EMPLOYEE HEALTH BENEFITS SUMMARY
JULY 1, 2023 - JUNE 30, 2024

THE CITY OF
ALPHARETTA
GEORGIA

Inside you will find information about our:

Eligibility & Enrollment | Medical Benefits | Wellness Benefits | Dental Benefits | Vision Benefits | Disability Benefits | Life Benefits

This booklet provides a summary of plan highlights. Please consult the carrier's contract for complete information on covered charges, limitations, and exclusions. This is not a binding contract. The carrier's contract will prevail. If you have questions please contact the carrier or Alliant Insurance Services.

WELCOME

2023-2024

2 Park Plaza
Alpharetta, GA 30009
Phone: 678.297.6000
www.alpharetta.ga.us

Fellow Employees,

I am excited and honored to be back in Alpharetta and part of an outstanding team of dedicated professionals who share a passion for service this wonderful community and improving the lives of others. Each of you and the work that you do are a big part of what makes Alpharetta an awesome community, and the Major, City Council, and I value and appreciate you and this team.

We are pleased to present this guide to our 2023-2024 health and wellness benefits program. We are even more pleased to let you know that, after tough negotiations, the City is renewing our insurance benefits through Cigna with no increase to your monthly premiums.

In addition, we will continue the premium discounts offered for tobacco-free families and for participation in our EHG Wellness Program. Healthy lifestyles benefit you and your family, and we are happy to be able to continue this program to encourage you to enjoy activities and programs that improve your health and wellbeing. You will also continue to have access to a variety of tools through Cigna for accessing online medical information, confidentially storing, and following your personal health information, and finding the best healthcare providers at the best prices.

I hope that you will take time to become familiar with our benefits program and learn how to get the most out of it for you and your family. Remember, though, that the Benefits Division of our Finance Department is committed to helping you understand and use your benefits, so please do not hesitate to contact them with questions or assistance.

My best wishes for your good health and happiness!

Chris Lagerbloom
City Administrator

Contents

Our Benefit Goals

We evaluate our benefit programs each year to make sure that we accomplish several goals.

We strive to:

- Promote health and wellness among City of Alpharetta employees and their dependents
- Provide employees with affordable access to health benefits
- Provide competitive benefits programs
- Educate employees on the appropriate use of health benefits
- Provide resources to support employees and their dependents as they make important decisions about their health and health care
- Educate employees on all of the benefits and resources available to them

You Can Lower Your Health Benefit Premium Costs

Here are ways you can lower your costs this year:

- Sign the affidavit committing not to use tobacco
- Participate in our Employee and Spouse Wellness Program with Engagement Health Group prior to July 1, 2023
- Stay engaged in the Wellness Program year-round

Your Benefits are Paid for With Pre-Tax Dollars

Every penny in your paycheck counts.

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

What Does a Cafeteria Plan Mean to Me?

You save at least 15% in Federal Tax

You save 7.65% in FICA Tax

You save 6% in Georgia State Tax

Reminder of Health Care Reform changes to your benefits:

- Over-the-counter drugs require a prescription from your doctor to be eligible for reimbursement under the medical Flexible Spending Account (FSA) or the Health Savings Account (HSA)
- Lifetime limits have been eliminated on all medical plans
- Dependents can remain on medical, dental, and vision insurance thru the end of the calendar year in which they reach age 26, without maintaining student status, even if they are married
- Preventive care visits (including certain screenings and immunizations) are covered at 100%, so there is no charge to you when you visit a network provider

Claims Questions or Problems

Alliant Insurance Services is the City of Alpharetta'sadvisory firm.

We are available to help you resolve any problems you have with your employee benefits.

If you have a problem or a question about a claim:

1. Call your insurance carrier's customer service department.
2. If the carrier does not resolve your problem, please call Benefits Specialist, Leslie Russell, at 678-297-6042.

Benefits Eligibility

The City of Alpharetta provides a comprehensive employee benefit program to all full-time employees working 30 hours or more per week. Employees are eligible for coverage on the first day of the month following 30 days of full-time employment.

Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed legal guardian.

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children up to age 26
- Children of any age if incapable of self-sustaining employment by reason of mental retardation or physical disability (as determined by the health insurance carrier) and chiefly dependent upon the policyholder for support and maintenance (documentation must be provided)

Many employees have other dependents living with them who are not eligible for our benefit plans.

Dependents NOT eligible to be added to our benefit plans:

- Grandchildren, nieces, nephews or other children that do not meet specifications listed to the left
- Common law spouses or domestic partners (same or opposite sex)
- Ex-spouses
- Parents, step-parents, grandparents, aunts, uncles, or other relatives that are not qualified legal dependents (even if they live in your house)

Making Changes to Your Benefits

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

Once enrolled, most pre-tax benefit elections cannot be changed until the next annual Open Enrollment period unless you have a qualifying Life Status Change. Open Enrollment generally occurs in May with plan changes effective each plan year from July 1 through June 30 of the following year.

For all new hired employees, you will be required to submit the appropriate paperwork to verify your dependents. Please refer to your new hire paperwork for a list of appropriate documents.

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

- Notify the Benefits Divison within 30 days of the date of the qualifying event,
- Provide proof of your life status event, and
- Complete and submit your enrollment form.

The Most Common Life Status Changes

- Marriage, divorce, legal separation
- Birth or adoption
- 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
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order, or other court order

Medical Benefits

City of Alpharetta provides employees with two medical benefit choices through Cigna.

The rising cost of health care is making it harder for some people to find affordable medical benefits. Our goal is to offer affordable benefit options that ensure you have access to high-quality services. You can choose from our Health Reimbursement Arrangement (HRA) Plan or our Health Savings Account (HSA) Plan. You will notice some similarities between our plans such as PCP selection, the network of providers, and free wellness visits. The differences are outlined as well to help you select the plan that best suits your needs.

Choosing a Primary Care Physician (PCP)

You decide if you want to choose a PCP as your personal doctor to help coordinate care and act as personal health advocate. It's recommended but not required. A PCP provides a valuable resource and can be a personal health advocate.

In-Network vs. Out-of-Network

Each time you seek medical care, you can choose your doctor — either a doctor who participates in the Cigna network or someone who does not. When you visit a participating doctor, you receive in-network coverage and pay lower out-of-pocket costs and have less paperwork. That's because our participating health care professionals have agreed to charge lower fees, and your plan covers a larger share of the charges. By choosing to see doctors or other health professionals who participate in the Cigna network, you don't have to file for benefits and the provider handles any necessary precertifications.

Your in-network and out-of-network deductibles will not cross accumulate. If you go out-of-network, you will have to meet the separate out-of-network deductible. However, the amount you pay for out-of-network services counts towards both your in-network and out-of-network deductibles.

If you need to see a specialist, you do not need a referral to see a doctor who participates in the Cigna network. Just make the appointment and go! Pre-certification may be necessary for hospitalizations and some types of outpatient care, but there is no paperwork for you (if you use an in-network health care provider). You also have the freedom to visit doctors or use facilities that are not part of the Cigna network, but your costs will be higher and you may need to file a claim. Cigna covers authorized medical services provided by an Open Access Plus participating hospital at your in-network benefits level – whether you were sent there by an in- or out-of-network doctor.

All family members contribute towards the family deductible. The plan cannot pay an individual's medical claim until the total family deductible has been met, even if he or she has met the individual deductible.

Wellness Visits and Select Preventive Generic Prescriptions

In-network wellness visits are covered at 100% and are not subject to the deductible. We encourage you and your dependents to follow the age-based schedule and have your wellness exams. Regular health screenings are one of your best tactics in managing the risk factors for various illnesses and diseases. Your PCP can tell you what screenings you need and when you need them. Remember, select preventive generic prescriptions are covered at 100% to plan members. The IRS mandates the covered preventive prescriptions. MyCigna.com updates the drug listing quarterly, identifying preventive medications with a "PM" symbol.

Using Cigna.com and MyCigna.com

MyCigna.com is for current plan members

Anyone can learn more about our plan or search the provider directory using Cigna.com. For better results, members should log into MyCigna.com.

To search for participating doctors, specialists, pharmacies, hospitals and facilities closest to home and work using www.Cigna.com:

- Go to the home page and click "Find a Doctor"
- Choose a Directory that applies to you
- Select the type of health care professional or facility you are looking for, or you can search by location and distance
- Select your plan and the type of doctor you need

Your search results will include a complete provider profile including the doctor's education, languages spoken and hospital affiliations. You will also get a detailed map with directions.

High-Deductible Health Plans

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, the City's HRA and HSA plans cover expenses at 90% up to the out of pocket maximum. Once you have met your out of pocket maximum, expenses are paid at 100% You may see the term HDHP associated with your HRA or HSA account.

HRA Plan

The HRA Plan includes an HRA account that is funded by the City of Alpharetta and managed by Cigna on behalf of the employee. Funds in the HRA are used to pay medical expenses subject to the plan deductible.

