2024 EMPLOYEE BENEFITS GUIDE

PLAN YEAR: JANUARY 1, 2024 – DECEMBER 31, 2024

Brookhaven
GEORGIA

INSIDE YOU WILL FIND INFORMATION ABOUT:

Eligibility & Enrollment | Wellness Program | Medical Benefits | Health Savings Account | Employee Assistance Plans
Dental Benefits | Disability Benefits | Life and AD&D Benefits | Flexible Spending Accounts | Retirement Plans

CONTENTS

To City of Brookhaven Employees:

It is that time of year again, time to consider and sign-up for benefit programs offered by the City of Brookhaven. As an employer, the City of Brookhaven believes in the wellbeing of employees and their families, including physical, mental, and long-term financial health. The employee benefits enrollment process can be confusing since it is only done once a year, but the choices you make during the open enrollment period to participate, or not, and at what level can be significant. Please rest assured that the Mayor and City Council continue to value the staff and the City's benefits package reflects that appreciation and commitment.

Sincerely,

Christian Sigman

Christian Sigman, City Manager

WELCOME

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

BENEFIT GOALS

The City of Brookhaven evaluates 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 employees and their dependents.
- Provide resources to support our employees and their dependents as they make important decisions about their health and health care.

As you enroll in your benefits, remember:

- Dependents can remain on the medical plan up to age 26 without maintaining student status, even if they are married.
- The City continues to fund the Health Savings Account for employees that elect the HDHP medical plan. Please refer to page 8 for contributions.
- The City rewards those that meet the annual Wellness goals, and are Tobacco free, with discounted rates for medical. These are the Preferred Rates on page 22.

BENEFIT ELIGIBILITY

SWORN POLICE OFFICERS

Sworn Police Officers are eligible for Medical, Dental, Vision, and FSA benefits on the first day of the month following 30 days of service. Basic Group Life, Disability, and Voluntary Life benefits will be effective on the first day of the month after your date of hire.

FULL-TIME EMPLOYEES

All other Full-time permanent employees are eligible for Medical, Dental, Vision, and FSA benefits on the first day of the month following 30 days of service. Basic Group Life, Disability, and Voluntary Life benefits will be effective on the first day of the month following 90 days of service.

Enroll the following dependents in our group benefits plan:

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

OPT-OUT BENEFITS

Waive Employee Coverage.

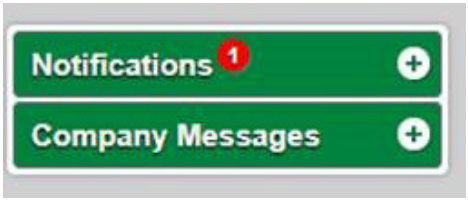
- Employees who decline medical coverage due to having coverage with another source are eligible for a $400 a month medical allowance. This allowance is taxable.
- Employees who are Medicare eligible are not eligible for the medical allowance.
- Forms are required to be completed and approved by HR to be eligible for the program.

BENEFITS ENROLLMENT

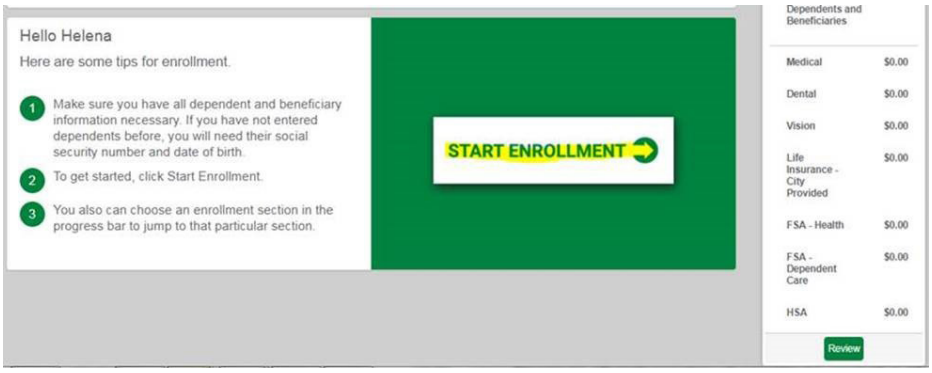
We are excited to offer online enrollment through Paycom, a web-based tool that allows you to make your benefit elections online.

ENROLLMENT INSTRUCTIONS

1. Sign into Paycom and click on the Benefits Checklist in Paycom.



2. Next Click on Start Enrollment. This will start the step by step process to enroll in or decline an offered benefit.



BENEFIT CHANGES

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

Once enrolled, most elections cannot be changed until the next annual Open Enrollment period unless you have a Qualifying Life Event. Open Enrollment generally occurs in November, with changes effective from January 1 to December 31 of the following year.

COMMON QUALIFYING LIFE EVENTS

- Marriage, divorce, legal separation
- Birth or adoption
- Receipt of a Qualified Medical Child Support Order or other court order
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period

To make benefit changes as a result of a Life Status Change, as allowed under Section 125 of the IRS Code

- Notify Human Resources within 30 days of the date of the qualifying event
- Provide proof of your life status event

TOBACCO AND NICOTINE CESSATION

The City of Brookhaven recognizes the health risks of tobacco and nicotine use, including vaping products. All City of Brookhaven buildings are smoke-free. Employees who are tobacco and nicotine free or become tobacco and nicotine free will receive a discount on their medical benefit premium. If you don't already live tobacco and nicotine free, we encourage you to do so.

TOBACCO AND NICOTINE CESSATION PROGRAMS

Employees who currently use tobacco and/or nicotine can refer to several tobacco and/or nicotine cessation resources in this guide to help you on your journey to quitting. Getting counseling and support can double your chances of successfully quitting tobacco and nicotine products.

One of your best resources for finding cessation programs is your Primary Care Physician. Your PCP can discuss over-the-counter and prescription medications. As part of the preventive care benefit of your Cigna medical plan, you can get certain FDA approved prescription drugs and many over-the-counter (OTC) nicotine replacement products at no cost to you with a prescription from your physician.

Tobacco and Nicotine Cessation Resource List.

Employees have several programs available to them through your wellness program and other resources.

