2024-2025
EMPLOYEE **BENEFITS**

city of Suwanee georgia

TABLE OF CONTENTS

WELCOME

Dear City of Suwanee Employees,

Our success is only possible with the dedication and skills of a winning team. At the City of Suwanee, we value the contribution of our employees to our ongoing success. We are also committed to attracting and retaining high-quality employees that understand and support our vision and goals. In a continuing effort to provide high-quality and cost effective benefit programs, we annually review all of our benefit plans.

It is important that you have access to a choice in medical plan selection so you can balance your own financial goals with your healthcare needs. We are pleased to inform you that although healthcare costs continue to rise annually, we were able to work with Cigna to only have a slight increase in rates for medical insurance and no increases in dental or vision insurance rates.

As such, we intend to renew our medical and dental insurance with our current provider, Cigna. We will again be offering two plan options: HMO and HDHP with a Health Savings Account (HSA). As in the past, the City of Suwanee will continue to fund most of the cost of the health insurance premium. You will see a slight increase to your paycheck for the new plan year starting July 1st 2024.

In addition to a traditional HMO plan, the City will again offer the HDHP/HSA option. This plan works a little differently than traditional plans and is designed to give employees greater control over their costs while still providing access to large networks and free preventive care. Additionally, the plan's associated HSA serves as a savings vehicle allowing you to accumulate funds to be used for health needs in the future.

Your ancillary benefits, disability and life insurance, will remain with Mutual of Omaha with the same benefit package. Vision insurance will remain with VSP.

At the City of Suwanee, we believe that by leading healthier lifestyles our employees can live longer, happier, and more productive lives. The City is committed along with our carriers to provide you the tools you need to get the most "mileage" out of your plans. You should closely review this booklet to determine the options that are right for you.

Thank you for all of your hard work and dedication.

Marvin Allen, City Manager

BENEFIT GOALS

We evaluate our benefits program each year to make sure that we accomplish several goals:

- Provide employees with affordable access to health benefits
- Provide a competitive benefits program
- Promote health and wellness among City of Suwanee employees and their dependents
- Provide resources to support employees and their dependents as they make important decisions about their health and health care

Some Benefits Are Paid For With Pre-Tax Dollars.

To help you stretch your income, we established a Cafeteria Plan or Flexible Benefit Plan that allows you to pay for your benefits using pre-tax money.

What Does a Cafeteria Plan Mean to Me?

- You save at least 15% in Federal Tax
- You save 7.65% in FICA Tax
- You save 6% in Georgia State Tax
- More flexibility - you have a menu of benefit alternatives and levels and can choose the right options for you

BENEFIT ELIGIBILITY

Full-time employees are eligible for benefits on the first day of the month following 30 days of service.

Employees Can Enroll The Following Dependents:

- Your legal spouse (same sex or opposite sex)
- Dependent children up to age 26:
  - Natural children
  - Legally adopted children
  - Stepchildren
  - Children for whom the employee has been appointed legal guardian.
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (subject to plan rules; documentation of handicapped status must be provided).

Dependents Not Eligible For Benefit:

- Grandchildren, nieces, nephews or other children that do not meet specifications listed above
- Common law spouses or domestic partners (same or opposite sex)
- Ex-spouses, unless required via court order (documentation required)
- Parents, step-parents, grandparents, aunts, uncles, and any other relatives that are not qualified legal dependents (even if they live with you)

BENEFITS CHANGES

Most benefit deductions are withheld from your paycheck on a pre-tax basis (medical, dental, and vision) and therefore your ability to make changes to these benefits is restricted by the IRS.

Open Enrollment elections are effective July 1, 2024 and stay in effect until June 30, 2025 unless you experience a Life Status Change.

COMMON QUALIFYING LIFE EVENTS

- Marriage, divorce, or 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 open enrollment

How To Make Benefit Changes.

To be eligible to make benefit changes because of a life event, you must notify Human Resources within 30 days of the date of the qualifying event. Proof of your life event may also be required. Changes outside of the 30-day period are not allowed until the next annual Open Enrollment period, unless you experience another qualified life event.

BENEFITS ENROLLMENT

Benefits enrollment will occur through Employee Navigator, a web-based tool that allows you to make benefit elections online. The Employee Navigator Self Service Portal is built to provide you with convenient, self-service access and the ability to manage your benefits anytime, anywhere.

After your enrollment is complete, you can view the system 24 hours a day, 7 days a week and can utilize it to:

- Update your personal information such as:
  - Home address, phone number and/or email
  - Add emergency contacts
  - Update beneficiary information
- View benefit information, such as:
  - Plan summaries for all benefits
  - Booklets and certificates

HOW TO ENROLL IN BENEFITS

1. **Log In.** Go to **employeenavigator.com** and click **Login**
   - **Returning users:** Log in with your username and password. If you have forgotten or need to reset your password, click Reset a forgotten password.
   - **First time users:** Click on your Registration Link in the email sent to you by your admin or Register as a new user. Create an account, and create your own username and password.

     Company Identifier: COSU

2. **Welcome!** After you login, click **Let's Begin** to complete your required tasks.

3. **Onboarding** (for first time users, if applicable). Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks, click Start Enrollment to begin your enrollments.

   TIP: If you hit "Dismiss, complete later" you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking "Start Enrollments".

4. **Start Enrollments**. After clicking Start Enrollment, you'll need to complete some personal & dependent information before moving to your benefit elections.

   TIP: Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

5. **Benefit Elections.** To enroll your dependents, click the checkbox next to the dependent's name under Who am I enrolling? Below your dependents you can view your available plans and the cost per pay period.

   To elect a benefit, click Select Plan underneath the plan cost. Click Save & Continue at the bottom of each screen to save your elections. If you do not want a benefit, click Don't want this benefit? at the bottom of the screen and select a reason from the drop-down menu.

6. **Forms.** If you have elected benefits that require a beneficiary designation, Primary Care Physician, or complete of an Evidence of Insurability form, you will be prompted to add in those details.

7. **Review & Confirm Elections.** Review the benefits you selected on the enrollment summary page to make sure they are correct then click Sign & Agree to complete your enrollment. Print a summary of your elections for your records or login at any point during the year to view your summary online.

   TIP: If you miss a step you'll see Enrollment Not Complete in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

8. **HR Tasks** (if applicable). To complete any required HR tasks, click Start Tasks. If your HR department has not assigned any tasks, you're finished!

MEDICAL

City of Suwanee provides employees and their eligible dependents with two medical plan options through Cigna.

CIGNA OPEN ACCESS PLANS

In-Network vs. Out-Of-Network.

Choose a provider who participates in your plan's network to 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 cost share.

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.