City Contributions to Your HRA

Participants in the HRA plan receive an HRA contribution of either $750 (employee only) or $1,250 (employee + spouse, employee + child(ren)) or $1,500 (family) for expenses subject to the plan deductible. Unlike the HSA plan, you may not make additional pre-tax contributions to the HRA. Funds left in your HRA rollover to a maximum amount equal to the plan deductible. These funds are not portable if you leave the City.

HSA Plan

The HSA Plan is funded by both the employee and the City of Alpharetta and is used to help pay for qualified medical, dental, and vision expenses incurred by the employee and their dependents.

City Contributions to Your HSA

Participants in the HSA plan receive an HSA contribution from the City of Alpharetta of either $1,000 (employee only) or $1,750 (employee + spouse, employee + child(ren)) or $2,000 (family) that can be used towards qualifying medical expenses before the plan deductible is met, as well as used for certain other medical, dental, and vision expenses. The funds can also be saved for future health expenses or for retirement and are portable if you leave the City.

HRA PLAN

City of Alpharetta's Health Fund Contribution	$750 employee $1,250 employee + spouse, employee + ch ld(ren) $1,500 family	
	In-Network	**Out-of-Network**
One-Way Accumulation: Anything you meet ir-network does *not* count towards your out-of-netw ork deductible.		
Collective Family Deductible: Must be met in full before Cigna pays.		
Plan Year Deductible (prescription drugs costs do not apply towards deductible)	$2,500 employee $5,000 family collective	$5,000 employee $10,000 family collective
Out-of-Pocket Maximum (includes deductible) (prescription drugs costs apply)	$3,000 employee $6,000 family	$7,500 employee $22,500 family
Member Coinsurance (applies to all expenses unless otherwise stated)	90%	60%
Lifetime Maximum	Unlimited	Unlimited
Routine Preventive Care	Cigna pays...	Cigna pays...
• Adult Physical Exams and Immunizations	100%, no deductible	70% after deductible
• Well-Child Exams/Immunizations (periodic visits, depending on age)	100%, no deductible	70%, no deductible
• Gynecology Examination	100%, no deductible	70% after deductible
• Mammograms	100%, no deductible	70% after deductible
• Digital Rectal Exam/Prostate Antigen Test *(covered for males over 50)*	100%, no deductible	70% after deductible
• Colorectal Cancer Screening *(for all members over age 50)*	100%, no deductible	70% after deductible
Physician Services	Cigna pays...	Cigna pays...
• Non-Specialist Visit (non-surgical)	90% after deductible	60% after deductible
• Specialist Office Visit (non-surgical)	90% after deductible	60% after deductible
• Cigna Virtual Care	90% after deductible	N/A
• Office Visit for Surgery	90% after deductible	60% after deductible
• Allergy Injections (coverage for allergy testing is based on the type of service performed and where it is rendered)	90% after deductible	
Diagnostic Lab and X-ray	90% after deductible	60% after deductible
Emergency Medical Care	Cigna pays...	Cigna pays...
• Urgent Care Provider	90% after deductible	90% after deductible
• Emergency Room	90% after deductible	90% after deductible
• Ambulance	90% after deductible	90% after deductible
Hospital Care		
• Inpatient	90% after deductible	60% after deductible
• Inpatient Maternity	90% after deductible	60% after deductible
• Outpatient Hospital Expenses	90% after deductible	60% after deductible
Mental Health Services	Cigna pays...	Cigna pays...
• Inpatient	90% after deductible	60% after deductible
• Outpatient	90% after deductible	60% after deductible

MEDICAL

*** The City's Health Fund Contribution pays first for any claims that count towards your deductible. Once you have used up your health fund balance, any remaining claims that go towards your deductible will be your responsibility. Your maximum liability towards your deductible is the remaining $1,750 for employee only or $3,750 for employee + spouse, employee + child(ren), or $3,500 for family. Any unused fund balances can roll over to the next plan year. You can accrue up to your deductible in your Cigna Choice Fund.**

- CONTINUED -

	In-Network	Out-of-Network
Alcohol/Drug Abuse		
• Inpatient	90% after deductible	60% after deductible
• Outpatient	90% after deductible	60% after deductible
Other Services	Cigna pays...	Cigna pays...
• Convalescent Services	90% after deductible	
• Home Health Care/Private Duty Nursing (limited to 120 days per plan year)	90% after deductible	60% after deductible
• Hospice Care - Inpatient	90% after deductible	60% after deductible
• Hospice Care - Outpatient	90% after deductible	60% after deductible
• Outpatient Short-Term Rehabilitation (limited to 60 days per plan year)	90% after deductible	60% after deductible
• Spinal Manipulation Therapy (limited to 20 days per plan year)	90% after deductible	60% after deductible
• Durable Medical Equipment (unlimited)	90% after deductible	60% after deductible
• Transplants (travel benefits available if using in-network LifeSource provider)	90% after deductible	70% after deductible
Prescription Drug (same for in- and out-of-net work) Prescription drugs are not eligible for HRA funds. Once you meet your out-of-pocket maximum, prescription drugs will be covered at 100%.		
• Select Preventive Generics	Free from any in-network participating retail pharmacy or Cigna Home Delivery!	
• Retail - up to a 30-day supply (same for in- and out-of-network)	Member pays 30% coinsurance up to $15 cap fo Member pays 40% coinsurance up to $60 cap fo Member pays 40% coinsurance up to $90 cap fo	generic drugs preferred brand name drugs non-preferred brand name drugs
• Mail Order/Rx90 Now - up to a 90-day supply (same for in- and out-of-network)	Member pays 20% coinsurance up to $30 cap fo Member pays 30% coinsurance up to $120 cap for Member pays 40% coinsurance up to $180 cap f supply from Cigna Tel-Drug Mail Order Drug Pro	generic drugs preferred brand name drugs or non-preferred brand name drugs per 90-day ram.

MEDICAL

HSA PLAN

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• Outpatient Hospital Expenses	90% after deductible	60% after deductible
Mental Health Services	Cigna pays...	Cigna pays...
• Inpatient	90% after deductible	60% after deductible
• Outpatient	90% after deductible	60% after deductible

*** The City 's HSA Contribution is provided upfront. You are responsible for making payments towards your deductible. You may use the City's contribution plus any money you set aside in your HSA account. Your maximum liability towards your deductible is the remaining $1,500 for employee only or $3,250 for employee + spouse, employee + child(ren), or $3,000 for family. Any unused fund balances will roll over to the next plan year. You can accrue as much as you like in your HSA, but you can only contribute every year up to the IRS maximum (for 2022 the maximum is $3,650 for individuals and $7,300 for employee + spouse, employee + child(ren), or family). Anyone over age 55 can add an additional $1,000 for catchup contributions.**

- CONTINUED -

	In-Network	Out-of-Network
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FAQs

Frequently Asked Questions About HSAs

What is the HSA and how does it work? Employees enrolled in a qualified HDHP are eligible to establish an HSA bank account through HSA Bank. You will receive a debit card that can be used for out-of-pocket health expenses. Depending on your coverage level, City of Alpharetta will contribute funds upfront to your HSA: $1,000 for employee only, $1,750 for employee + spouse or employee + child(ren), or $2,000 for family coverage. You may also make pre-tax contributions via payroll deduction or one-time contributions. The money accumulated in this special account can be used to pay any out-of-pocket expenses incurred prior to the annual deductible being met or other eligible health, vision, or dental expenses.

Are there certain requirements that need to be met to open an HSA account?

- You must be covered by a high-deductible health plan (HDHP)
- You cannot be covered by other non-HDHP health insurance
- You cannot be enrolled in Medicare, Tricare or have received any VA health benefits in last 3 months
- You cannot be claimed as a dependent

How do I set up my HSA account? Your health savings account is automatically set up when you enroll in the HSA medical plan. There is no separate form to fill out. After you receive your HSA debit card in the mail, you will activate your account with HSA Bank at **www.hsabank.com**.

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. You may use funds in your HSA or pay them as out-of-pocket expenses.

What expenses are counted towards my deductible? Only medical expenses, including prescriptions covered by your medical plan apply towards your deductible. HSA funds used for qualified health expenses not covered under your medical plan (for example, orthodontia) will not count towards your health plan deductible.

Who verifies that my HSA was used for qualified expenses? Save your receipts — in the event of an IRS audit, you are responsible for providing documentation to the IRS. Non-qualified withdrawals from your health savings account are taxable income and subject to a 20% tax penalty.