- Cigna members can access online coaching for nicotine cessation at myCigna.com.
- Cigna Lifestyle Management offers a nicotine replacement therapy, delivered right to your home.
- Employees can participate in Northside Hospital's smoking cessation classes. Call (404) 780-7653, email smokingcessation@northside.com, or visit northside.com/community-wellness/built-to-quit.
- Georgia Tobacco Quitline: call (877) 270-7867 or visit smokefree.gov.
- CDC Tobacco Information and Prevention Source (TIPS): cdc.gov/tobacco.
- American Lung Association – Atlanta: call (770) 434-5864 or visit lungusa.org.
- E-Cigarettes: e-cigarettes.surgeongeneral.gov.
- Kill the Can: killthecan.org.

Health Benefits Of Quitting.

- 20 minutes: Blood pressure and pulse rate drop to normal.
- 24 hours: Lower risk of sudden heart attack.
- 2 weeks to 3 months: Circulation improves, walking becomes easier, lungs work better, and wounds heal more quickly.
- 1-9 months: More energy; nasal congestion, fatigue, coughing, breathing improve.
- 1 year: Risk of coronary heart disease is half that of someone still using tobacco.
- 5 years: Lung cancer risk drops by nearly 50% and risk of mouth cancer is half that of a tobacco user.
- 10 years: Lower risk of cancer; risk of stroke/lung cancer are similar to if you never smoked.

MEDICAL

The City of Brookhaven offers three Cigna health plan options: a Health Maintenance Organization (HMO) plan, a Point of Service (POS) plan and a High Deductible Health plan with Health Savings Account (HSA).

No matter which plan you choose, we encourage you and your dependents to have annual wellness exams. Most in-network preventive exams and well-child exams (including immunizations) are 100% covered by our plans. Preventive exams can detect if you are at risk for or already have a chronic disease such as heart disease, diabetes, hypertension and certain cancers, which are preventable. Talk to your health care provider to find out which screenings are recommended for you and when you need them.

CIGNA HMO PLAN

The HMO plan only provides in-network benefits (except emergencies). Before choosing the HMO, make sure your doctor is considered in-network. The POS and HSA plans offer in- and out-of-network benefits; however, you pay less when you see in-network providers.

CIGNA POS PLAN

The Cigna POS Medical Plan works like a traditional health plan. You will pay copays for some services, such as PCP/Specialist office visits, prescriptions, emergency room and urgent care visits, etc. Hospitalizations or major diagnostic services are subject to the deductible being met first, and then those services are covered at 90%. Once you reach the out-of-pocket maximum, your plan will pay for covered healthcare costs at 100%.

CIGNA HSA PLAN

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

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

HMO PLAN

- You pay 0% coinsurance after your deductible.
- Best for those who will only see in-network providers.
- Lowest out-of-pocket costs.

POS PLAN

- 90% coinsurance after deductible for in-network benefits.
- Lower premiums than the HMO Plan.
- Best for those who want the flexibility to see out-of-network providers.

HSA PLAN

- Medical visit copays and prescription copays accumulate towards the deductible.
- Lowest premiums of all three plans.
- Save pre-tax money for future expenses.

CIGNA HMO MEDICAL PLAN SUMMARY	
NETWORK NAME	
COMMON BENEFITS	**IN-NETWORK**
Calendar Year Deductible (accrue separately for in- & out-of-network)	$500 individual / $1,500 family
Out-of-Pocket Maximum (includes deductible, coinsurance, copays)	$1,500 individual / $4,500 family
Coinsurance	Plan pays 100%
Office Visits	
Preventive Care	Plan pays 100%; deductible waived
Primary Care Physician (PCP) / Retail Health Clinics	$25 copay / $15 copay with C CCD provider
Virtual Visit (MDLIVE)	$15 copay
Specialist	$50 copay / $40 copay with C CCD provider
Urgent Care	$60 copay
Hospital Services	
Inpatient Facility / Physician & Professional Services	Plan pays 100% after deductible
Outpatient Facility	$150 copay per admission
Outpatient Physician & Professional Services	Plan pays 100% after deductible
Emergency Room (waived if admitted)	$150 copay
Therapy Services	
Physical / Occupational / Speech / Hearing / Chiropractic Care	$50 copay
Labs, X-Rays & Diagnostics	
Independent Lab / Outpatient Facility	Plan pays 100%
Outpatient Radiology Services	Plan pays 100% after deductible
Advanced Imaging (MRI, MRA, CAT/PET scan)	Plan pays 100% after deductible
Mental Health / Substance Abuse	
Inpatient Services	Plan pays 100% after deductible
Outpatient Services	Plan pays 100%
Other Services	
Skilled Nursing Facility	Plan pays 100% after deductible
Hospice Care	Plan pays 100% after deductible
Ambulance (medically necessary only)	Plan pays 100% after deductible
PRESCRIPTION DRUG BENEFITS	
30-Day Retail: Generic / Brand / Non-Preferred / Specialty copays	$15 / $35 / $60 / 20% up to $300 max
90-Day Retail: Generic / Brand / Non-Preferred copays	$45 / $105 / $180
90-Day Home Delivery: Generic / Brand / Non-Preferred copays	$15 / $70 / $180
COMMON BENEFITS	**OUT-OF-NETWORK**
Calendar Year Deductible (accrue separately for in- & out-of-network)	No Benefit
Out-of-Pocket Maximum (includes deductible, coinsurance, copays)	No Benefit
Coinsurance	No Benefit