OPEN ACCESS HMO (IN-NETWORK BENEFITS ONLY)	
NETWORK NAME: CIGNA OPEN ACCESS HMO	**IN-NETWORK (WHAT YOU PAY)**
Calendar Year Deductible: Individual / Family (carryover deductible provision included; does not credit out-of-pocket amount. Benefits for an individual within a family are paid once the individual deductible has been met)	$1,500 / $4,500
Out-of-Pocket Maximum: Individual / Family (Includes deductible, coinsurance, and copays)	$3,500 / $7,000
MOST COMMONLY USED BENEFITS	
Office Visits	
• Preventive Care	Plan pays 100%; no copay/deductible
• Primary Care Physician / Specialist	$40 copay / $60 copay
• Virtual Care	$40 copay
Emergency Care	
• Urgent Care (all services including lab & x-ray)	$75 copay
• Emergency Room (all services including lab & x-ray)	$250 copay
• Ambulance	Plan pays 90% after deductible
Inpatient Services	
• Office Surgery (copay applies even if no office visit charges are incurred)	Plan pays 100% after office visit copay
• Inpatient Services* (includes anesthesia, lab & x-ray subject to reimbursement)	Plan pays 90% after deductible
• Behavioral Health / Substance Abuse*	Plan pays 90% after deductible
Outpatient Services	
• Outpatient & Ambulatory Surgery* (includes anesthesia)	Plan pays 90% after deductible
• Lab, X-ray (independent lab & x-ray paid based on status of facility)	Plan pays 90% after deductible
• Advanced Radiology (MRI, MRA, PET, CT-Scan, Nuclear)	Plan pays 90% after deductible
• Behavioral Health / Substance Abuse	$60 copay
• Therapy Services (Speech/Physical/Hearing/Occupational): 20-visits	$60 copay
• Chiropractic Services: 20-visits	$60 copay
• Skilled Nursing Facility* / Home Health Care / Hospice Care*	Plan pays 90% after deductible
Other Services	
• Durable Medical Equipment	Plan pays 90% after deductible
• Hearing Aids (one device per ear; through age 18)	$3,000 max per 6 months
PRESCRIPTION DRUG (deductible and out-of-pocket maximums are integrated with medical)	
Retail Pharmacy	
• Tier 1: 30-Day / 90-Day	$15 copay / $45 copay
• Tier 2: 30-Day / 90-Day	$30 copay / $90 copay
• Tier 3: 30-Day / 90-Day	$60 copay / $180 copay
Mail Order / Home Delivery Pharmacy: Up to 90-Day	25% to $300 max.

*precertification required

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

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HSA		
Annual Employer HSA Contribution Deposited directly into employee's established HSA account	**Employee: $750** **Employee + Spouse: $1,250**	**Employee + Child(ren): $1,250** **Family: $1,750**
NETWORK NAME: CIGNA OPEN ACCESS POS	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible: Individual / Family (in-network and out-of-network expenses do not cross accumulate)	$2,800 / $5,200 $3,200 (ind. within a family)	$5,600 / $10,400 $6,000 (ind. within a family)
Out-of-Pocket Maximum: Individual / Family (Includes deductible, coinsurance, and copays)	$3,500 individual $7,000 family	$10,500 individual $21,000 family
MOST COMMONLY USED BENEFITS		
Office Visits		
• Preventive Care	Plan pays 100%; no deductible	Plan pays 70% after deductible
• Primary Care Physician / Specialist	Plan pays 90% after deductible	Plan pays 70% after deductible
• Virtual Care	$59 copay	N/A
Emergency Care		
• Urgent Care (all services including lab & x-ray)	Plan pays 90% after deductible	Plan pays 90% after deductible
• Emergency Room (all services including lab & x-ray)	Plan pays 90% after deductible	Plan pays 90% after deductible
• Ambulance	Plan pays 90% after deductible	Plan pays 90% after deductible
Inpatient Services		
• Office Surgery	Plan pays 90% after deductible	Plan pays 70% after deductible
• Behavioral Health / Substance Abuse	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient Services		
• Outpatient & Ambulatory Surgery* (includes anesthesia)	Plan pays 90% after deductible	Plan pays 70% after deductible
• Lab, X-ray (independent facilities paid based on status)	Plan pays 90% after deductible	Plan pays 70% after deductible
• Advanced Radiology (MRI, MRA, PET, CT-Scan, Nuclear)	Plan pays 90% after deductible	Plan pays 70% after deductible
• Behavioral Health / Substance Abuse	Plan pays 90% after deductible	Plan pays 70% after deductible
• Therapy Services (Speech/Physical/Hearing/Occupational)	Plan pays 90% after deductible	Plan pays 70% after deductible
• Chiropractic Services: 20-visits	Plan pays 90% after deductible	Plan pays 70% after deductible
• Skilled Nursing Facility*/Home Health Care/Hospice Care*	Plan pays 90% after deductible	Plan pays 70% after deductible
Other Services		
• Durable Medical Equipment	Plan pays 90% after deductible	Plan pays 70% after deductible
• Hearing Aids (one device per ear)	$3,000 max per 6 months	$3,000 max per 6 months
PRESCRIPTION DRUG (deductible and out-of-pocket maximums are integrated with medical)		
Retail Pharmacy: 30-Day / 90-Day		
• Tier 1	$15 copay / $45 copay	$15 copay / $45 copay
• Tier 2	$35 copay / $90 copay	$35 copay / $90 copay
• Tier 3	$60 copay / $180 copay	$60 copay / $180 copay
Mail Order / Home Delivery Pharmacy: Up to 90-Day	2.5x copay ($38/$75/$150)	2.5x copay ($38/$75/$150)

*precertification required

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

HEALTH SAVINGS ACCOUNT (HSA)

City of Suwanee offers employees enrolled in the Cigna HDHP Medical Plan with the option to contribute pre-tax dollars to a Health Savings Account (HSA) to help with out-of-pocket qualified health expenses for you and your qualified dependents. Your HSA is administered by Cigna in partnership with Optum Bank.

USING YOUR HSA

You can use your HSA funds to pay for "qualified medical expenses," even if an expense is not covered by your health plan. For example, few health plans cover the cost of acupuncture, but you can use your HSA to pay for it.

Your HSA dollars are available not only to you, but also to your spouse and dependents, even if they are not covered by your high-deductible health plan. The list of "qualified medical expenses" is defined by the IRS, and it includes a wide range of dental, vision and medical expenses. You should become generally familiar with the list and consult it as needed to determine if an expense can be paid for with your HSA.

2024 ANNUAL HSA CONTRIBUTION LIMITS

The 2024 maximum IRS contribution limits, including employer contributions, are as follows:

- Single Coverage: $4,150
- Family Coverage: $8,300
- Age 55+ Catch Up Contribution: $1,000

Employer HSA Contributions.

City of Suwanee contributes to employee Health Savings Accounts. The total annual employer contributions are:

- Employee Only: $750
- Employee + Spouse: $1,250
- Employee + Child(ren): $1,250
- Family: $1,750

HSA ELIGIBLE EXPENSES

Expenses that qualify for payment or reimbursement from your HSA tax free are defined by federal regulation. For more information about qualified medical expenses, visit the IRS website at **irs.gov** or **optumbank.com**.

Other Qualified HSA Expenses.

