 4, Ext. 61565

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
(866) 444-3272

Paperwork Reduction Act Statement.

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. DOL Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (96 hours). In any case, plans and insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources to find a wellness program with the same reward that is right for you considering your health status.

NOTICE REGARDING WELLNESS PROGRAM

City of Miltons wellness program is a voluntary program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. As part of wellness program activities, you may be asked to complete a voluntary health assessment that asks a series of questions about your health-related activities and behaviors and whether you have or

had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the health assessment, participate in medical examinations or health screenings, or any other wellness-related activities.

You may also be offered the chance to complete a biometric screening, which will include a blood test for cholesterol and glucose, height, weight, body mass index (BMI), blood pressure and waist circumference. You are not required to complete any wellness activities, participate in the biometric screening or any other types of wellness screenings or exams offered by the City of Milton.

However, ncentives may be available for employees who participate in certain wellness-related activities [preventive care, wellness challenges, educational events, etc.]. If you are unable to participate in any of the wellness activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

The information from your Health Assessment and the results from any health screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as health coaching or other relevant programming. You also are encouraged to share your results or concerns with your own doctor.

Protections From Disclosure Of Medical Information.

We are required by law to maintain the privacy and security of your personally identifiable health information. The City of Miltonmay use aggregate information it collects to design a program based on identified health risks in the workplace. Wellness program vendors will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are medical professionals to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, contact Human Resources.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

PART A: General Information.

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan.

However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit*.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information please check your summary plan description or contact your HR Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **healthcare.gov** for more information, including an online application for health insurance coverage and contact information.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer.

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. EMPLOYER NAME City of Milton	4. EMPLOYER IDENTIFICATION NUMBER (EIN) 51-0608862	
5. EMPLOYER ADDRESS 2006 Heritage Walk	6. EMPLOYER PHONE NUMBER 678-242-2516 / 678-242-2620	
7. CITY Milton	8. STATE GA	9. ZIP CODE 30004
10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB? Niki Graham		
11. PHONE NUMBER (IF DIFFERENT FROM ABOVE)	12. EMAIL ADDRESS niki.graham@miltonga.gov	

Here is some basic information about health coverage offered by this employer:

* As your employer, we offer a health plan to:

☒ All employees. Eligible employees are:

All Full Time Employees who work at least 30 hours per week.

☐ Some employees. Eligible employees are:

* With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal Spouse, Legal Children (biological/step/court ordered) and totally disabled children of any age, claimed as a dependent on your tax return.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or it you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **healthcare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **healthcare.gov** to find out if you can get a tax credit to lower your monthly premiums.

CARRIER CONTACTS

MEDICAL / DENTAL – CIGNA
(866) 494-2111 | **myCigna.com**

HSA - HEALTHEQUITY
(866) 346-5800 | **healthequity.com**
Email: **memberservices@healthequity.com**

VISION – VSP
(800) 877-7195 | **vsp.com**

LIFE AND AD&D / DISABILITY – UNUM
(866) 679-3054 | **unum.com**

EMPLOYEE ASSISTANCE PROGRAM – FEI
(800) 824-4372 | **feieap.com**

AFLAC – WAYNE BROWN, WBI SOLUTIONS
(803) 413-9229 | **Wayne@wbisolutions.org**

HRA / FSA – BASIC
(800) 372-3539, Option 1 | **basiconline.com**

CITY OF MILTON

NIKI GRAHAM, HUMAN RESOURCES DIRECTOR
(678) 242-2516 | **niki.graham@miltonga.gov**

MONIQUE WILLIAMS, HUMAN RESOURCES GENERALIST
(678) 242-2620 | **monique.williams@miltonga.gov**

RELATION INSURANCE

MICHELLE FORD, SR. ACCOUNT MANAGER
(678) 740-0223 | **michelle.ford@relationinsurance.com**

JANE SANDERSON, ACCOUNT MANAGER
(678) 367-3302 | **jane.sanderson@relationinsurance.com**

CORY S. NEWTON, EXECUTIVE VICE PRESIDENT
(336) 253-5353 | **cory.newton@relationinsurance.com**

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