CIGNA POS MEDICAL PLAN SUMMARY	
NETWORK NAME	
COMMON BENEFITS	**IN-NETWORK COVERAGE**
Calendar Year Deductible (accrue separately for in- & out-of-network)	$1,000 individual / $3,000 family
Out-of-Pocket Maximum (includes deductible, coinsurance, copays)	$5,000 individual / $15,000 family
Coinsurance	Plan pays 90%
Office Visits	
Preventive Care	Plan pays 100%; deductible waived
Primary Care Physician (PCP) / Retail Health Clinics	$25 copay / $15 copay with C CCD provider
Virtual Visit (MDLIVE)	$15 copay
Specialist	$50 copay / $40 copay with C CCD provider
Urgent Care	$60 copay
Hospital Services	
Inpatient Facility / Physician & Professional Services	Plan pays 90% after deductible
Outpatient Facility / Physician & Professional Services	Plan pays 90% after deductible
Emergency Room (waived if admitted)	$150 copay
Therapy Services	
Physical / Occupational / Speech / Hearing / Chiropractic Care	$50 copay
Labs, X-Rays & Diagnostics	
Independent Lab / Outpatient Facility	Plan pays 100%
Outpatient Radiology Services	Plan pays 100% after deductible
Advanced Imaging (MRI, MRA, CAT/PET scan)	Plan pays 100% after deductible
Mental Health / Substance Abuse	
Inpatient Services	Plan pays 90% after deductible
Outpatient Services	$40 copay
Other Services	
Skilled Nursing Facility	Plan pays 90% after deductible
Hospice Care	Plan pays 90% after deductible
Ambulance (medically necessary only)	Plan pays 90% after deductible
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK & OUT-OF-NETWORK**
30-Day Retail: Generic / Brand / Non-Preferred / Specialty copays	$15 / $35 / $60 / 20% up to $300 max
90-Day Retail: Generic / Brand / Non-Preferred copays	$45 / $105 / $180
90-Day Home Delivery: Generic / Brand / Non-Preferred copays	$15 / $70 / $180
COMMON BENEFITS	**OUT-OF-NETWORK COVERAGE**
Calendar Year Deductible (accrue separately for in- & out-of-network)	$3,000 individual / $9,000 family
Out-of-Pocket Maximum (includes deductible, coinsurance, copays)	$15,000 individual / $45,000 family
Coinsurance	Plan pays 70% / 60%

CIGNA HSA MEDICAL PLAN SUMMARY	
NETWORK NAME	
COMMON BENEFITS	**IN-NETWORK**
Calendar Year Deductible (accrue separately for in- & out-of-network)	$3,000 individual / $5,400 family / $3,200 individual in a family
Out-of-Pocket Maximum (includes deductible, coinsurance, copays)	$5,000 individual / $14,000 family / $5,000 individual in a family
Coinsurance	Plan pays 100%
Office Visits	
Preventive Care	Plan pays 100%; deductible waived
Primary Care Physician (PCP) / Retail Health Clinics	Plan pays 100% after deductible
Virtual Visit (MDLIVE)	Plan pays 100% after deductible
Specialist	Plan pays 100% after deductible
Urgent Care	Plan pays 100% after deductible
Hospital Services	
Inpatient Facility / Physician & Professional Services	Plan pays 100% after deductible
Outpatient Facility / Physician & Professional Services	Plan pays 100% after deductible
Emergency Room (waived if admitted)	Plan pays 100% after deductible
Therapy Services	
Physical / Occupational / Speech / Hearing / Chiropractic Care	Plan pays 100% after deductible
Labs, X-Rays & Diagnostics	
Independent Lab / Outpatient Facility	Plan pays 100% after deductible
Outpatient Radiology Services	Plan pays 100% after deductible
Advanced Imaging (MRI, MRA, CAT/PET scan)	Plan pays 100% after deductible
Mental Health / Substance Abuse	
Inpatient Services	Plan pays 100% after deductible
Outpatient Services	Plan pays 100% after deductible
Other Services	
Skilled Nursing Facility	Plan pays 100% after deductible
Hospice Care	Plan pays 100% after deductible
Ambulance (medically necessary only)	Plan pays 100% after deductible
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK & OUT-OF-NETWORK**
Rx Deductible: Medical deductible applies (all copays listed below are after the deductible is met)	
30-Day Retail: Generic / Brand / Non-Preferred / Specialty copays	$15 / $35 / $60 / 20% up to $300 max
90-Day Retail: Generic / Brand / Non-Preferred copays	$45 / $105 / $180
90-Day Home Delivery: Generic / Brand / Non-Preferred copays	$15 / $70 / $180
COMMON BENEFITS	**OUT-OF-NETWORK**
Calendar Year Deductible (accrue separately for in- & out-of-network)	$7,800 individual / $15,600 family
Out-of-Pocket Maximum (includes deductible, coinsurance, copays)	$15,000 individual / $45,000 family
Coinsurance	Plan pays 70%

HEALTH SAVINGS ACCOUNT (HSA)

The City of Brookhaven offers employees enrolled in the HSA Medical Plan with the option to contribute pre-tax dollars to a Health Savings Account (HSA) through BenefitWallet to help with out-of-pocket health expenses for you and your qualified dependents.

USING YOUR HSA

Employees enrolled in a qualified HDHP are eligible to establish an HSA bank account that can be used for qualified out-of-pocket health expenses. You will receive a debit card to pay for eligible expenses, or you can reimburse yourself if you pay out-of-pocket.

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

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.

BENEFITWALLET HSA

A welcome kit will be mailed to the address provided during enrollment. You must complete an electronic and/or paper signature for us to actually open an HSA. Please note, BenefitWallet cannot post deposits (either payroll or direct deposits), or issue a debit card or checkbook until you take the necessary actions to open an account.

Your HSA Has Triple Tax Advantages.

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

Requirements To Open An HSA.

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

2024 ANNUAL HSA CONTRIBUTION LIMITS

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

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

Employer HSA Contributions.

City of Brookhaven contributes to employee Health Savings Accounts each pay period. The total annual employer contributions are as follows:

- Employee Only: $194
- Employee + Spouse: $388
- Employee + Child(ren): $369
- Family: $582

HSA Eligible Expenses.

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

- Acupuncture
- Ambulance
- Artificial limbs/teeth
- Chiropractor
- Contact lenses
- Dental treatment
- Diagnostic devices
- Doctor's office visits
- Eyeglasses & exams
- Fertility enhancements
- Hearing aids
- Laboratory fees
- Long-term Care
- Nursing home
- Physical therapy
- Prescription drugs
- Psychiatric care
- Psychologist
- Speech therapy
- Weight-loss programs
- Wheelchair
- X-rays

Employees MUST authorize their HSA account with BenefitWallet before contributions can be made. Please look for this authorization via a Human Resources email.