Generally, you can't use HSA funds to pay for health insurance premiums, but there are exceptions, including:

- Health plan coverage while receiving federal/state unemployment benefits
- COBRA continuation coverage after employment ends with a company that offers health coverage
- Eligible long-term care insurance
- Dental care, including extractions & braces
- Prescription medications
- Vision care, including contact lenses, prescription sunglasses, LASIK surgery
- Chiropractic services
- Acupuncture
- Hearing aids & batteries
- Doctor office visits
- Medicare premiums (not including premiums for a Medicare supplemental policy) and other expenses, including deductibles, copays and coinsurance for:
  - Part A (hospital + inpatient services)
  - Part B (physician + outpatient services)
  - Part C (Medicare HMO/PPO plans)
  - Part D (prescription drugs)

DESIGNATING A BENEFICIARY

It is important to select a beneficiary when setting up a HSA. This will ensure that your HSA money is immediately available to your beneficiary upon your death. You may select more than one beneficiary and assign the portion of your account that would go to each.

- What if you don't select a beneficiary? If you do not specify a beneficiary and you are married, your HSA becomes your spouse's HSA account. If you are not married at the time of your death, the funds will go to your estate and may be subject to taxation.
- How do you designate your beneficiary? Log in to your HSA and select "Manage your profile" from the "Self Service" links. You'll find a link to "Beneficiary Designation" on the "Profile" page.

FREQUENTLY ASKED QUESTIONS ABOUT HEALTH SAVINGS ACCOUNTS

What is a HDHP?

A High-Deductible Health Plan (HDHP) is a health plan that has a lower monthly cost and pays no benefit until a higher annual deductible is met. Once the annual deductible is met, health expenses are paid at 100% and the prescriptions are covered at a copay.

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 as an initial lump sum deposit at enrollment. You can also make post-tax contributions and deduct them from your income when you file your taxes. You can change your contribution at any time during the plan year as long as you follow the IRS annual limits.

How are medical expenses paid prior to my annual deductible being met?

Expenses incurred are paid by the employee until the annual deductible is met. Use funds in your HSA or pay them as out-of-pocket expenses. Only qualified health expenses covered by your medical plan apply towards your deductible.

Who verifies HSA funds are used for qualified expenses?

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

Can I have an HSA and an FSA?

No, you cannot have an HSA and Health FSA; however, you can have an FSA for dependent care.

What happens to my HSA if I never withdraw funds, change jobs, or retire?

Money in your HSA accumulates interest and balances will rollover year over year. HSA funds are portable if you change employers or retire. Funds can be withdrawn for any reason, without penalty once you reach age 65.

CIGNA MEMBER WEBSITE & MOBILE APP

myCigna helps consumers manage health care benefits and provides access to WebMD's suite of health information and decision support tools. The myCigna app gives you an easy way to personalize, organize and access your important health information on the go, including:

- Download and Save Membership cards
- Health care provider search
- File Claims and Review Information
- Contact Cigna with the tap of a finger

How To Register.

1. Go to myCigna.com and select "Register Now".
2. Enter your personal details (name, address and date of birth).
3. Confirm your identity with secure information like your Cigna ID, social security number or a security question.
4. Create a user ID and password.
5. Review and submit.

CIGNA VIRTUAL CARE (TELEHEALTH)

Register for a myCigna account to access virtual care and 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
- Nausea
- Pink eye
- Rashes
- Shingles
- Joint aches
- Sore throats
- Sinus infections
- Skin infections

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
- Life changes
- Eating disorders
- Panic disorders
- Bipolar disorders
- Parenting issues
- Relationship issues
- Postpartum depression

Schedule An Appointment.

1. Access MDLIVE by logging into **myCigna.com** and clicking on 'Talk to a doctor' or call **(888) 726-3171**.
2. Select the type of care you need: medical care or counseling. The cost will be displayed on both **myCigna.com** and MDLIVE.
3. Follow the prompts for an on-demand urgent care visit to make an appointment for primary or behavioral care.

HEALTHY REWARDS

Cigna's Healthy Rewards® program provides discounts of up to 60% on various wellness programs and services, ranging from Weight Management and Nutrition, to Vision and Hearing Care, and Nicotine Cessation. To learn more about these and other Healthy Rewards® programs, visit **myCigna.com** or call **(800) 258-3312**.

ACTIVE & FIT DIRECT PROGRAM

Cigna members and dependents age 18+ are eligible to join the Active & Fit gym membership network as a part of Healthy Rewards. Memberships are $28 per month (plus a $28 enrollment fee) which allows you access to multiple local gyms in the Active & Fit network. Access premium exercise studios with 20-70% discounts plus access to digital workout videos.

Go to **myCigna.com** → 'Wellness' → 'Exercise' → 'Healthy Rewards' → 'Gym Memberships & Digital Workouts'.

OMADA

Omada is a digital lifestyle program that inspires healthy habits through technology and support programs that help you accomplish the necessary changes in the areas of eating, activity, stress, and sleep. Omada is available at no additional cost if you or your covered adult dependents are enrolled in the City medical plan through Cigna, are at risk for diabetes or heart disease, and are accepted into the program.

Omada Features:

- 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

RECOVERYONE PHYSICAL THERAPY

You have access to RecoveryOne for Cigna, an online physical therapy program included with your health plan at no additional cost. Visit **lp.recoveryone.com**.

With RecoveryOne For Cigna, You Get:

- Online PT you can do when you want, from the comfort and safety of your home
- Customized recovery plans to meet your needs
- An app that guides you through your exercises
- Video, voice, and chat conversations with your support team
- Weekly check-ins with a certified health coach

IDENTITYFORCE - ID THEFT PROTECTION

IdentityForce through Sontiq offered through your Cigna medical plan at no additional cost.

Privacy And Security.

- Password Manager
- Bank and Credit Card Activity Alerts
- Advanced Fraud Monitoring
- Identity Threat Alerts
- Smart SSN Tracker (SSN Monitoring)

Credit Monitoring.

- Credit Report Assistance and Monitoring
- Credit Report and Score (Quarterly)
- Credit Score Simulator
- Credit Freeze and Lock Assistance (Adult and Child)

Restoration Services.

- White Glove Restoration
- Pre-existing Identity Theft Restoration
- Stolen Funds Replacement
- Fraud Remediation

Three ways to enroll in IdentityForce:

1. Employees with Cigna medical who are registered on **myCigna.com** will receive an enrollment link email directly from IdentityForce.
2. Call **(833) 580-2523**.
3. Visit **cigna.identityforce.com/starthere**.

CIGNA SELF-SERVICE DIGITAL TOOLS

Happify.

A self-directed program with activities, science-based games and guided meditations. These are designed to help employees reduce stress and anxiety, gain confidence, defeat negative thoughts and boost overall health and performance.

iPrevail.

A digital therapeutics program designed by experienced health care providers, to help employees take control of the stresses of everyday life. It's loaded with interactive video lessons and one-on-one coaching to help with depression and anxiety.