Do doctors require payment at the time of service? If you see an in-network physician, you are responsible to pay the Cigna negotiated rate to your doctor, until your deductible is met. If you use an out-of-network physician, you are responsible for the total amount charged. The doctor's office should submit a claim with their charges to Cigna. Cigna will then apply all discounts that apply and credit your deductible. Once the claim is processed, you will receive an explanation of benefits (EOB) showing the amount you are responsible for. Some doctors may require that you pay the full amount or a portion of the bill upfront, but most will simply bill Cigna and then bill you for the balance once the claim has been processed. Doctor's offices do have the capability to obtain how much of your deductible you have met and can estimate the amount you owe up to your out-of-pocket maximum. If you pay at the time of service, make sure to compare your patient responsibility amount with the EOB to ensure you have not overpaid. You can use your HSA funds for this expense.

What happens to my HSA if I never withdraw funds, change jobs, or retire? Funds in your HSA are yours, even if you change employers or retire. The less that you spend on current medical expenses, the more money stays in your account accumulating interest. Under IRS guidelines, HSAs are treated like IRAs. HSA funds are never taxed or penalized if they are used for qualified medical expenses. Funds can be withdrawn for any reason, without penalty once you reach age 65. Ordinary income taxes will apply for withdrawals made for non-qualified medical expenses.

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.

How do I make deposits to my account? Deposits to your HSA can be made through pre-tax payroll deductions or as an initial lump sum deposit at enrollment. Unlike an FSA, you can change your HSA payroll deductions during the year. You can also make post-tax contributions and deduct them from your income when you file your taxes. Combined employee/employer contributions for the 2022 calendar year cannot exceed $3,650 for individuals or $7,300 for families. Anyone over age 55 can add an additional $1,000 for catch-up contributions.

What tax reporting does HSA Bank provide as part of the HSA administration? HSA Bank files with the IRS Form 1099-SA and Form 5498-SA for account holders. Copies will be sent to account holders for your records. Form 1099-SA reports the distributions you took from your HSA. Form 5498-SA reflects all contributions for the previous year, which can be made up until the deadline for filing the federal income tax return for the current year.

Do I need to file any special forms with my federal tax return to report contributions to my HSA? Yes. You will need to file IRS Form 8889-Health Savings Accounts with your federal tax return. Please consult a tax advisor if you have specific questions.

HSAand Medicare

- When an employee turns 65 and enrolls in Medicare, they are still HDHP eligible, but do not qualify for an employer-sponsored, pre-tax HSA. However, if your spouse and you are both enrolled in your employer's HDHP and you enroll in Medicare, your spouse can still open their own, individual HSA at an outside bank not sponsored by the employer. You or your spouse can then make post-tax, tax-deductible contributions into their HSA, up to the maximum determined annually by the IRS.

- You can take tax-free distributions for eligible expenses even after you are no longer HSA eligible, as long as you still have a balance in your account. This includes yourself, your spouse, and your tax dependents, whether or not the dependents are covered on your medical plan. If your spouse has an HSA but you are not eligible, you can use their account for reimbursements.

- If you name your spouse as beneficiary of your HSA, upon your death your HSA passes to your spouse with balances and tax advantages intact. In addition, if your spouse remarries, they can reimburse their new spouse's eligible expenses tax-free. If you name any other person as the beneficiary, the HSA is liquidated and the assets pass to that person, who may incur a tax liability.

- You are only enrolled in Medicare Part A (inpatient services) automatically if you are over age 65 and are receiving Social Security or Railroad Retirement Benefits. You're enrolled in Part A and Part B (outpatient services like doctor visits, lab work and imaging) automatically if you are collecting Social Security disability benefits or are diagnosed with amyotrophic lateral sclerosis (ALS). Otherwise, you must sign up to receive coverage through Medicare.

- You may not reimburse your own or anyone else's Medicare premiums tax-free until you, the account owner, turn age 65. If you have an older spouse and want to reimburse his or her Medicare premiums tax-free, they must open an HSA before they enroll in Medicare and contribute at least the $1,000 annual catch-up to cover his Medicare premiums until you turn age 65 and can reimburse their premiums tax-free from your HSA.

- Finally, if you decide to delay enrolling in Medicare, make sure to stop contributing to your HSA at least six months before you do plan to enroll in Medicare. This is because when you enroll in Medicare Part A, you receive up to six months of retroactive coverage, not going back farther than your initial month of eligibility. If you do not stop HSA contributions at least six months before Medicare enrollment, you may incur a tax penalty.

Cigna One Guide

Cigna One Guide is part of the Cigna Health Matters℠ solution side, a service that delivers the ideal balance of convenient digital support and personalized, expert guidance. Cigna One Guide simplifies and strengthens the connection between you, your Cigna plans, and your overall health and well-being. Features include:

- Pre-enrollment guidance on choosing the right plan
- Onboarding support to help use the plan
- Education on health plan features, ways to maximize benefits and earn available incentives
- Guidance in finding the right doctor, lab, convenience care center or pharmacy
- Immediate connection to health coaches, pharmacists and other resources
- Dedicated one-on-one support in complex situations
- Proactive messaging based on individual health needs
- Access to personal One Guide via phone or Click to Chat with the MyCigna mobile app

New 1-touch log-in to myCigna

Now with fingerprint access, the myCigna app makes it easier than ever to stay in-network—and save. Download the app today.

Available on the App Store | ANDROID APP ON Google play | Available on kindle fire

A phone call away

Any time you need us at Cigna, feel free to call the toll-free number on the back of your Cigna ID card for assistance 24 hours a day, 7 days a week. You can order an ID card, update insurance information, and check claim status.

Cigna Care Designation

Choosing the right doctor is a big decision – one where you want a doctor you can trust with your health – and you can afford. The Cigna Care Designation is one decision-making tool you can use to choose a doctor. Cigna checks their education and board certifications. They also check to see if the quality of their care has earned recognition from within the medical industry.

What does the Cigna Care Designation mean?

Before Cigna awards a doctor the Cigna Care Designation, they do a lot of fact-finding. Doctors in several medical specialties are assessed for quality and cost efficiency, since quality care doesn't have to mean higher costs. Whenever you use the myCigna online directory to find a doctor, you'll see top-performing doctors are shown with the Cigna Care Designation symbol. This gives you an unbiased evaluation of quality and cost that you can trust.

Get help choosing a hospital, too.

Just look for the Centers of Excellence Designation.

Choose an in-network hospital that's right for you. Cigna reviews how successful a hospital is in treating common conditions. Their ratings are based on actual patient outcomes, average lengths of stay, and average costs gathered from outside sources. Hospitals that demonstrate better health outcomes at lower costs for one of the reviewed conditions earn the top rating – the Cigna Centers of Excellence designation. See the hospital ratings on myCigna.com.

MyCigna's Prescription Drug Tools

MyCigna can help you make better decisions about your prescription drugs.

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 Medication

When it comes to medication costs, nobody likes surprises. That's why Cigna created the Price a Medication feature. You can easily compare the price of a medication before you get to the pharmacy counter – or, even before you leave the doctor's office.

90Now: Maintenance Medication

Your Cigna plan now offers a new retail pharmacy network that gives you more choice in where you can fill your 90-day maintenance prescriptions. There are thousands of retail pharmacies in your new network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores. All of which are places you may already shop. If you prefer the convenience of having your medications delivered to your home, you may still use The Cigna Home Delivery Pharmacy program.

More Choice

Under your pharmacy plan, you can fill your maintenance medication in a 90-day or 30-day supply.

Why fill a 90-day supply?

Filling your prescription in a 90-day supply may help you stay healthy because having a 90-day supply of your medication on-hand typically means 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.

Here are some of the 90-day retail pharmacies in your network:

- CVS (including Target and Navarro)
- Walmart
- Access Health (including Benzer Pharmacy, Marcs, Big Y, Marsh Drugs, LLC and Snyder Drug Emporium)
- Good Neighbor Pharmacies (including Big Y, Super RX, Medical Center Pharmacy, Family Pharmacy and King Kullen Pharmacy)

For more information about your new pharmacy network, you can go to Cigna.com/Rx90network or call 800-285-4812 for Cigna Home Delivery.

How to Save Money with Cigna!

With healthcare costs continuing to rise, it's more important than ever to be conscious of how much you are paying for the care you receive. Becoming an educated healthcare consumer is a great way to help you manage your out-of-pocket healthcare expenses. You don't have to go it alone. Cigna is on your side. Cigna has the tools and support you need to help you find a quality in-network doctor near you, including 24/7 live customer service, plus a host of valuable resources to help you manage and track claims, and compare cost and quality information. Cigna tools are accessible online or on the go, through myCigna.com or with the free myCigna mobile App.

Top Seven Tips to Save Money with Cigna

1. Schedule your annual checkup.

Preventive care is key to good health and is covered at 100%. Getting your annual checkup can help keep you in shape. Covered services include:

- Routine physical examinations
- Well baby and child care
- Screening mammography
- Screening colonoscopy or sigmoidoscopy
- Cervical cancer screenings
- Prostate cancer screening
- Diabetes screenings
- Bone and mineral density tests

The best way to treat a serious illness is by catching it early or stopping it from happening. During your checkup, your doctor can often detect the early signs of more serious issues. Remember, in order to receive the 100% preventive care benefit, services must be received in accordance with USPTF guidelines under Health Care Reform and your physician must code the claims as preventive.