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.

Can I change my contributions?

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.

Do doctors require payment at the time of service?

Most network physicians will bill Cigna first and then bill you for your adjusted costs.

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 RESOURCES

CIGNA MEMBER ACCOUNT – myCigna

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

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

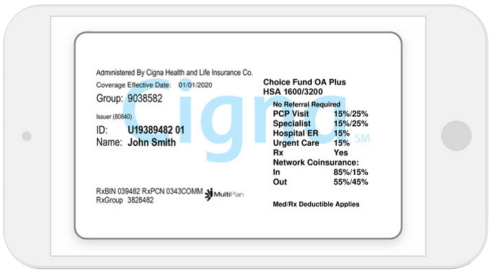
Register For Your Cigna Member Account.

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

CIGNA DIGITAL ID CARD

Cigna members have immediate access to digital ID cards and proof of coverage anytime, right from myCigna.com or the mobile app. Effective 1/1/2025, physical ID cards will no longer be issued. We encourage members to get into the habit of using myCigna or the app to view ID cards.

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



CIGNA VIRTUAL CARE (TELEHEALTH)

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

Virtual Medical Care.

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

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

Virtual Behavioral Health Care.

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

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

Schedule An Appointment.

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

CIGNA CARE MANAGEMENT

Cigna offers comprehensive care management solutions for members.

Precertification.

Precertification tells you whether a procedure, treatment or service will be covered under your medical plan and helps you get the right care in the right setting to avoid costly or unnecessary care.

Dedicated Care Managers.

Our care managers work with members, their families and their doctors, integrating medical, behavioral, pharmacy, disability, and disease management, all while helping customers maximize their benefits.

Outstanding customer support.

Our care management is delivered through a multidisciplinary team of a nurse, social worker, medical director, pharmacist and behavioral professional.

Specialty Care Management.

Cigna's Specialty Care Management programs are designed to help members with complex health issues and feature care managers who are nurses with expertise in condition management.

HEALTHY REWARDS®

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

Active&Fit Direct Program.

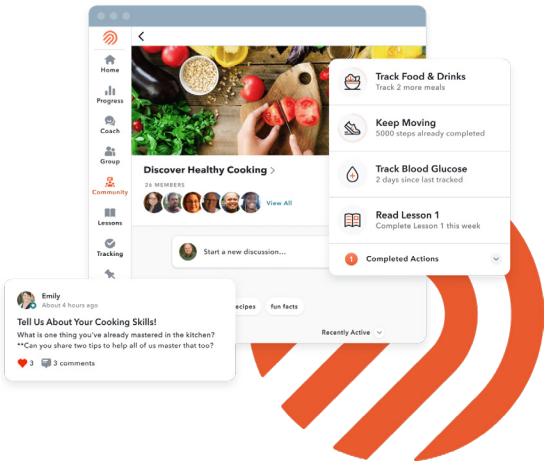
Members and their dependents over the age of 18 are eligible to join the Active & Fit gym membership network. Access multiple local gyms and standard fitness centers in the Active & Fit network, plus digital workout videos for $28 per month (plus a $28 enrollment fee). Login to myCigna.com, choose 'Wellness' then click 'Healthy Rewards-Discount Programs.'

OMADA – DIABETES PREVENTION PROGRAM

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

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

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



IDENTITYFORCE THROUGH CIGNA

IdentityForce offered through Cigna is included in your Cigna medical coverage at no additional cost.

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

- Password Manager
- Bank and credit card activity alerts
- Data breach notifications
- Medical ID fraud protection
- Lost wallet assistance & stolen funds replacement
- Credit Report, freeze and lock assistance
- Pre-existing Identity Theft Restoration

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

SAVE MONEY WITH CIGNA

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

Cigna has the tools and support you need to help you find a quality in-network doctor near you, including 24/7 live customer service, plus a host of valuable resources to help you manage and track claims, and compare cost and quality information. Cigna tools are accessible 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 (check-up) and specific tests, certain health screenings, and most immunizations. These services can take place during the same visit. You and your provider will decide what 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. Even though you may feel fine, getting your preventive care at the right time can help you take control of your health.

Which preventive services are covered?

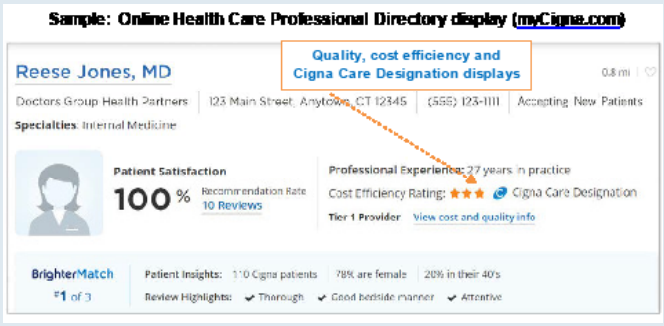
Many plans cover preventive care at no additional cost to you when you use a health care provider in your plan's network. Use the provider directory on myCigna.com for a list of in-network health care providers and facilities.

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. This gives you an evaluation of quality and cost-efficiency that you can trust.



Find a provider

Go to myCigna.com and click 'Find a Doctor or Service'. In the online directory. Look for the Cigna Care Designation symbol

Find a hospital

View ratings, cost and quality information on myCigna.com. Look for the Cigna Centers of Excellence designation

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.

Find an in-network provider:

The provider directory on myCigna.com shows you results based on your health plan network and your location.

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

Example: type "Primary Care Provider"> Results for In Network primary care providers near your area will be displayed.

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 a Health Reimbursement Account (HRA) or Health Savings Account (HSA) plan through Cigna, you may be able to use your funds to help pay for your eligible out-of-pocket expenses. Review your plan materials for more information.

Please note: Kroger and Kroger affiliated pharmacies are not in-network with Cigna.