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. You don't have to go it alone. Cigna is on your side.

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 online or on the go, through **myCigna.com** or with the free myCigna mobile App.

1. Stay On Top Of Preventive Care.

What is preventive care?

Preventive care is a specific 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 and specific tests, certain health screenings, and most immunizations.

Most of these services can take place during the same visit. 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. It can also 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 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.

2. Find The Best Providers.

The Cigna Care Designation is one decision-making tool you can use to choose a doctor.

Before we award a doctor the Cigna Care Designation, we do a lot of fact-finding. Doctors in 21 different medical specialties are assessed for quality and cost efficiency, since quality care doesn't have to mean higher costs.

When you use the myCigna online directory to find a doctor, you will see top-performing doctors are shown with the Cigna Care Designation symbol – an evaluation of quality and cost-efficiency that you can trust.

Get help choosing a hospital, too! Just look for the Centers of Excellence Designation.

Choose an in-network hospital that's right for you. Hospitals that demonstrate better health outcomes at lower costs for one of the reviewed conditions earn our top rating – the Cigna Centers of Excellence designation.

3. 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.

How to 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**. Select 'Find Care & Costs'
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

4. 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 the 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. Review your plan materials for more information.

Here are three ways to spend less on medication:

1. 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. Always check with your doctor or pharmacist to understand your options.
2. Compare drug costs at different pharmacies. Login to **myCigna.com** → Select Prescriptions Tab → Select "Price a Medication" → Enter or Select a Drug Name → Enter Form/Dosage, Quantity, Frequency and Duration → Get cost estimates.
3. Ask your doctor about getting a 90-day (3-month) supply of your prescription. You'll make fewer trips to the pharmacy for refills. And you're less likely to miss a dose. 90-day prescriptions may be filled using Cigna Home Delivery Pharmacy or select in-network retail pharmacies.

To get started using home delivery:

1. Log into the myCigna App or **myCigna.com**.
2. Click on the Prescriptions tab and select 'My Medications' from the dropdown menu.
3. Click the button next to your medication name to move your prescription(s).

5. The Value Of In-Network Labs.

You can save money if you use an in-network lab. Cigna's network includes national labs like LabCorp or Quest as well as regional and local labs. It's easy to 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 and give you quality service at a lower cost. When your doctor says 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.

6. Shop With Cigna For The Best Outpatient Facilities For Diagnostic Tests.

MRI, CT and PET scans can cost much less at some facilities. Make a more informed choice about where you get your services. Cigna's team can find the most cost-effective facility for a service and will compare costs for hundreds of procedures. Call Cigna customer service at **(800) 244-6224** or view the provider directory on myCigna.com to see the costs of services in your area.

How to search for outpatient facilities:

Log in to **myCigna.com** and select the 'Find Care & Costs' Tab. Search by 'Primary Care, Doctor by Type, Doctor by Name, Reason for Visit or Locations'.

FREESTANDING FACILITY VS OUTPATIENT HOSPITAL	
RADIOLOGY CENTER COST	**OUTPATIENT HOSPITAL COST**
MRI: $706	MRI: $1,676
CT Scan: $457	CT Scan: $1,376

Potential Savings: Over $900

National averages of participating facilities; actual costs will vary. The information provided is intended to be general information. It is not intended as medical advice. You should consider all relevant factors and consult with your treating doctor when selecting a provider for care.

7. 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 can be 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. Call Cigna at **(800) 244-6224**.

ER UTILIZATION GUIDE

When your life or health is in serious danger, there's only one option — the emergency room. But for those times when the situation isn't life-threatening but still needs immediate care, there are lots of options that can be more convenient, less expensive and more appropriate.

- An Urgent Care Center is a walk-in clinic staffed by doctors who treat conditions that should be looked at right away, but aren't as severe as emergencies. Doctors in an urgent care often do X-rays, lab tests and stitches.
- A Walk-In Doctor's office is convenient option to an ER visit because employees don't have to be an existing patient or have an appointment to receive care. These offices handle most routine care and common illnesses.
- A Retail Health Clinic is a clinic where medical professionals provide basic medical care. These clinics are almost always located in retail stores, supermarkets and pharmacies.
- Cigna Virtual Care can help you get the care you need for a wide range of minor acute conditions. Televisits with MDLIVE can cost less than going to a convenience care or urgent care clinic, and significantly less than going to an emergency room.

CONVENIENCE CARE CLINICS

When you need treatment for common ailments and injuries, get high-quality, affordable services for a variety of routine medical conditions through Convenience Care Clinics located throughout the country.

Because we believe that your doctor has primary responsibility for your care and treatment, the results of your diagnosis and treatment are sent to your doctor with your permission. If you have a more severe condition, or require treatment in a different setting, the Convenience Care clinician will refer you to your doctor or an Emergency Room.

Use Convenience Care For The Following Conditions:

- Allergies
- Athlete's foot
- Bladder infections
- Bronchitis
- Cold sores
- Ear infections
- Influenza
- Laryngitis
- Minor burns/rashes
- Minor skin infections
- Mononucleosis
- Pink eye and styes
- Poison ivy
- Pregnancy testing
- Ringworm
- Sinus infections
- Strep throat
- Wart removal

Convenience Care Clinics also provide vaccinations:

- Td (Tetanus, Diphtheria)
- DTaP (Diphtheria, Tetanus, Pertussis)
- MMR (Measles, Mumps, Rubella)
- Pneumonia
- Hepatitis A & B

Participating Clinics.

Refer to the provider directory for a complete list of Convenience Care Clinics in the Cigna network.

- Cigna Medical Group CareToday
- MinuteClinic
- RediClinic
- Take Care Health
- Target Clinic
- The Little Clinic

Lower — Cost and Time — Greater

VIRTUAL CARE	CONVENIENCE CARE CLINIC	DOCTOR'S OFFICE	URGENT CARE	EMERGENCY ROOM
For minor medical conditions. Connect with board-certified doctors or providers via video or phone through MDLive.	For minor medical conditions. Staffed by nurse practitioners & physician assistants in retail stores & pharmacies.	Best for routine or preventive care, and to keep track of medications.	For non-life threatening conditions. Staffed by nurses & doctors. Typically have extended hours.	For immediate treatment of critical injuries/illness. Open 24/7. For life-threatening situations, call 911 or go to the nearest ER.
• Colds and flu • Rashes • Sore throats • Headaches • Stomachaches • Allergies • UTIs and more	• Colds and flu • Rashes/skin conditions • Sore throats, earaches, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccines	• General health issues • Preventive care • Routine checkups • Immunizations and screenings	• Fever/flu symptoms • Minor cuts, sprains, burns, rashes • Headaches • Lower back pain • Joint pain • Minor breathing issues	• Sudden numbness or weakness • Uncontrolled bleeding • Seizure • Loss of consciousness • Shortness of breath • Chest pain • Head injury • Major trauma • Blurry or loss of vision
Costs the same or less than a doctor's office visit. Appointments are usually in an hour or less.	Costs the same or lower than a doctor's office visit. No appointment needed.	May charge copay, coinsurance, and/or deductible. Usually need appointment.	Costs are lower than an ER. No appointment needed. Wait times will vary.	Costs the most. No appointments needed. Wait times may be long.