Call Cigna 24/7/365 at 1-800-244-6224 to help find a primary care provider within your area!

2. Find the best providers.

The Cigna Care Designation (CCD) is one decision-making tool you can use to choose a doctor. Cigna checks education and board certifications, and they also check to see if the quality of care has earned recognition from within the medical industry. Providers who meet Cigna's specific quality and cost-efficiency criteria will have the Cigna Care Designation symbol next to their name in the online provider directory tools. Quality recognition ratings are assigned to providers and provider groups indicating the quality criteria met, and stars are used to communicate cost-efficiency performance as compared with their peers of the same specialty type and geographic market. Additionally, stars illustrate cost efficiency. Results in the top category for cost-efficiency assessment will be displayed with three stars.

Sample: Online Health Care Professional Directory display (myCigna.com)

Cigna Care Designation Symbol

Cost Efficiency Rating

3. Find the most cost effective Rx.

There are three ways to spend less on medicine:

- Buy generic. When it comes to generic vs. brand name drugs, the main difference is name and appearance. Generic drugs are manufactured to be just as effective as brand name drugs and they are less expensive. Always check with your doctor or pharmacist to understand your options.
- Ask your doctor about getting a three-month supply of your prescription. 90-day prescriptions may be filled using Cigna Home Delivery Pharmacy or your preferred retail pharmacy. You may be able to save money when you switch from a retail pharmacy to Cigna's Home Delivery Pharmacy. Call Cigna Home Delivery Pharmacy at 1-800-835-3784.
- Compare drug costs at different pharmacies. Login to myCigna.com > Select Prescriptions Tab > Select "Price a Medication" > Enter or Select a Drug Name > Enter Form/Dosage, Quantity, Frequency and Duration > Get cost estimates.

4. Stay In-Network.

Costs will be lower if you choose to see doctors, hospitals and facilities in Cigna's network. If you use an out-of-network provider, your costs can add up quickly. You're going to pay full price and not the discounted price an in-network doctor would charge. Out-of-Network doctors / facilities may balance bill you for the amount that Cigna does not cover. When you are scheduled for surgery, ensure that the surgeon, anesthetist, and facility are all In-Network.

How to search for an In-Network Provider:

- The provider directory on myCigna.com shows you results based on your health plan network and your location. Log in to my Cigna.com> Select Find Care & Costs Tab> Find care and cost estimates in your area by "Primary Care, Doctor by Type, Doctor by Name, Reason for Visit or Locations"> Select "Doctor by Type" and Enter a specialty or type of doctor> For example, type "Primary Care Provider"> Results for In-Network primary care providers near your area will be displayed.
- Know before you go. 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. Cigna is available 24/7/365! Call anytime day or night for live customer service at 1-800-244-6224.

5. Shop with Cigna for the best outpatient facilities for diagnostic tests.

Costs can vary significantly depending on where you receive care. MRIs, CTs and PET scans can cost much less at some facilities. You can save by making a more informed choice about where you get your services. You could save money without giving up quality care. Local facilities offer the same services at a lower cost.

- The provider directory on myCigna.com shows you cost of service within your location. Login to myCigna.com> Select Find Care & Costs Tab> Find care and cost estimates in your area by "Primary Care, Doctor by Type, Doctor by Name, Reason for Visit or Locations"> For example, Select "Reason for Visit" and Enter procedure "Shoulder MRI Scan with Dye"> Select Facilities> Results for facility costs near your area will be displayed.
- Connect directly with the Cigna Customer Service team. Cigna's team can find the most cost-effective facility for a service. Cigna will help you compare costs for hundreds of procedures. Call anytime day or night for live customer service at 1-800-244-6224.

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 here is intended to be general information on how you can get the most out of your plan and your health care dollars. 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.

6. The value of In-Network labs.

One of the biggest contributors to your health care costs may be laboratory expenses. 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.

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 you need treatment for common ailments and injuries, you have more choices. Now you can get high-quality, affordable services for a wide variety of routine medical conditions through different types of settings.

Cigna Health Information Line: A telephone service staffed by nurses that helps you understand and make informed decisions about health issues you are experiencing, at no extra cost. It can help you choose the right care in the right setting at the right time, whether it's reviewing home treatment options, following up on a doctor's appointment, or finding the nearest urgent care center. Just call Cigna at 1-800-244-6224.

Your Guide For Where To Go When You Need Medical Care				
Cigna Virtual Care	Convenience Care Clinic	Doctor's Office	Urgent Care Center	Emergency Room
Treat minor medical conditions. Connect with board-certified doctor via video or phone.	Treat minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies.	The best place to go for routine or preventive care, to keep track of medications.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to nearest ER.
Colds and flu Rashes Sore throats Headaches Stomachaches Fever Allergies Acne UTIs and more	Colds and flu Rashes or skin conditions Sore throats, earaches, and sinus pain Minor cuts or burns Pregnancy testing Vaccines	General health issues Preventative care Routine checkups Immunizations and screenings	Fever and flu symptoms Minor cuts, sprains, burns, rashes Headaches Lower back pain Joint pain Minor respiratory symptoms Urinary tract infections	Sudden numbness, weakness Uncontrolled bleeding Seizure or loss of consciousness Shortness of breath Chest pain Head injury/ major trauma Blurry or loss of vision
Costs same or less than a visit with primary care provider. Appointments typically in an hour or less.	Costs same or lower than doctor's office. No appointment needed.	May charge copay/ coinsurance and/or deductible. Usually need appointment.	Costs lower than ER. No appointment needed. Wait times will vary.	Costs highest. No appointments needed. Wait times may be long.

The information provided here is intended to be general information on how you can get the most out of your plan and your health care dollars. 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.

Give Your Baby a Healthy Start

Cigna Healthy Babies Program can help.

New babies are precious miracles. That's why it's so important as an expectant mom to become well-informed about your pregnancy and know what to expect before and after the new baby arrives. *Healthy Pregnancies, Healthy Babies* is available at no charge to Cigna health plan members.

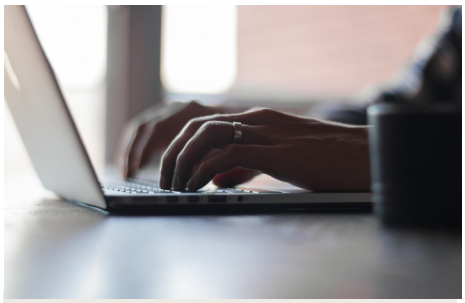
To enroll, just call the toll-free number on your Cigna HealthCare ID card.

When you enroll, you'll get:

- Free educational materials about pregnancy and babies
- Round-the-clock access to a toll-free information line staffed by experienced registered nurses
- Newborn care and more

You may also be eligible for support from a registered nurse case manager if you or your baby has special health care needs.

You can log on to myCigna.com or the MyCigna app for tools and information from WebMD®, the nation's leading provider of online consumer health care information. You'll find articles from some of the most trusted names in medicine on planning for a healthy pregnancy, monitoring your pregnancy, labor and delivery, and caring for your baby.



MyCigna's Medical Encyclopedia

Members can access online medical content on a range of topics including, health, medical tests, medications, and support groups.

Spanish speaking members can access online health information through the Healthwise® Online Spanish Health Guide. This guide provides information on more than 220 common health problems and 3,000 medications.

NurseLine

When you need care, you're covered, 24 hours a day, 7 days a week, worldwide. Cigna customer service representatives are available to take your calls, and you can also speak with a health care professional over the phone, any time, day or night just by calling the number on the back of your ID card.

MyCigna's Health Record

Health Record stores and maintains personal health information in a central, secure location.

Within the tool, members can select current conditions, medications, allergies, surgeries, immunizations, and input their personal information. This information is readily available in one secure location, making it easy to find the health information you need, when you need it.

Use Health Record with the Prescription Drug History tool. Prescription Drug History allows members to view both retail and Cigna Tel-Drug prescription claim history for up to 16 months. By clearly organizing this data, you can easily share important information with your doctors and keep it for your records.

Cigna Health Advisor

Cigna Health Advisor program is free for HRA and HSA plan members. Health Advisor offers coaching and other services based on plan members individual health status and needs.

Health and Wellness Outreach

The program takes a holistic look at a member's risk for hypertension, hyperlipidemia (high cholesterol), prevention, physical activity, pre-diabetes, and healthy eating, in order to assess the benefits of an outreach call. Cigna's outreach uses behavior modification techniques and other motivational interviewing styles to help drive behavior change and help members reach established goals.