Here are three ways to spend less on medication:

1. Buy generic. When it comes to prescription medications, 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 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 supply of your prescription. You'll make fewer trips to the pharmacy for refills. And you're more likely to stay healthy because with a 90-day supply on-hand, 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 start using home delivery, log into the myCigna App or myCigna.com. Click on the Prescriptions tab and select 'My Medications' from the drop down menu. Then 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 instead of an Out-of-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.

These In Network labs can provide general and specialty laboratory and pathology testing in locations that are convenient and cost-effective. You have a choice when it's time for lab tests, like blood work. Labs in Cigna's network give you quality service at a lower cost. 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 to get services. Cigna's team can find the most cost-effective facility for a service by comparing costs for hundreds of procedures. To find the costs of services within your location call Cigna at (800) 244-6224 or view the provider directory on myCigna.com.

How to search for outpatient facilities:

1. Log in to myCigna.com and select the 'Find Care & Costs' Tab
2. Find care and cost estimates in your area by 'Primary Care, Doctor by Type, Doctor by Name, Reason for Visit or Locations'

Example: Select 'Reason for Visit' and enter the procedure 'Shoulder MRI Scan with Dye'. Then select 'Facilities' to view the results for facility costs near your area.

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 are almost always located in retail stores, supermarkets and pharmacies.
- Use Cigna Virtual Care to get care for minor and acute conditions. Virtual visits with MDLIVE usually cost less than going to an urgent care clinic, and significantly less than an emergency room.

Cigna Health Information Line.

This service, staffed by nurses, helps you make informed decisions about health issues 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. Just call Cigna at (800) 244-6224.

LOWER COST AND TIME GREATER

Virtual Care	Convenience Care Clinic	Doctor's Office	Urgent Care Center	Emergency Room
For minor medical conditions. Connect with board-certified doctors or providers via video or phone through MDLIVE.	For minor medical conditions. See 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 Issues • Minor cuts or burns • Pregnancy testing • Vaccines	• General health issues • Preventative 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, Chest pain • Loss of consciousness • Shortness of breath • Head injury/major trauma • Blurry or loss of vision
Costs the same or less than a doctor's office visit. Appointments 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.

PRESCRIPTION DRUGS

DrugCompare™ and Price-a-Drug can help you make better decisions about your prescription drugs. For more information about your pharmacy network, you can go to Cigna.com/Rx90network or call (800) 285-4812 for Cigna Home Delivery.

DRUGCOMPARE™

Drug Compare is an interactive, web-based tool that allows users to compare condition-specific drug treatment options on 50 separate conditions, and search for valuable information on medications covered under the Cigna Pharmacy Management prescription drug list. Information includes possible side effects, dosage instructions, drug interaction alerts, and side by side comparisons of over 200 of the most commonly prescribed medications for features such as cost, side effects, and drug interactions.

PRICE-A-DRUG

Using Price-a-Drug members can easily check their out-of-pocket costs for a specific prescription drug at any network pharmacies and Cigna Tel-Drug. The drug prices and plan costs shown will be specific to the member's plan and the exact pharmacy location selected for the search.

90NOW: MAINTENANCE MEDICATION

Under your pharmacy plan, you can fill your maintenance medication in a 90-day or 30-day supply. For specified maintenance medications, you must obtain a 90 day prescription (filled at either a 90 day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30 day fills, you pay the entire cost of the medication.

Why fill a 90-day supply?

Filling your prescription in a 90-day supply may help you stay healthy because you're less likely to miss a dose. It also means you can make fewer visits to the pharmacy to refill your medication, and depending on your plan, you may be able to save money by filling your prescriptions 90-days at a time.

90-day retail pharmacies in your network:

- CVS (including Target and Navarro)
- Walmart

Please note: Kroger and Kroger affiliated pharmacies are not in-network with Cigna.

DENTAL

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

Routine dental care does more than brighten your smile. Routine dental exams can help catch serious health problems, such as diabetes, leukemia, heart disease and kidney disease. A healthier mouth may help you have a healthier life.

TOTAL CIGNA DENTAL PPO

Visit any dentist with the Total Cigna DPPO plan. You receive two routine cleanings and exams per year at no charge.

In-Network Dental Care.

Choosing a provider in Cigna's Total DPPO Network will save you money. Your plan covers in-network preventive services at 100%. While there is no deductible for preventive services, these do count towards your annual maximum benefit.

To find an in-network dental provider, call **(866) 494-2111**, visit myCigna.com, or go to Cigna.com and click "Find a Doctor, Dentist or Facility." Follow the prompts and select the plan 'DPPO/EPO > Total Cigna DPPO.'

Out-Of-Network Dental Care.

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

DENTAL PLAN SUMMARY		
NETWORK NAME: TOTAL CIGNA DPPO	**IN-NETWORK**	**OUT-OF-NETWORK**
Maximum Annual Benefit (per ind. 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 & Diagnostic Care Oral exams, cleanings, x-rays, sealants, fluoride application, emergency pain relief	Plan pays 100% no deductible	Plan pays 100% no deductible
Class II: Basic Restorative Care Fillings, root canal/endodontics, repairs, brush biopsy space maintainers, surgery, anesthetics, periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible
Class III: Major Restorative Care 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
Orthodontia Lifetime Maximum	$1,500	$1,500
Class IX- Implants	Plan pays 50% after deductible	Plan pays 50% after deductible

See plan certificate for frequency of service limitations and exclusions.

VISION

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

EyeMed members can take care of their vision and have routine eye exams, while saving money on all of their eye care needs. Eye exams can spot early signs of diabetes, high blood pressure, high cholesterol, heart disease, cataracts and glaucoma. Manage your vision benefits, find an eye doctor, print ID cards, get special offers and more on eyemed.com.

EYEMED VISION CARE

When you stay in-network, you keep more money in your pocket. Our Provider Locator helps you find the best fit.