CIGNA HEALTHCARE WELLNESS

With the Cigna Healthcare℠ Wellness Experience, together with Virgin Pulse, you can set achievable goals, challenge friends to healthy competitions, tackle stress and enjoy a healthier lifestyle.

- **Take a digital coaching journey.** Choose a goal that's meaningful to you. Journeys® personalized digital coaching guides you to take small, achievable steps, so that you can "try on" and build lasting healthy habits.
- **Challenge yourself — and others.** Add a friendly dose of competition to your well-being journey when you challenge friends and colleagues to create new healthy habits, like taking the most steps or burning the most calories.
- **Track your progress.** Integrate with your Apple Watch®, Fitbit® and many other fitness tracking apps and devices, so you get credit for all your activity.
- **Spread the motivation.** Share in the fun — and offer free account access to up to 10 friends and family members — to encourage and motivate each other.

Get Started Today.

1. Set up your profile today on **myCigna.com** or by downloading the myCigna app.
2. Select the Wellness tab, then click "Get Started" to enroll.

Don't forget to turn on notifications for the app to enable helpful reminders and information about upcoming opportunities — so you get the most out of your mobile experience.

WHAT IS A PREVENTIVE CARE SERVICE?

Preventive care services are provided when you don't have any symptoms and haven't been diagnosed with the health issue connected with the preventive service. For example, a flu vaccination is given to prevent the flu before you get it. Other preventive care services like mammograms can help detect an illness when there aren't any symptoms.

Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. During a wellness exam, you and your doctor will determine what tests and health screenings are right for you based on your age, gender, personal health history and current health.

PREVENTIVE CARE SERVICES SUMMARY	
SERVICE	**GENDER, AGE, FREQUENCY**
Well-baby/child/person Exams	• Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months; additional visit at 2-4 days for infants discharged less than 48 hours after delivery • Ages 3 to 21 once a year • Ages 22 and older periodic visits, as doctor advises
Breast Cancer Screening (mammogram)	• Women ages 40 and older, every 1- 2 years
Cervical Cancer Screening (pap test) **HPV DNA Test with pap test**	• Women ages 21- 65, every 3 years • Women ages 30- 65, every 5 years
Cholesterol/Lipid Disorders Screening	• Screening of children and adolescents (age 2-10) at risk due to known family history; when family history is unknown; or with personal risk factors • All men ages 35 and older, or ages 20-35 if risk factors • All women ages 45 and older, or ages 20-45 if risk factors
Colon Cancer Screening	The following tests will be covered for colorectal cancer screening, ages 50+: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually • Flexible sigmoidoscopy every 5 years • Double-contrast barium enema (DCBE) every 5 years • Colonoscopy every 10 years • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - requires precertification
Diabetes Screening	• Adults with sustained blood pressure greater than 135/80
Osteoporosis Screening	• Age 65 or older (under 65 for women at risk). Computed tomographic bone density study requires precertification
Prostate Cancer Screening (PSA)	• Men ages 50 and older or age 40 with risk factors
Sexually Transmitted Infections Screening	• All sexually active adolescents. All adults at risk
Skin Cancer Prevention	• All genders ages 10- 24 (counseling to minimize exposure to ultraviolet radiation)
Tobacco Use/Cessation Interventions	• All Adults; Pregnant Women

YOUR PRESCRIPTION DRUG LIST (PDL)

It's important to know which medications your plan covers. Cigna makes it easy by providing up-to-date drug lists online. To learn more, visit **myCigna.com** or the mobile app or call **(800) 285-4812**.

See How Your Plan Covers Medications.

1. Go to **Cigna.com/PDL**
2. Scroll down until you see a pdf of the Cigna Performance 4-Tier Prescription Drug List (all specialty medications covered on Tier 4).
3. Look for a medication name. Medications are listed by the condition they treat, then alphabetically within tiers (or cost-share levels).

Cigna Home Delivery Pharmacy.

Cigna Home Delivery is designed especially for members who take medications on a regular basis, such as those used for diabetes, asthma, heart conditions, high blood pressure, birth control and more. You will enjoy:

- Easy refills; up to a 90-day supply means fewer refills
- Reminder service at **Cigna.com/CoachRx** that alerts you to refill/take your medication
- Cigna's free QuickFill service will call or email you when its time to refill your prescriptions
- Fast answers from Cigna pharmacists 24/7, just call **(800) 285-4812**

Quickswitch makes filling a prescription simple. Just call and we will request a prescription from your doctor. Once we receive it, we will fill your medication and mail it to your home or other location of your choice.

Your Prescription Drug Plan - Generic Drugs.

If a brand name drug is requested when there is a generic equivalent, the member must purchase the generic drug, or pay 100% of the difference between the brand name price and the generic price, plus the appropriate brand name copay (unless the physician indicates "Dispense As Written" DAW).

30-Day Specialty Medication Supply Limit.

Specialty medications are used to treat rare and chronic conditions. They are costly and are one of the fastest growing components of health care costs. On average, members fill specialty medications twice a year costing around $6,300 per prescription. As a member continues through therapy, the need often arises to change prescriptions due to side effects or because new medications become available. Specialty medications are limited to a 30-day supply at retail and Cigna Home Delivery Pharmacy.

PPACA NO COST-SHARE ($0) PREVENTATIVE MEDICATIONS

This is a list of the preventive prescription medications and the over-the-counter (OTC) products available to you at no cost-share under the Patient Protection and Affordable Care Act (PPACA).

For your plan to cover these medications at 100%, you'll need to get a prescription from your doctor - even for the OTC products which are typically available without a prescription. This list is updated as the U.S. Preventive Services Task Force makes new recommendations.

Log in to the myCigna® App or **myCigna.com** to learn how your plan covers preventive medications, such as:

- Aspirin Products
- Breast Cancer Prevention
- Emergency Contraception
- HIV Infection
- Pediatric Multivitamins
- Pre-Exposure Prevention
- Smoking Cessation
- Vaccines

PRESCRIPTION TIPS

Free Prescriptions.

Some grocery stores offer a list of antibiotics, high blood pressure and diabetes medications at no cost (dosage restrictions and quantity limits 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!

DENTAL – CIGNA

Good oral hygiene is part of a healthy lifestyle. 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 DPPO ADVANTAGE NETWORK

Selecting a dental provider in Cigna's Total DPPO Advantage Network will save you money. If you choose to see an out-of-network dentist, they will send you a bill for anything that Cigna does not cover.

In-Network Benefits.

To find an in-network provider call **(866) 494-2111**. When searching online for in-network dentists, make sure that Cigna DPPO Advantage is under selected plans.