Education and Referral Coaching

Cigna's health advisors provide support to members on a variety of topics. Through a combination of early identification and health coaching, health advisors gain an understanding of a member's particular issues or concerns and provide information that is appropriate for that member. In addition to talking with a member, they deliver health-related information in the form of web-based content, audio tapes, and videos. Health advisors refer members to Cigna's online coaching programs (if appropriate), to Cigna's clinical support programs, or to an external program, when a member is identified as possibly experiencing an unmet clinical service need.

Preference Sensitive Care

Cigna supports members decision-making abilities by supplying evidence-based medical information, identifying member preferences and values, and answering questions about the potential benefits/disadvantages of a specific course of action. Health advisors provide preference sensitive coaching for back pain, coronary artery disease revascularization, benign uterine conditions, osteoarthritis of the hip (joint replacement), osteoarthritis of the knee (joint replacement), breast cancer, and prostate cancer.

Health Matters℠

Cigna's health engagement solution. Cigna is committed to helping customers improve their health. Cigna's goal is to help align customers to the right health programs and help each customer engage in available programs and services that are appropriate for their health journey. Cigna has rolled out a new messaging program called Health Matters℠ Messages. Employees/Customers can opt into messaging through myCigna.com or their coach can enter their opt-in preference through Cigna's clinical tool, HealthEview®.

Health Trackers

Allows plan members to track health measurements over time and display results in easy-to-read charts. Members enter their information for key health indicators such as blood pressure, blood sugar, cholesterol (total/LDL/HDL), exercise, height, and weight. Data can be edited easily, displayed in charts, printed, and shared with medical professionals.

Omada (Prevention Program)

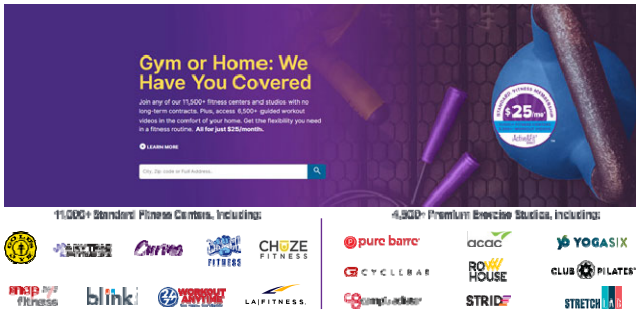
The goal is to help you accomplish the changes that matter most in the areas of eating, activity, stress, and sleep. The program is available at no additional cost if you or your covered adult dependents are enrolled in the company medical plan offered through Cigna, are at risk for diabetes or heart disease, and are accepted into the program.

Omada features:

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

Active&Fit Direct (Gym Membership Program)

As a Cigna Customer, you have access to discounts on health programs through Cigna Healthy Rewards program. Cigna members and any dependents over the age of 18 are eligible to join the Active & Fit gym membership network. Start by logging in to myCigna.com> Wellness> Exercise> Healthy Rewards> Gym Memberships & Digital Workouts. Memberships are $25 per month (plus a $25 enrollment fee) which allows you access to multiple local gyms in the Active & Fit network. You have access to standard fitness centers for just $25 and/or premium exercise studios with 20-70% discounts plus access to digital workout videos.



Engagement Health Group: Helping to Improve Your Health

A healthy lifestyle can prevent up to 80% of chronic illness or disease. EHG's customized wellness program for COA is geared to help our employees maintain or improve their overall well-being through personalized coaching, fun educational events, and inspirational wellness challenges.

Employees who choose to participate in the City of Alpharetta Wellness Program will pay a lower Wellness Rate shown on page 29.

In order to receive the Wellness Rate discount of $50 per pay period on your medical premiums, you and your spouse (if applicable) must maintain compliance with the following requirements and deadlines:

June 1st, 2023 to August 1st, 2023- Complete all Enrollment Steps in the Wellness Program :

- Register on MyWellSite for first time users OR log-in if you are a returning user
- Complete the health questionnaire on MyWellSite
- Upload proof of your annual physical
  - Admissible documents: Health Data & Proof of Physical Form OR EOB from Cigna
- Upload your blood work results
  - Admissible documents: Health Data & Proof of Physical Form OR upload lab results from your lab or medical provider (often found on the lab or medical provider's patient portal).

*Blood work results and proof of annual physical accepted from January 1, 2023 through August 1, 2023.

If ALL Enrollment Steps are not completed by August 1, 2023, then you will be removed from the Wellness Program & retro charged the Non-Wellness Rate back to July 1, 2023.

October 1st, 2023- Complete a Results Coaching Session

If a Results Coaching session is not completed by October 1st, 2023, then you will be removed from the Wellness Program and retro charged the Non-Wellness Rate back to August 1, 2023.

January 1st, 2024- Complete the required number of Follow-Up coaching based on your risk:

- High: at least two sessions
- Moderate: at least one session
- Low: no follow-up coaching required

If the required number of Follow-up Coaching Sessions are not completed by January 1st, 2024, then you will be removed from the Wellness Program and retro charged the Non-Wellness Rate back to September 30, 2023.

June 1st, 2024- Complete the required number of follow up coaching based on your risk:

- High: at least five sessions for the program year
- Moderate: at least three sessions for the program year
- Low: no follow-up coaching required

If the required number of Follow-up Coaching sessions and/or two Wellness Activities are not completed by June 1, 2024, then you will be retro charged the Non-Wellness Rate back to January 1, 2024.

city of alpharetta wellness program
a journey to wellness

Engagement Health Group Wellness Program includes:

- Easy-to-understand health summary
- Opportunity to meet with Health Coaches onsite
- Advocacy support to help navigate other benefits and resources provided by the City of Alpharetta
- A variety of health promotion activities
- Schedules, alerts and health information to guide you to better health
- Personal Health Platform to track your health progress, participate in challenges, and have access to other health resources

Telephonic coaching is available for spouses.

If medical conditions prevent you from participating in the stated program, alternative means will be made available.

You Pay for Using Tobacco

Tobacco users pay for their addiction both in the amount of money they spend on tobacco products and by having a lower quality of life because they have more health risks and health problems than non-tobacco users. A tobacco user spends on average $2,500 a year on tobacco alone and incurs higher health care costs over their lifetime. Living tobacco free can help you save thousands of dollars, improve your energy level, and your quality of life.

Non-Tobacco Users Pay Less

City of Alpharetta rewards employees who don't use tobacco products with lower health insurance premiums. Employees and their covered dependents who are tobacco free will pay less for their health insurance than employees who use tobacco, or who have covered dependents who use tobacco. If you or your covered dependents are users and quit, you can pay less too! In order to qualify for the discount, you will need to complete and sign a non-tobacco use affidavit.

Health Benefits of Quitting

Within 20 minutes:
- Your heart rate drops

Within 12 hours:
- The carbon monoxide level in your blood is normal

Within 2 weeks to 3 months:
- Your circulation improves and your lung function returns to normal

Within 1 to 9 months:
- Your coughing and shortness of breath decrease

Within 1 year:
- Your risk of heart disease is about half that of a tobacco user

Within 5 years:
- Your risk of stroke equals a non-tobacco user

Resource List

Your Physician

Cigna Lifestyle Management
Tobacco Cessation Program

Georgia Tobacco Quitline
1-877-270-7867

CDC-Tobacco Information and Prevention Source (TIPS)
www.cdc.gov/tobacco

Smoke Free Support
www.smokefree.gov

Northside Hospital
https://www.northside.com/smoking-and-tobacco-resources
404-780-7653

E-Cigarettes
https://e-cigarettes.surgeongeneral.gov/

Finding the Right

Tobacco Cessation Program

Studies show that tobacco cessation treatment programs through a facility or physician that also include therapy and social support are usually most effective for long-term success than other alternatives. The program that works best for you may be very different from the program that works best for someone else. Talk to your primary care physician; that person is one of your best resources for finding cessation programs designed to meet your total health needs. Your physician can discuss over-the-counter and prescription medications and provide a reference as well. Our health partners offer programs that you also may want to take advantage of, such as:

EHG's onsite 8-week program that helps participants make a plan to quit smoking. EHG also focuses on motivation for quitting, methodsof quitting, dealing with triggers, managing withdrawal symptoms, avoiding weight gain and handling relapses.

Cigna Quit Today®, a program that helps plan members develop a personal quit plan to become and remain tobacco free. You can choose from two options, a telephone program or an online program — or use both! You also have access to one free course of over-the-counter nicotine replacement therapy per individual per calendar year. Visit **www.myCigna.com** or call **1-866-417-7848** to enroll.

Flexible Spending Accounts

City of Alpharetta offers a Flexible Spending Account (FSA) through Admin America. These accounts allow employees to use pre-tax money for qualified expenses.

The rising cost of health and dependent care (or day care) is encouraging more employees to take advantage of FSAs. You can save anywhere from 10 – 30% by using pre-tax money in an FSA to pay for health or dependent care expenses incurred during the plan year. Determine how much you anticipate spending on qualified expenses throughout the year and fund your FSA for that amount through bi-weekly pre-tax payroll deductions. You can then use those funds to pay for eligible expenses using a debit card at the time of service, or by submitting a receipt after-the-fact. Please keep your itemized receipts in case you are ever subject to an audit.