- Search by zip code, your current location, doctor name, practice name or network
- See each provider's info at a glance — hours, specialties, proximity to you
- Filter results by services, brands, language spoken and more
- Schedule an eye exam online at many locations

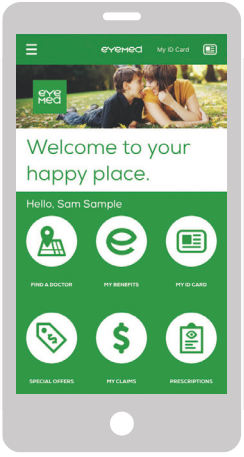
VISION PLAN SUMMARY		
VISION CARE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Eye Exam (once every 12 months)	$10 copay	Up to $45 allowance
Frames (once every 24 months)	$130 allowance, then 20% off balance	Up to $70 allowance
Standard Lenses (once every 12 months) Single Vision / Bifocal / Trifocal / Lenticular	$25 / $25 / $25 / $25 copay	Up to: $25 / $40 / $60 / $60
Lens Options (added to base price of lens) • Scratch Coating/Tint/UV Treatment • Standard Polycarbonate • Anti Reflective Coating • All Other Options	 $15 $40 $45 20% off retail price	 Not Covered
Contact Lenses (once every 12 months) • Conventional • Disposable • Medically Necessary	 $130 allowance, then 15% off balance $130 allowance $0 copay; paid in full	 Up to $104 Up to $104 Up to $200
Contact Lenses Fitting (standard / premium)	Up to $40 / 10% off retail price	Not Covered
Laser Correction Surgery Lasik or PRD from U.S. Laser Network	15% off retail or 5% off promo price	Not Covered

See plan certificate for frequency of service limitations and exclusions.

EyeMed Mobile App.

Get the most from your benefits – anytime, anywhere with the new EyeMed Mobile App.

- See benefits and eligibility at-a-glance
- Find an in-network eye doctor with the Provider Locator
- View your ID card and track your claims
- Grab special offers to help you save more
- Set upcoming exam and contact lens replacement reminders



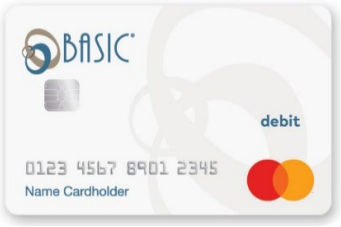
FLEXIBLE SPENDING ACCOUNTS

The city of Brookhaven offers employees the option to enroll in two types of Spending Accounts, an FSA for Healthcare expenses and a DCA for Dependent Care expenses. Employees who enroll in the HDHP medical plan with the Health Savings Account may enroll in the DCA, but not the FSA.

Use pre-tax money in an FSA to pay for health or dependent care expenses incurred during the plan year. Fund your FSA for a predetermined through bi-weekly pre-tax payroll deductions and pay for eligible expenses using a debit card at the time of service or by submitting a receipt after-the-fact. Please note that all Flexible Spending Accounts are separate and you cannot co-mingle funds.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

A Health Care FSA is used to pay for qualified medical, dental and vision expenses incurred by you and your dependents during the plan year.



About your Health Care FSA.

- The Health Care FSA annual contribution limit is projected to increase from $3,050 to $3,200. Your election will be in effect through December 31, 2024.
- Access your full annual contribution at anytime during the plan year for incurred expenses.
- You cannot change your annual contribution during the plan year unless you have a qualifying life event.
- The deadline for manual claim submission is 90 days after the end of the plan year.

Healthcare FSA Eligible Expenses.

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

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

Unused Funds.

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

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

How To Plan Ahead.

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

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

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

About Your Dependent Care FSA.

- The Dependent Care Flexible Spending maximum allowed per IRS will remain $5,000.
- Your unused balances do not carry over and cannot be refunded (use-it-or-lose-it).
- You ONLY have access to funds that have been withheld from your paycheck. If you submit receipts for a higher amount, you will be reimbursed as future deductions are deposited into your account
- The deadline for submission of manual claims is 90 days after the end of the plan year.

Dependent Care Eligible Expenses.

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

Dependent Care Ineligible Expenses.

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

LIFE AND AD&D

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

Life Benefits Versus AD&D Benefits.

If the insured's passing was related to a medical condition such as cancer, only the life insurance would provide a payout, If the insured's passing was related to an automobile accident, both life and AD&D would provide a payout.

BASIC LIFE AND AD&D

The City of Brookhaven provides all eligible employees with Basic Life and AD&D at no cost to you.

Full-Time Employees.

Full-time employees receive a Basic Life benefit and AD&D benefits of 3x annual earnings, to a maximum benefit of $750,000. Employees are eligible for benefits on the first day of the month following 90 days of service.

Public Safety Employees.

Public Safety employees are given an additional $50,000 life insurance benefit and are eligible for Life and AD&D on the first day of the month following 0 days of service.

Other Eligible Employees.

City Council members and Mayors will receive a $50,000 life insurance benefit.

SUPPLEMENTAL LIFE AND AD&D

In addition to the Basic Life and AD&D benefits provided to you at no cost by the City of Brookhaven, eligible employees have the opportunity to purchase additional Life and AD&D coverage for yourself, and additional Life insurance coverage for your spouse and/or child(ren). The AD&D benefit is equal to your Life benefit amount.

Dependent Coverage.

You must purchase employee coverage to purchase dependent coverage. Dependent children are covered to age 20 and age 24 if they are a full-time student. You must present proof of student status to The Standard.

Evidence of Insurability (EOI).

Evidence of Insurability (EOI) is required for new employees to purchase insurance above the Guaranteed Issue (GI) amount, or for any employee who wants to increase their coverage after new hire enrollment.

If you or your dependents have medical conditions that make it difficult to purchase life insurance on your own, you should consider applying for life insurance when you are hired. EOI may involve completing a medical questionnaire, obtaining a physical, and receiving carrier approval before your insurance takes effect.

VOLUNTARY LIFE AND AD&D SUMMARY

COVERAGE	INCREMENTS	BENEFIT	EOI REQUIRED	AGE REDUCTION
Employee	$10,000	Up to 3x salary	Benefits over $50,000	Age 65-69: 65% Age 70-74: 50% Age 75+: 35%
Spouse	$5,000	Up to $250,000; not to exceed 100% of employee benefit	Benefits over $15,000	
Child(ren)	$2,000	$10,000	N/A	N/A

HOUSING REIMBURSEMENT PROGRAM

The housing reimbursement program provides additional compensation to City of Brookhaven Police Department sworn officers who reside within the city limits.