- When you choose a DPPO Advantage dentist, you may receive higher in-network benefit coverage which may result in lower out-of-pocket expenses.
- Pay less for covered services! In-network dentists have agreed to offer services at lower negotiated rates, approximately 35% off average area charges with DPPO Advantage.
- Save on out-of-pocket costs for services not covered by your plan. In-network dentists may offer discounts for procedures on their fee schedules.
- In-network dentists will submit claims for you.
- In-network dentists are screened through a process modeled after the highest national quality standards.

Preventive Services.

Our plan covers preventive services at 100% if you see an in-network dentist. While there is no deductible for preventive services, these do count towards your annual maximum benefit. If you receive preventive services at an out-of-network dentist, they will balance-bill you for anything that Cigna does not pay.

Out-Of-Network Benefits.

Cigna will pay all out-of-network claims based on the 90th UCR. This means that they will look at what 9 out 10 dentists in your area are charging, and pay claims based on that amount.

- Your out-of-pocket expenses will generally be higher because out-of-network dentists have not agreed to offer Cigna plan customers negotiated rates.
- You may have to file your own claims.

CIGNA DENTAL PLAN SUMMARY		
NETWORK: TOTAL CIGNA DPPO ADVANTAGE	**IN NETWORK**	**OUT OF NETWORK**
Maximum Annual Benefit (per individual per calendar year)	$1,500	$1,500
Calendar Year Deductible (waived for Type I Services)	$50 individual / $150 family	$50 individual / $150 family
Reimbursement Levels	Based on reduced contract fees	90th UCR
Class I: Preventive Services Oral exams, routine cleanings, full mouth x-rays, bitewing x-rays, panoramic x-rays, fluoride application (to age 14)	Plan pays 100% no deductible	Plan pays 100% no deductible
Class II: Basic Restorative Services White fillings, root canal therapy/endodontics, space maintainers, oral surgery- simple extractions, anesthetics	Plan pays 80% after deductible	Plan pays 80% after deductible
Class III: Major Restorative Services Crowns, dentures, bridges, inlays/onlays	Plan pays 50% after deductible	Plan pays 50% after deductible
Class IV- Orthodontia (dependents up to age 19)	Plan pays 50% after deductible	Plan pays 50% after deductible
Class IX- Implants	Plan pays 50% after deductible	Plan pays 50% after deductible

See plan certificate for frequency of service limitations and exclusions.

Get Connected To myCigna.

It's easy to get things done with myCigna, our secure customer website. Register at **myCigna.com** and utilize the following tools and services:

- View your personalized dental plan information
- Print a personalized ID card
- Enjoy discounts on various health and wellness products and services
- Search for claims
- Use interactive tools to learn more about oral health

Find A Network Provider.

1. Visit **cigna.com** and click 'Find a Doctor' at the top of the screen.
2. Select 'plan through employer'.
3. Enter the location you want to search, then click 'Pick'.
4. Under Dental Plans select 'Cigna Dental PPO' then click 'Choose' to load the selected plan in the search.
5. You may enter a physician name and click 'Search'.

VISION – VSP

The Vision Plan, administered by VSP, offers a nationwide network composed of private practice optometrists and ophthalmologists, many of which offer extended evening and weekend hours.

VSP VISION PLAN

VSP only contracts with optometrists and ophthalmologists who own their private practices. It is our philosophy that our providers have the ultimate stake in their practice and will provide the best level of patient care. They have a vested interest in building patient loyalty and maintaining lifelong relationships with their patients. VSP doctors:

- Average nineteen years in private practice
- Are specially trained and licensed to diagnose and treat many medical eye conditions
- Are credentialed to the highest standards

At Your Vision Appointment.

You do not need an ID card to use VSP providers. At the time of service, simply identify yourself as a VSP member. The provider will call VSP member services to verify eligibility, receive authorization and provide the services. When using an out-of-network provider, you will need to get an itemized invoice/receipt from your service provider and submit it to the VSP Claims Department for reimbursement.

VSP Doctors Can Detect Symptoms Of:

- Thyroid disorders
- Neurological disorders
- Hypertension
- High cholesterol
- Diabetes
- Tumors

VSP Doctors Can Help Treat And Manage:

- Macular degeneration
- Diabetic retinopathy
- Cataracts
- Corneal diseases
- Eye infections
- Glaucoma

Contact VSP.

- Visit **vsp.com**
- Call **(800) 877-7195**
- Scan the QR Code for an up-to-date list of in-network providers.

VSP VISION PLAN SUMMARY		
BENEFIT	**IN NETWORK**	**OUT OF NETWORK**
Eye Exams (once every 12 months)	$10 copay	Up to $45 allowance
Lenses (once every 12 months) • Single Vision • Bifocal • Trifocal • Lenticular	 $30 copay $30 copay $30 copay $30 copay	 Up to $30 allowance Up to $50 allowance Up to $65 allowance Up to $100 allowance
Frames (once every 24 months)	You pay 80% of any amount over $200	Up to $70 allowance
Contact Lenses (once every 12 months)	Plan pays up to $130 for contacts and contact lens exam (fitting and evaluation)	Up to $105 allowance
Laser Correction Surgery	15% off usual and customary rates	No discount
Glasses and Sunglasses	20% off additional glasses & sunglasses, including lens options, from any VSP doctor within 12 months of your last Well Vision Exam	No discount

See plan certificate for frequency of service limitations and exclusions.

DISABILITY

Disability insurance is one of the most important things to consider as part of your financial wellness strategy. 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.

City of Suwanee pays for 100% of the cost of these valuable benefits so that you and your loved ones have peace of mind in case something happens.

SHORT TERM DISABILITY (STD)

Short-Term Disability 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)

Long Term Disability 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 SUMMARY		
	SHORT-TERM DISABILITY (STD)	**LONG-TERM DISABILITY (LTD)**
Eligibility	Active, full-time employees working a minimum of 40 hours per week	Active, full-time employees working a minimum of 40 hours per week
Benefit Percentage	60% of weekly earnings up to $1,500 per week	60% of monthly covered earnings up to $5,000 per month
Benefit Duration	Up to 11 weeks	Up to Social Security Normal Retirement Age (SSNRA)
Elimination Period	14 days after accident or sickness	90 days after accident or sickness
Benefit Cost	100% paid by City of Suwanee	100% paid by City of Suwanee

Pre-Existing Condition Limitation (LTD) – 3 months prior to effective date / 12 months after effective date.

LIFE AND AD&D – MUTUAL OF OMAHA

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 Suwanee provides all eligible employees and their eligible dependents with company paid Basic Life and AD&D insurance at no cost to you.

Additional Basic Life and AD&D Benefits.

- Benefit Reduction Schedule (applies to total benefit): 65% at age 70, 45% at age 75, 30% at age 80, 20% at age 85
- Terminal Illness: The lesser of 50% up to $100,000.
- Conversion is included.