Keep your card!

The cards are valid through the expiration date, whether or not you have exhausted your FSA funds. Your first card is provided at no charge. When your card nears expiration, a new card will automatically be mailed to you at no charge. If you need a replacement card during any other time, there is a $10 replacement card fee.

Health Care FSA – used to pay for qualified medical, dental, and vision expenses incurred by you and your dependents during the plan year. See box for examples of eligible expenses. **You may not have a Health Care FSA if you enroll in the HSA medical plan.**

- Annual maximum contribution is $3,050.
- You have access to your full annual contribution at anytime during the plan year for qualified expenses incurred during the plan year.
- You cannot change your annual contribution amount during the plan year, so be conservative in determining the amount you decide to contribute.
- Deadline to incur claims for this plan year is June 30, 2024. Deadline to submit claims is September 30, 2024.

Dependent Care FSA – used to pay for qualified dependent child care or elder care expenses incurred during the plan year, to allow you (and/or your spouse if married) to work or go to school full-time.

- Annual maximum contribution is $5,000.
- You ONLY have access to funds that have been withheld from your paycheck. If you submit receipts for a higher amount, you will be automatically reimbursed as future payroll deductions are deposited into your account.
- Deadline to incur claims for this plan year is June 30, 2024. Deadline to submit claims is September 30, 2024.

Admin America®

Health Care FSA Eligible Expenses

- Medical plan copays and deductibles
- Dental and orthodontia expenses
- Vision care expenses including lasik, glasses and contact lenses
- Over-the-counter drugs prescribed by your physician
- Tobacco cessation programs and related drugs with a doctor's prescription
- Infertility treatment
- Psychology and psychoanalysis medical expenses

Please refer to our plan document for a full list of eligible expenses and exclusions.

Dependent Care FSA Expenses:

- Care at a licensed nursery school or day care facility
- Before and after school care for children 12 and under
- Day Camps
- Nannies and Au Pairs

Dependent Care Ineligible Expenses:

- Services provided by a dependent (son, daughter, or spouse)
- Overnight camp expenses
- Baby sitting expenses for time when you are not working or at school
- Late payment fees
- Tuition expenses for school
- Meal expenses

Important Rules Regarding FSAs

- Accounts are separate and you cannot co-mingle funds.
- Dependent Care FSAs are subject to the **USE IT OR LOSE IT** provision; unused balances do not carry over and cannot be refunded.
- Health Care FSAs can rollover up to $550.

	In-Network Dental Benefit	Out-of-Network Dental Benefit
Calendar Year Deductible	None	None
Reimbursement Levels	Based on reduced contracted fees	90th percentile of reasonable and customary allowances
Preventive Services *(frequency and age limitations apply)* Oral exams, dental cleanings, x-rays, and Fluoride treatments for children	100%	100% of reasonable and customary allowances
Basic Services Root canal therapy, scaling, amalgam fillings, composite fillings (anterior and posterior teeth), uncomplicated extractions, denture repairs and crown lengthening	80%	80% of reasonable and customary allowances
Major Services Inlays, onlays, crowns, crown build ups, stainless steel crowns full or partial dentures and bridges	50%	50% of reasonable and customary allowances
Orthodontia *(appliance must be placed prior to age 20)* Lifetime maximum $1,250	50%	50% of reasonable and customary allowances
Maximum Annual Benefit* *(per individual per calendar year)* The dental plan runs on a calendar year, January - December	$1,250	$1,250

***Progressive Maximum:** Members that utilize Preventive Services in one year can increase their Annual Maximum in the following year by $100, up to four consecutive years.

Year 1: $1,250 Year 2: $1,350 Year 3: $1,450 Year 4: $1,550

Dental Plan

Good oral hygiene is part of a healthy lifestyle.

City of Alpharetta offers a dental plan through Cigna, to provide employees and their dependents access to a large network of dentists.

It's About More Than a Pretty Smile

Our oral health affects our ability to speak, smell, taste, chew, and swallow. However, oral diseases, which can range from cavities to oral cancer, cause pain and disability for millions of people each year.

Visit Your Dentist Regularly

Regular preventive visits to your dentist can help protect your health, and we are talking about more than just your mouth. Recent studies have linked gum disease to damage elsewhere in the body. According to the Centers for Disease Control and Prevention, there may be associations between oral infections and diabetes, heart disease, stroke, and preterm, low-weight births. Research is underway to further examine these connections.

Our plan covers preventive services at 100% in-network, with no deductible. Plan members can visit a Cigna Dental Network Provider every six months for an oral exam and the plan pays for 100% of preventive services.

Cigna Dental Oral Health Integration Program

It's a program that reimburses out-of-pocket costs for preventive dental treatments to combat dental issues such as gum disease and tooth decay. The program is for people with certain medical conditions, such as Heart Disease, Diabetes, Maternity, and much more, with a higher risk of oral health issues. There's no additional cost for the Oral Health Integration Program – if you qualify, you get reimbursed. If you have the Cigna dental plan, you're eligible for the program. To learn more about who qualifies and how to get reimbursed, go to myCigna.com or call the number on the back of your Cigna ID card.

Finding a Network Dentist

Go to www.myCigna.com

You can search for a Network dentist by name, specialty, or location.

EyeMed Vision Care

As an EyeMed Vision Care member, you can improve your health by taking care of your vision and having routine eye exams, while saving money on all of your eye care needs.

Your vision benefit is available through thousands of provider locations on the EyeMed ACCESS Plan. To start using your benefit, visit www.eyemed.com or call 1-866-723-0514 to locate a participating provider.

Vision Care Service	In-Network	Out-of-Network
Exam (once every 12 months)	$10 copay	Up to $35
Retinal Imaging	Up to $39	N/A
Contact Lens - Fit and Follow Up		
Standard	Up to $55	No coverage
Premium	10% off retail	No coverage
Frames (once every 24 months)	$100 allowance, 20% of balance over $100 (no copay)	Up to $45
Standard Plastic Lenses (once every 12 r	nths)	
Single Vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lens Options (paid by member and adde	to the base price of the ler s)	
UV Coating	$15	No coverage
Tint (Solid and Gradient)	$15	No coverage
Standard Scratch Resistance	$15	No coverage
Standard Polycarbonate	$40	No coverage
Standard Anti-Reflective	$45	No coverage
Standard Progressive	$75	No coverage
Other	20% off retail	No coverage
Contact Lenses (once every 12 months, a	lowance covers materials oı ly)	
Conventional	$115 allowance, 15% off balance over $115 (no copay)	Up to $92
Disposable	$115 allowance, (no copay)	Up to $92
Medically Necessary	Paid in full, no copay	Up to $200
LASIK or PRK Vision Correction Procedures	15% off retail price or 5% off promotional pricing	No coverage

Did you know?

Taking care of your vision can also mean early detection for symptoms of:

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

A qualified vision care professional can help treat and manage:

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

Life Insurance and AD&D

The City of Alpharetta provides all full-time employees working 30 hours per week or more with a life insurance benefit equal to 3.5 times salary, rounded to the next highest $1,000, up to a maximum of $750,000. The City also provides Accidental Death and Dismemberment which pays an additional benefit equal to the basic life benefit if a death is due to an accident. As an additional benefit, the City provides a $5,000 spousal life insurance policy and a $2,500 dependent child(ren) life benefit at NO COST to employees.

Optional Life and AD&D

In addition to the life insurance provided free by the City of Alpharetta, you can purchase additional life insurance in increments of $10,000 up to $500,000 for yourself, and up to 100% of the employee benefit for your spouse in $5,000 increments up to $250,000. The child(ren) benefit amount is $500 from 14 days to 6 months and $10,000 from 6 months to age 26. You must purchase employee coverage to be able to purchase coverage for your spouse or child(ren).

Optional Accidental Death and Dismemberment (AD&D) insurance is available to you and your dependents. Optional AD&D Insurance may only be elected if the member is already enrolled or is enrolling in Optional Life Insurance.

Why buy life insurance?

Life insurance provides a lump sum cash benefit to surviving dependents to cover immediate expenses such as funeral expenses or ongoing living expenses. Life insurance benefits often help survivors adjust to the loss of income related to the death of a wage earner or provide funds for college or retirement for the survivors.

Benefit Reduction

Your benefits will reduce to 50% at age 70, 35% at age 75, and 25% at age 80. (Employee only) - spouse does not reduce.

Optional Life Insurance Coverage Amounts*

	Amount	Evidence of Insurability
Employee	≤$100,000	Not Required
Employee	$110,000 to $500,000	Required
Spouse	≤$30,000	Not Required
Spouse	$35,000 to $250,000	Required
Child(ren)	$10,000	Not Required

** Waiver of the Evidence of Insurability requirement applies to employees who are newly eligible (new hires) only. All other employees must submit evidence of insurability for any election amount or any increase in their current election.*

What is Evidence of Insurability?