Housing reimbursement can only be used for the rent or payment of a mortgage for a single family home, condominium, apartment or any unit suitable for housing one family. The taxable allowance amount is $1,000 per month up to a maximum of $9,600 per year. Please note: these limits are subject to change as IRS maximums are released for 2023. Maximums will match those set by the IRS.

DISABILITY

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

SHORT-TERM DISABILITY (STD)

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

STD provides income continuation for a short period of time if you are unable to work due to a non-work related accident or illness. Pregnancy is also covered under STD. Short-Term Disability is a taxable benefit.

Short-Term Disability Eligibility

Sworn Police Officers are eligible on the first day of the month following 0 days of service.

All other Full-time permanent employees are eligible on the first day of the month following 90 days of service.

LONG-TERM DISABILITY (LTD)

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

LTD provides income continuation in the event you will be out of work for a long period of time due to covered injury or illness. Long-Term Disability is a taxable benefit.

Long-Term Disability Eligibility

All Full-time permanent employees are eligible for LTD benefits 91 continuous days after their Short-Term Disability benefits begin.

DISABILITY SUMMARY		
	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Benefit Percentage	60% of gross wages up to $2,500 per week	60% of monthly salary up to $10,000
Benefit Waiting Period	14 days after qualifying accident or illness	90 days after qualifying accident or illness
Benefit Duration	Up to 90 days	Age 65 or SSNRA

RETIREMENT SAVINGS PLANS

ONEAMERICA®

The City of Brookhaven provides eligible employees with a comprehensive retirement program consisting of a 457(b) plan, a 401(a) plan, and a Social Security replacement plan. These benefits are administered by OneAmerica.

The 457(b) plan allows employees to defer part of their pay on a tax-deferred basis into the investment of their choice. The City will match 2 to 1 your contributions to the 457(b) into a 401(a) plan of eligible compensation (i.e. if you put 5% into the 457(b) plan), the City of Brookhaven will contribute 10% into the 401(a) plan.

Retirement Plan Details

- Salary Deferral Contributions. You may contribute from 1% to 100% of your pay each pay period toward your retirement plan. For 2022 an individual can contribute up to $20,500* into your 457(b) tax free (may be subject to change pending new IRS guidance).
- Catch-Up Contributions. If you are age 50 or older by December 31st, you can contribute an additional $6,500* in a catch-up contribution.
- Vesting. You are always 100% vested in the contributions you choose to defer. Employees will be 100% vested in the contributions the City of Brookhaven matches after completing one year of service.
- Investments. Contributions will automatically be directed into the plan's investment default if you do not select investment options when you sign up for all retirement plans.
- Contact OneAmerica. Employees can call OneAmerica's Participant Service Center at (800) 249-6269.

EMPLOYEE ASSISTANCE PROGRAM

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

CIGNA EMPLOYEE ASSISTANCE PROGRAM

All City of Brookhaven employees have access to Cigna's Employee Assistance Program, regardless of enrollment in the offered medical plans. A master's level Member Advocate from Cigna EAP will confidentially consult with you over the phone and will provide you with resources, action plans, and information to help you address your issue. You may also receive referrals to support groups, community resources, an Cigna network counselor, or your health plan.

Employees enrolled in a Cigna medical plan can login to myCigna.com and select the Employee Assistance Program (EAP) under the 'My Coverage' tab. If you do not have Cigna health coverage, visit myCigna.com and select the 'Register Now' button. Select EAP only and use the company code of 'brookhaven.' Contact Cigna EAP services at (877) 622-4327, TTY/TDD users call 711.

Cigna EAP Features:

- Face to Face Counseling
- Legal Assistance
- Financial Assistance
- ID Recovery
- Tobacco Cessation
- Dependent Care Resources
- Crisis Consultation
- Monthly webinars
- Self-assessment tools

Emotional Health

- Get 1-3 sessions per issue per year with a dedicated, licensed counselor at no cost.
- Confidential phone consultations are available to you and anyone living in your household at no cost.

Home Life Referrals

Get assistance with referrals to community resources and services, such as child care, senior care, and pet care.

STANDARD'S EMPLOYEE ASSISTANCE PROGRAM

Standard's EAP Program makes it easy to access support, guidance, and resources. Health Advocate℠ provides Standard's EAP services. Their professionals can help with referrals to support groups, a network counselor, community resources, or your health plan.

Contact Standard EAP.

Call (888) 293-6948 or visit healthadvocate.com/standard3. Employees can also download the EAP Mobile App. Choose The Standard- EAP- 3 visits to access your benefits.

TRAVEL ASSISTANCE PROGRAM

The Travel Assistance program is provided free by the City and is administered through UHC Global. Employees, their spouse, and children through age 25 are covered with your Life insurance from The Standard.

Travel Assistance provides many benefits related to travel including, but not limited to, pre-trip assistance, medical assistance while traveling, emergency transportation, and legal services. Employees will receive a wallet card which lists the contact information for UHC Global. Support is available 24 hours a day, 365 days a year.

In the U.S., Canada, Puerto Rico, U.S. Virgin Islands, and Bermuda, call (800) 527-0218. All other locations worldwide, call 1-410-453-6330 collect. You can also email assistance@uhcglobal.com or visit standard.com/travel.

BENEFIT RATES

- Preferential Wellness Rates: applicable for those employees who met the 2023 Wellness requirement.
- Standard Rates: applicable for those employees who did not meet the 2023 Wellness requirement.
- Tobacco and Nicotine User Rates: applicable for those employees who use tobacco and/or nicotine products.