BASIC LIFE AND AD&D SUMMARY		
COVERAGE	**ELIGIBILITY**	**BENEFIT AMOUNT**
Employee Life and AD&D	Active, full-time employees working a minimum of 40 hours per week	Life and AD&D: 2x annual salary, up to a maximum of $250,000
Spouse Life	Must be enrolled in City of Suwanee's medical plan; coverage ends at age 70	$10,000
Child(ren) Life	Must be unmarried and enrolled in City of Suwanee's medical plan	14 days–6 months: $500 6 months–19 years (26 if full-time student): $5,000

VOLUNTARY LIFE AND AD&D

City of Suwanee provides eligible employees with the opportunity to purchase additional Life and AD&D coverage for yourself and your eligible dependents at discounted group rates. You must purchase employee coverage to be able to purchase dependent coverage.

VOLUNTARY LIFE AND AD&D SUMMARY		
COVERAGE	**MAXIMUM BENEFIT**	**GUARANTEED ISSUE**
Employee	Increments of $10,000; 5x annual salary up to a maximum of $250,000	$100,000
Spouse	Increments of $5,000; Up to $100,000, not to exceed 50% of employee amount	$10,000
Child(ren)	14 days to 19 years (26 if a full-time student): $10,000	$10,000

Additional Voluntary Life and AD&D Benefits.

- Benefit Reduction Schedule (applies to total benefit): 65% at age 70, 45% at age 75, 30% at age 80, 20% at age 85
- Waiver of premium: If you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
- Terminal Illness: The lesser of 50% up to $100,000.
- Portability and Conversion is included.

Evidence Of Insurability (EOI).

Our carrier guarantees that employees will be able to purchase life insurance coverage for the Guarantee Issue (GI) amount during New Hire enrollment. To purchase voluntary life coverage above those amounts, the carrier requires Evidence of Insurability (EOI). If you or your dependents have medical conditions that make it difficult to purchase life insurance on your own, understanding EOI and the GI is important. EOI means you may need to complete a medical questionnaire, obtain a physical, and receive carrier approval before your insurance takes effect.

Life Insurance Enrollment Time Frames

- **New Hires:** You may apply for coverage up to $100,000 for yourself, and $10,000 for your spouse, and $10,000 for your child(ren) through the normal enrollment process. To purchase coverage above that, you will be required to provide EOI.
- **Marriage, Adoption or Birth:** If you are already enrolled in employee life insurance you can enroll new dependents as long as you follow normal Life Status Change deadlines. If you wish to increase your employee life amount above $100,000 or spouse coverage above $10,000, you must complete the EOI Form and submit it within the normal Life Status Change deadlines.
- **Open Enrollment Period/Late Entrant:** If you/your spouse are currently enrolled in voluntary life you may continue your coverage. If you are requesting more coverage than you presently have, EOI is required. For employees who waived coverage as a new hire and are now enrolling for the first time, EOI is required for any election amount.

TRAVEL ASSISTANCE – WORLDWIDE TRAVEL ASSISTANCE

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. Available to you and your eligible dependents on any single trip, business or personal travel, up to 90 days in length, and more than 100 miles from home.

- Plan ID Number: 9900MOO2
- For inquiries within the U.S. call **(800) 856-9947** (toll free).
- For inquiries outside the U.S. call **(312) 935-3658** (collect).

EMPLOYEE ASSISTANCE PROGRAM (EAP) – FEI

The City of Suwanee cares about the health and well-being of its employees and recognizes that a variety of personal problems can disrupt their personal and work lives.

FEI EMPLOYEE ASSISTANCE PROGRAM

Through the Employee Assistance Program (EAP), the City of Suwanee provides confidential access to professional counseling services for help in confronting such personal problems as alcohol and other substance abuse, marital and family difficulties, financial or legal troubles, and emotional distress. The EAP is available to all employees and their immediate family members offering problem assessment, short-term counseling, and referral to appropriate community and private services.

EAP Consultations Are Free.

There is no cost for consultations with an EAP counselor. If further counseling is necessary, the EAP counselor will outline community and private services available and will let employees know whether any costs associated with private services may be covered by their health insurance plan. Costs that are not covered are the responsibility of the employee.

No issues are too small or too large, and a professional counselor is available to help you when you need it. Schedule face-to-face, phone, video, text or chat assistance with professionals that's private, confidential and at no cost to you and your household members.

Confidential EAP Services.

Your Assistance Program can help you reduce stress, improve mental health, and make life easier by connecting you to the right information, resources, and referrals. All services are free, confidential, and available to you and your family members. This includes access to short-term counseling and a wide range of services.

- **Mental Health Sessions.** Manage stress, anxiety, and depression, resolve conflict, improve relationships, and address any personal issues. Choose from in-person sessions, video counseling, or telephonic counseling. Up to six (6) sessions per issue per year.
- **Life Coaching.** Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and achieve greater balance. Up to six (6) sessions per year.
- **Financial Consultation.** Build financial wellness related to budgeting, buying a home, paying off debt, resolving general tax questions, preventing identity theft, and saving for retirement or tuition.
- **Legal Referrals.** Receive referrals for personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.
- **Work-Life Resources and Referrals.** Obtain information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.
- **Personal Assistant.** Save time with referrals for travel and entertainment, seeking professional services, cleaning services, home food delivery, and managing everyday tasks.
- **Medical Advocacy.** Get help navigating insurance, obtaining doctor referrals, securing medical equipment, and planning for transitional care and discharge.
- **Member Portal.** Access your benefits 24/7/365 through your member portal with online requests and chat options. Explore thousands of self-help tools and resources including articles, assessments, podcasts, and resource locators.

How To Use Your EAP.

1. Call the toll-free EAP access number anytime at **(800) 638-3327** or visit **fei.mylifeexpert.com** and submit an online form.

   Note: Your company code is needed to create your account the first time. Company Code: Suwanee.
2. Your call will be answered by an intake counselor who will do a 10-12-min intake process to assess your needs and make appropriate referrals to an EAP counselor, legal, financial, and/or work-life services.
3. You will be given a referral to a local counselor or connected with an attorney, financial coach, or Work-Life Specialist as relevant.

BI-WEEKLY BENEFIT COSTS				
BENEFIT	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Cigna Open Access HMO Medical Plan	$83.01	$157.72	$154.07	$248.70
Cigna HDHP with HSA Medical Plan	$56.43	$107.98	$105.68	$170.13
Cigna Dental PPO Plan	$3.79	$7.55	$8.29	$13.49
VSP Vision Plan	$3.89	$6.23	$6.36	$10.25
Short Term Disability (STD)	100% Employer Paid	---	---	---
Long Term Disability (LTD)	100% Employer Paid	---	---	---
Basic Life and AD&D	100% Employer Paid			
Voluntary Life and AD&D	*See Voluntary Life Rate Chart*			

VOLUNTARY LIFE AND AD&D RATES	
EMPLOYEE AGE[1]	BI-WEEKLY COST PER $1,000
< 29	$0.109
30 - 34	$0.120
35 - 39	$0.131
40 - 44	$0.180
45 - 49	$0.280
50 - 54	$0.510
55 - 59	$0.800
60 - 64	$0.960
65 - 69	$1.620
70 - 74	$3.791
75 - 79	$4.610
80+	$8.720
CHILD(REN) BENEFIT	BI-WEEKLY COST[2]
$10,000	$1.10

1. Spouse coverage is based on employee age; ends at age 70.
2. Child per pay period cost is the total cost for all dependent children enrolled.