Cigna requires Evidence of Insurability in order for employees to purchase insurance above $100,000. If you or your dependents have medical conditions that make it difficult to purchase life insurance on your own, this amount is relevant to you. Evidence of Insurability requires you to complete a medical questionnaire, obtain a physical (at the carrier's request), and receive carrier approval before your insurance takes effect. Life enrollment time frames are limited as detailed below:

- **New Hires** – You may apply for coverage up to the amount requiring Evidence of Insurability through the normal enrollment process.
- **Marriage, Adoption or Birth** – If you are already enrolled in employee life, you can enroll new dependents as long as you follow normal event deadlines. If you wish to increase your employee life amount above $100,000, you must complete the Evidence of Insurability Form and submit it within the normal life event deadlines.
- **Open Enrollment Period** – If you currently have life insurance coverage, you can continue your existing coverage. If you are requesting more coverage than you presently have, Evidence of Insurability is required. For employees who waived coverage as a new hire and are enrolling for the first time now, Evidence of Insurability is required for any election amount.

Disability

One third of all Americans between the ages of 35 and 65 will become disabled for more than 90 days, according to the American Council of Life Insurers. Short-Term Disability (STD) insurance provides income continuation if you are ever unable to work due to a non-work related accident or illness. Long Term Disability (LTD) insurance provides income continuation for both non-work and work-related accidents or illnesses. The City of Alpharetta pays the full cost of both STD and LTD for full-time employees.

STD

STD benefits are paid on the 15th day after a qualifying accident or illness. STD lasts for up to 24 weeks and pays a weekly benefit equal to 66.67% of your basic salary to a maximum of $2,500 per week.

LTD

LTD benefits begin on the 181st day after a qualifying accident or illness and pays a monthly benefit equal to 60% of your monthly salary up to $10,000 per month, after 6 months of a continuous disability. The maximum benefit period is to age 65 or the Social Security Normal Retirement Age.

If you were disabled and unable to work, how would you pay your bills?

Disability Insurance provides income protection to insure that you have a consistent flow of income if you are unable to work for an extended period of time due to a disabling illness or injury.

If you suffer from an illness or injury and are unable to work, do you know how you will pay your rent or mortgage, car payments, utilities, and health insurance? The loss of income can be so devastating that the U.S. Department of Housing and Urban Development estimates that 46% of all home foreclosures are caused by a disability.

If you are like most Americans, your monthly expenses eat up most of your paycheck and little is left for saving. Disability insurance provides the protection you need, so that if you have a disabling illness, you can focus on your health and not your bills.

Cincinnati Life

Life insurance is a way to help provide financial security for your family. Offering voluntary products at the workplace is a cost-effective way to help you secure the protection you need for yourself and your family.

This voluntary program gives you the opportunity to purchase personally-owned life insurance for yourself, spouse, dependents and grandchildren. There are several advantages of purchasing life insurance through payroll deduction, including:

Guaranteed Issue

No medical examination will be required for new hires. There is also a guarantee issue for spouses of new hires 60 and under.All existing employees electing this plan for the first time will need to fill out an Evidence of Insurability (EOI) form.

Portable

You and your family members can keep your policies even if your employment ends or you retire. You personally own your policy. You will receive bills at home, if you choose to end your employment.

Convenience

Premiums will be automatically deducted from your paycheck on a post-tax basis.

Two competitive products to choose from:

1. **Whole Life Insurance provides you with coverage for your entire life.** Unlike term, whole life is permanent. It provides coverage with guaranteed level premiums and death benefit that are guaranteed to be there as long as the premiums are paid.
2. **Term Life Insurance provides you with coverage for a specific period of time.** Term life insurance offers great coverage when you have a temporary need or limited funds to purchase the amount of coverage needed.

THE CINCINNATI LIFE INSURANCE COMPANY

Please contact Haley Gustavel and Jordan Gustavel at 770-536-2218 for rates concerning this product.

Aflac Insurance Plans

24/7 Accident Advantage Plan

In the event of an unexpected injury, Aflac can help protect your personal finances. Aflac's Accident Advantage Plan provides cash benefits for a covered person's death, dismemberment, or injury caused by a covered accident that occurs on or off the job. The plan also provides fixed dollar benefits for various types of emergency treatment related to the covered accident.

There are no underwriting questions to answer and no coordination of benefits – Aflac will pay regardless of any other insurance you may have. There are no network restrictions – you choose your own health care provider. The 24-hour coverage is portable – you can take it with you if you change jobs or retire. The policy includes:

- A wellness benefit payable for routine medical exams to encourage early detection and prevention.
- Benefits payable for fractures, dislocations, lacerations, concussions, burns, emergency dental work, eye injuries, and surgical procedures.
- Benefits payable for initial treatment, X-rays, major diagnostic exams, and follow-up treatments.
- Benefits payable for physical, speech, and occupational therapy.
- Daily hospitalization benefits payable for hospital stays, and additional daily benefits paid for stays in a hospital intensive care unit.

Cancer Protection Assurance

Although major medical insurance can help with the costs of cancer treatment, you still may have to cover deductibles and copays on your own. Additionally, cancer treatment can necessitate out-of-pocket expenses that aren't covered by major medical insurance, including travel, food, lodging, child care, and household help. Aflac's Cancer Protection Assurance policy will pay cash benefits directly to you, to help you with the financial consequences of cancer that may not be covered by major medical insurance.

The Cancer Protection Assurance policy pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable throughout cancer treatment. All treatment must be approved by the National Cancer Institute or other approval as applicable. Benefits are payable the calendar month during which a covered person receives and incurs charges for the applicable treatment. Some of the benefits under this plan include:

- Onetime payout per covered person of $4,000 to employee or spouse and $8,000 to dependent child when diagnosed as having Internal Cancer or an Associated Cancerous Condition.
- $1,200 once per calendar month in which the charge for physician-prescribed injected chemotherapy is incurred.
- $1,200 once per calendar month in which the charge for radiation therapy is incurred.
- $7,000 for bone marrow transplantation for the treatment of internal cancer or an associated cancerous condition and $750 to the covered person's bone marrow donor to cover expenses incurred as a result of the transplantation procedure.
- $75 wellness/cancer screening benefit per year per covered person.

Hospital Confinement Indemnity Insurance

Aflac will pay a Hospital Confinement Benefit of $1,000 when a covered person requires hospital confinement for 23 or more hours for a covered sickness or injury and a charge is incurred. This benefit is payable once per period of hospital confinement, per covered person. Confinements must be separated by a minimum of 90 days from the previous covered hospital confinement for this benefit to be payable. No lifetime maximum.

Other benefits under the Hospital Protection Plan

- Rehabilitation Facility Daily Benefit
- Hospital Emergency Room Benefit
- Hospital Short-Stay Benefit
- Ambulance Benefit
- Physician Visit Benefit
- Medical Diagnostic and Imaging Benefit
- Surgical Benefit
- Invasive Diagnostic Exam Benefit

AFLAC PROGRAMS

Critical Care Protection

Aflac's Critical Care Protection Policy helps provide financial peace of mind if you experience a serious health event, such as a heart attack or stroke. You will receive a lump sum benefit upon diagnosis of a covered event with additional benefits to be paid for things such as a hospital confinement, ambulance, transportation, lodging, and therapy. All cash benefits are paid directly to you, unless otherwise assigned, and can be used for any out-of-pocket expenses you have such as car payments, mortgage or rent payments, or utility bills.

Critical Care Protection offers more types of benefits compared to the other critical illness coverage on the market:

- Pays $7,500 upon diagnosis of having had a specified health event, which increases to $10,000 for dependent children
- Pays $300 per day for covered hospital stays
- Pays benefits for physical therapy, speech therapy, rehabilitation therapy, home health care, and many more
- Transportation and lodging benefits payable for travel to receive treatment
- Guaranteed renewable: as long as premiums are paid, the policy cannot be cancelled by the carrier.

Specified health events covered by the Critical Care Protection policy include:

- Heart Attack
- Stroke
- Coronary Artery Bypass Graft Surgery (CABG)
- Sudden Cardiac Arrest
- Third-Degree Burns
- Coma
- Paralysis
- Major Human Organ Transplant
- End-Stage Renal Failure
- Persistent Vegetative State

Aflac Dental Insurance

Millions of people believe a smile is the most important physical attribute—more so than hair, eyes, or figure. The best way to maintain or improve your smile is to brush and floss your teeth daily, visit your dentist, and apply for an Aflac Dental insurance policy. Aflac Dental is different from many other dental plans you may have seen.