PREFERENTIAL WELLNESS RATES				
BENEFIT	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
HMO Medical	$67.00	$140.71	$130.66	$204.37
POS Medical	$36.08	$74.15	$70.04	$110.33
HSA Medical	$0.00	$0.00	$0.00	$0.00
Dental	$0.00	$8.23	$7.58	$15.56
Vision	$2.29	$4.36	$4.59	$6.74
Basic Life and AD&D	100% Employer Paid	*N/A*	*N/A*	*N/A*
Disability	100% Employer Paid	*N/A*	*N/A*	*N/A*

STANDARD RATES				
BENEFIT	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
HMO Medical	$71.61	$150.38	$139.64	$218.41
POS Medical	$38.56	$79.25	$74.85	$117.91
HSA Medical	$0.00	$0.00	$0.00	$0.00
Dental	$0.00	$8.23	$7.58	$15.56
Vision	$2.29	$4.36	$4.59	$6.74
Basic Life and AD&D	100% Employer Paid	*N/A*	*N/A*	*N/A*
Disability	100% Employer Paid	*N/A*	*N/A*	*N/A*

TOBACCO AND NICOTINE USER RATES				
BENEFIT	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
HMO Medical	$99.38	$200.17	$189.53	$298.87
POS Medical	$67.31	$136.39	$128.72	$202.77
HSA Medical	$26.28	$52.57	$49.94	$78.84
Dental	$0.00	$8.23	$7.58	$15.56
Vision	$2.29	$4.36	$4.59	$6.74
Basic Life and AD&D	100% Employer Paid	*N/A*	*N/A*	*N/A*
Disability	100% Employer Paid	*N/A*	*N/A*	*N/A*

SUPPLEMENTAL LIFE AND AD&D MONTHLY RATES									
AGE	< 29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
Employee / Spouse Life Rate per $1,000	$0.08	$0.09	$0.10	$0.15	$0.22	$0.38	$0.62	$0.84	$1.49
Child Supplemental Life Rate Per $1,000	$0.20	Employee / Spouse / Child Supplemental AD&D Rate Per $1,000							$0.04

REQUIRED NOTICES

COBRA CONTINUATION COVERAGE RIGHTS

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

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

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

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICARE PART D DISCLOSURE NOTICE

Notice about your Prescription Drug Coverage and Medicare: Please read this notice carefully and keep it where you can find it. This notice has information about our company's group health plan prescription drug coverage, and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

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

Because our plan is considered creditable coverage, you can enroll and/or stay enrolled in our plan, and not pay a higher premium if you later decide to join a Medicare drug plan.

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

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

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

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

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

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail from Medicare every year. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call (800) 633-4227. TTY users should call (877) 486-2048.

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

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare that offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you have maintained creditable coverage, and are not required to pay a higher premium amount (a penalty).

Date:	November 1, 2023
Name of Entity/Sender:	City of Brookhaven
Contact--Position/Office:	Lillian Young, Director of Human Resources
Address:	4362 Peachtree Road Brookhaven, GA 30319
Phone Number:	404-637-0478

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Paperwork Reduction Act Statement.

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

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

NOTICE REGARDING WELLNESS PROGRAM

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

However, employees who choose to participate in the wellness program will receive incentives of a preferrential wellness rate and a 'free day' off (8-12 hours based on your type of employment) for completing a designated number of wellness activities or preventive health screenings. Although you are not required to complete any wellness activities, participate in the biometric screening or any other types of wellness screenings or exams, only those who do so will receive the incentive.

The information and the results from your biometric screening, or other type of medical examination or screening, 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 and lifestyle management programs. 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. Although the City of Brookhaven's wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, the City of Brookhaven 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.

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 employer's Human Resources department (see back cover) and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

HIPPA NOTICE OF PRIVACY PRACTICES REMINDER

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

HIPPA Special Enrollment Right.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION

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

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 Resources Department for assistance.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

PART A: General Information.

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

How Can I Get More Information?

For more information please check your summary plan description or contact your Human Resources 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.

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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 Brookhaven	4. EMPLOYER IDENTIFICATION NUMBER (EIN) 46-1567295	
5. EMPLOYER ADDRESS 4362 Peachtree Road N.E.	6. EMPLOYER PHONE NUMBER (404) 637-0478	
7. CITY Brookhaven	8. STATE GA	9. ZIP CODE 30319
10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB? Lillian Young		
11. PHONE NUMBER (IF DIFFERENT FROM ABOVE)	12. EMAIL ADDRESS lillian.young@brookhavenga.gov	

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

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

☑ All employees. Eligible employees are:

All Full-time employees who work a minimum of 30 hours per week.

☐ Some employees. Eligible employees are:

* With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

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

☐ We do not offer coverage.

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

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

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

CARRIER CONTACTS

MEDICAL & DENTAL – CIGNA
(800) 244-6224 | mycigna.com

HEALTH SAVINGS ACCOUNT – BENEFITWALLET
(877) 472-4200 | www.mybenefitwallet.com

VISION – EYEMED
(866) 939-3633 | eyemed.com

FLEXIBLE SPENDING ACCOUNTS – BASIC
(800) 372-3539 | www.basiconline.com

LIFE AND AD&D – THE STANDARD
(800) 628-8600 | www.standard.com

LONG-TERM DISABILITY – THE STANDARD
(800) 368-1135 | www.standard.com

SHORT-TERM DISABILITY – THE STANDARD
(800) 368-2859 | www.standard.com

EMPLOYEE ASSISTANCE PROGRAM – CIGNA
(888) 712-1567 | www.cignaeap.com
Company Code: brookhaven

EMPLOYEE ASSISTANCE PROGRAM – THE STANDARD
(888) 293-6948 | healthadvocate.com/standard3

TRAVEL ASSISTANCE – THE STANDARD/UHC GLOBAL
(800) 527-0218 (USA) | assistance@uhcglobal.com
1-410-453-6330 (Worldwide)

CITY OF BROOKHAVEN

LILLIAN YOUNG – DIRECTOR OF HUMAN RESOURCES
(404) 637-0478 | lillian.young@brookhavenga.gov

MELISSA BROWN – HUMAN RESOURCES MANAGER
(404) 637-0469 | melissa.brown@brookhavenga.gov

MARTHA ALLEN– HUMAN RESOURCES GENERALIST
(404) 637-0466 | martha.allen@brookhavenga.gov

RELATION INSURANCE

MICHELLE FORD – SENIOR ACCOUNT MANAGER
(678) 740-0223 | michelle.ford@relationinsurance.com

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

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

Additional resources can be found in Benefits section under Benefits Form and Links in Paycom.

Relation™
relationinsurance.com