To calculate your cost for Voluntary Life and AD&D insurance, use this formula.

You can find your rate in the chart to the left.

_____ (Volume) x _____ (Rate) = _____ / 1000 = _____ (Monthly Cost)

To calculate your per pay period cost:

_____ (Monthly Cost) x 12 = _____ (Annual Cost) / 26 = _____ (Per Pay Period Cost)

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 continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more 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 continuation coverage 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 continuation coverage 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 continuation coverage 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 any 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 divorce or legally separate 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 continuation coverage 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 continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage 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 continuation coverage: 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 continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

- The end of employment or reduction of hours of employment
- 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 continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, 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 continuation coverage 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 or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Instead of enrolling in COBRA continuation coverage, 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 continuation coverage. Learn more about many of these 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 continuation coverage 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 continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage 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 continuation coverage 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. Visit **medicare.gov/medicare-and-you** for more information.

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 of the current Notice of Privacy Practices may be obtained by contacting your HR Department.

HIPPA SPECIAL ENROLLMENT RIGHT

Loss of Other Coverage: If you have declined or will be declining 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 or 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.

MEDICARE PART D DISCLOSURE NOTICE

Important Notice from the City of Suwanee 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 your current prescription drug coverage with City of Suwanee and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. 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 or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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.
2. The City of Suwanee has determined that the prescription drug coverage offered by Cigna's Medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Suwanee coverage will not be affected. The Cigna OAPIN (HMO) Medical plan at City of Suwanee offers Tier 1 Drugs at $15 Copay, Tier 2 Drugs at $30 Copay, and Tier 3 Drugs at $60 Copay. The HDHP (HSA) Medical plan offers Tier 1 Drugs at $15 Copay, Tier 2 drugs at $35 Copay and Tier 3 Drugs at $60 Copay, after the deductible of $2,600 (Individual) and $5,200 (family) has been satisfied. All prescriptions must be covered by Cigna's drug formulary. If you keep the City of Suwanee's coverage and enroll in Medicare Part D, both plans will coordinate coverage. The City of Suwanee plan will be primary.

If you do decide to join a Medicare drug plan and drop your current City of Suwanee coverage, be aware that you and your dependents will only be able to get this coverage back at open enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Suwanee and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may 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 November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Suwanee changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see inside back cover of your copy of "Medicare & You" handbook for the number) for personalized help
- Call 800-MEDICARE / **(800) 633-4227**. TTY (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call **(800) 772-1213** (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2024
Name of Entity/Sender:	Michelle Hunter
Contact--Position:	Human Resources Division Director
Address:	330 Town Center Avenue Suwanee, GA 30024
Phone Number:	(470) 350-1206

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 (or 96 hours as applicable). 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).

PREMIUM ASSISTANCE UNDER MEDICAID & 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 already 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/CHIP office, call **(877) 543-7669** or visit **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 January 31, 2024. Contact your State for more information on eligibility.

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment 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):
https://www.mycohibi.com/
HIBI Customer Service: (855) 692-6442

FLORIDA – Medicaid
Website: **https://www.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/families-and-children**
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: **in.gov/fssa/hip/**
Phone: (877) 438-4479
All other Medicaid Website: **in.gov/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
HIPP Phone: (800) 967-4660

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://kynect.ky.gov**
Phone: (877) 524-4718
Kentucky Medicaid: **https://chfs.ky.gov/agencies/dms**

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

MAINE – Medicaid
Enrollment Website: **www.mymaineconnection.gov/benefits/s/?language=en_US**
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: 711
Email: **masspremassistance@accenture.com**

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: **http://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: **https://www.hhs.nd.gov/healthcare**
Phone: (844) 854-4825

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx**
Phone: (800) 692-7462
CHIP Website: **www.dhs.pa.gov/CHIP/Pages/CHIP.aspx**
CHIP Phone: (800) 986-KIDS (5437)

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

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

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

TEXAS – Medicaid
Website: **https://www.hhs.texas.gov/services/health/medicaid-chip**
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: **https://dvha.vermont.gov/members/medicaid/hipp-program**
Phone: (800) 250-8427

VIRGINIA – Medicaid and CHIP
Website: **https://coverva.dmas.virginia.gov/**
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, 2024, 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. Department of Labor, 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.

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 your plan administrator or Human Resources to find a wellness program with the same reward that is right for you considering your health status.

NOTICE REGARDING WELLNESS PROGRAM THE NOTICE ISSUED BY THE EEOC IS BELOW:

The City of Suwanee's 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, health screenings, or any other wellness-related activities.

However, employees who choose to participate in certain wellness-related activities [preventive care, wellness challenges, educational events, etc.] will receive an incentive of up to $100. Additional small incentives may be available for employees who participate in certain wellness-related activities [wellness challenges, educational events, etc.]. Although you are not required to complete wellness activities, only employees who do so will receive incentives. 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 Suwanee may 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 health 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 for purposes of providing you services 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, please contact Human Resources.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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.

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 your Human Resource Department for assistance.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND 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 about your coverage offered by your employer, 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 for a Health Insurance Marketplace in your area.

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* 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 Suwanee	4. EMPLOYER IDENTIFICATION NUMBER (EIN) 58-095007	
5. EMPLOYER ADDRESS 330 Town Center Avenue	6. EMPLOYER PHONE NUMBER (470) 350-1206	
7. CITY Suwanee	8. STATE GA	9. ZIP CODE 30026
10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB? Michelle Hunter		
11. PHONE NUMBER (IF DIFFERENT FROM ABOVE)	12. EMAIL ADDRESS **mhunter@suwanee.com**	

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 and COBRA participants.

  ☐ Some employees. Eligible employees are:

* With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Legal spouses, dependent children up to age 26, unmarried children of any age if totally disabled and claimed as a dependent on the employee's federal income 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 if 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 PLANS - CIGNA
Group #: 00607884
(800) 244-6224 | **mycigna.com**

DENTAL PLAN - CIGNA
Group #: 00607884
(800) 244-6224 | **mycigna.com**

VISION PLAN - VSP
Group #: 30008467
(800) 877-7195 | **vsp.com**

HSA - OPTUM HEALTH BANK
(866) 234-8913 *(option 1)* | **optumhealthbank.com**

DISABILITY - MUTUAL OF OMAHA
Group #: G000B2GB
(800) 877-5176 | **mutualofomaha.com**

LIFE - MUTUAL OF OMAHA
Group #: G000B2GB
(800) 775-8805 | **mutualofomaha.com**

EAP - FEI
(800) 638-3327 | **fei.mylifeexpert.com**

CITY OF SUWANEE

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SARAH MUNZ
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Relation™
relationinsurance.com