Aflac Dental provides benefits for periodic checkups and cleanings, X-rays, fillings, crowns, and much more. Because Aflac doesn't use a network of dentists, you can go to any dentist you choose. There is no annual deductible and the policy year maximum is $1,400. With Aflac Dental's Annual Maximum Building Benefit, you can receive even more benefits. Aflac will increase each covered person's Policy Year Maximum by $100 after each 12 consecutive months the policy is in force up to a maximum of $500 per covered person.

Aflac Group Critical Illness

A group critical illness plan helps prepare you for the added costs of battling a specific critical illness. After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness such as Cancer, Heart Attack, Stroke and Renal Failure. If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase Spouse coverage. Each Dependent Child is covered at 50 percent of the primary insured amount at no additional charge. Recurrence of a previously diagnosed cancer is payable provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months. To learn more about this benefit and obtain the rate sheet, please contact our Aflac representative Bart Irby-404-932-2643 or barton_irby@us.aflac.com.

AFLAC COVERAGE

Cancer Care Classic

Rates	Amount
Individual (age 18-75)	$19.73
Insured and Spouse (age 18-75)	$35.85
One Parent Family (age 18-75)	$19.73
Two Parent Family (age 18-75)	$35.85

24/7 Accident Advantage

Rates	Amount
Individual (18-64)	$13.46
Insured and Spouse (18-64)	$17.94
One Parent Family (18-64)	$20.87
Two Parent Family (18-64)	$26.26

Aflac Dental Insurance

Rates	Amount
Individual (18-70)	$15.67
Insured and Spouse (18-70)	$30.49
One Parent Family (18-70)	$30.10
Two Parent Family (18-70)	$45.50

Critical Care Protection

Rates	18-35	36-45	46-55	56-70
Individual	$5.85	$9.42	$12.68	$16.45
Insured and Spouse	$9.04	$15.47	$21.84	$30.16
One Parent Family	$6.44	$9.82	$13.06	$16.90
Two Parent Family	$10.14	$16.77	$23.34	$31.98

Hospital Confinement

Rates	18-49	50-59	60-75
Individual	$28.60	$32.24	$36.28
Insured and Spouse	$48.24	$57.46	$64.94
One Parent Family	$41.54	$43.82	$48.89
Two Parent Family	$52.40	$59.81	$69.17

RATES ARE SEMI-MONTHLY

Refer to the policy and outline of coverage for complete definitions, details, limitations, and exclusions.

BENEFIT COSTS

BI-WEEKLY MEDICAL BENEFIT COSTS

Medical	HSA				HRA			
	EE Only	EE + SP	EE + CH(N)	Family	EE Only	EE + SP	EE + CH(N)	Family
Non-Wellness Rate (Tobacco User)	$111.08	$151.48	$145.05	$178.63	$132.55	$199.75	$191.93	$251.87
Non-Wellness Rate (Non-Tobacco User)	$66.08	$106.48	$100.05	$133.63	$87.55	$154.75	$146.93	$206.87
Wellness Rate (Tobacco User)	$61.08	$101.48	$95.05	$128.63	$82.55	$149.75	$141.93	$201.87
Wellness Rate (Non-Tobacco User)	$16.08	$56.48	$50.05	$83.63	$37.55	$104.75	$96.93	$156.87

BI-WEEKLY DENTAL & VISION COSTS

	EE Only	EE + SP	EE + CH(N)	Family
Dental	$2.67	$5.98	$6.00	$7.18
Vision	$1.00	$1.50	$1.50	$3.00

- *Medical, dental, and vision deductions are taken out of every paycheck on a bi-weekly basis.*
- *Optional Life and AD&D Insurance, Aflac, and Cincinnati Life products are taken out of two paychecks per month. During the two months per year where you have three paychecks, the third paycheck will not have a deduction for these lines of coverage.*

OPTIONAL LIFE INSURANCE*

Age	$1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
34 & Under	$0.045	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
35-39	$0.070	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$4.90	$5.60	$6.30	$7.00
40-44	$0.11	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	$11.00
45-49	$0.18	$1.80	$3.60	$5.40	$7.20	$9.00	$10.80	$12.60	$14.40	$16.20	$18.00
50-54	$0.27	$2.70	$5.40	$8.10	$10.80	$13.50	$16.20	$18.90	$21.60	$24.30	$27.00
55-59	$0.40	$4.00	$8.00	$12.00	$16.00	$20.00	$24.00	$28.00	$32.00	$36.00	$40.00
60-64	$0.66	$6.60	$13.20	$19.80	$26.40	$33.00	$39.60	$46.20	$52.80	$59.40	$66.00
65-69	$1.195	$11.95	$23.90	$35.85	$47.80	$59.75	$71.70	$83.65	$95.60	$107.55	$119.50
70-74	$1.69	$16.90	$33.80	$50.70	$67.60	$84.50	$101.40	$118.30	$135.20	$152.10	$169.00
75+	$3.66	$36.60	$73.20	$109.80	$146.40	$183.00	$219.60	$256.20	$292.80	$329.40	$366.00

Semi-Monthly Cost of $10,000 Optional Life Insurance –Child(ren) $0.50

**Semi-Monthly Rates for Optional Life Insurance for Employee and Spouse (spouse premiums are based on employee's age)*

OPTIONAL AD&D INSURANCE*

	$1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
Employee	$0.016	$0.16	$0.31	$0.47	$0.62	$0.78	$0.93	$1.09	$1.24	$1.40	$1.55
Spouse	$0.011	$0.11	$0.22	$0.33	$0.44	$0.55	$0.66	$0.77	$0.88	$0.99	$1.10

Semi-Monthly Cost of $10,000 Optional AD&D Insurance –Child(ren) $0.16

**Optional AD&D Insurance may only be elected if the member is already enrolled or is enrolling in Optional Life Insurance.*

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 www.healthcare.gov.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.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 www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility -

ALABAMA—Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA—Medicaid
The AK Health Insurance Premium Payment Program Website:
http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS —Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA—Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
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:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program
(HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA—Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecoery. com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA—Medicaid
A HIPP Website: https://medicaid.georgia.gov/health insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA 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 19-64 Website:
http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA—Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS—Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY—Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA—Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE—Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740. TTY: Maine relay 711

MASSACHUSETTS—Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840

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: 1-800-657-3739

MISSOURI—Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA—Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA—Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA—Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid
Phone: 1-800-992-0900

NEW HAMPSHIRE—Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY—Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html CHIP
Phone: 1-800-701-0710

NEW YORK—Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

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

NORTH DAKOTA—Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA—Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

OREGON—Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA—Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND—Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA—Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA—Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS—Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH—Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website:
http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT—Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA—Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON—Medicaid
Website: https://www.hca.wa.gov/ P
hone: 1-800-562-3022

WEST VIRGINIA—Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN—Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING—Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-nd-eligibility/
Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice from the City of Alpharetta 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 the City'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.

The City'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 (a penalty) 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 (employees and/or their dependents) 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 or longer 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 www.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 www.socialsecurity.gov, or call them at (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:	May 4, 2023
Name of Entity/Sender:	Leslie Russell
Contact--Position/Office:	Benefits Specialist
Address:	2 Park Plaza Alpharetta, GA 30009
Phone Number:	678-297-6042

ANNUAL NOTICES

COBRA Continuation Coverage

A federal law known as the Consolidated Omnibus Reconciliation Act (COBRA) requires that most employers that sponsor group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where coverage from the terms of the plan would otherwise end. This notice is intended to inform you of your rights and obligations from the continuation coverage provisions of the law.

If you are an employee and are covered by the group health plan, you have a right to choose this continuation coverage if you lose your group health coverage from the terms of the plan because of reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you are the spouse of an employee and are covered by the group health plan, you have the right to choose this continuation coverage if you lose your group health coverage from the terms of the health plan for any of the following reasons:

- The death of your spouse
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction of your spouse's hours of employment
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare

If an employee's dependent child is covered by the group health plan, he or she has the right to continuation coverage if group health coverage from the terms of the health plan is lost for any of the following reasons:

- The death of a parent
- A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment
- Parents' divorce or legal separation
- A parent becomes entitled to Medicare
- The dependent ceases to be a dependent child within the terms of the health plan

The individuals described above, who are entitled to COBRA continuation coverage, are called qualified beneficiaries. If a child is born to a covered employee or if a child younger than age 18 is adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage, the newborn or adopted child also is a qualified beneficiary. These new dependents can be added to COBRA upon timely notification to the plan administrator in accordance with the terms of the group health plan.

Under the law, the employee or a family member has the responsibility to inform the plan administrator of a divorce, legal separation or a child losing dependent status within the terms of the health plan. This information must be provided within 60 days the event or the date on which coverage would end under the terms of the plan because of the event. If the information is not provided within 60 days, rights to continuation coverage through COBRA ends. The employer has the responsibility to notify the plan administrator of an employee's death, termination of employment or reduction in hours or Medicare entitlement.

When the plan administrator is notified that one of these events has happened, the plan administrator will, in turn, notify you of your right to choose continuation coverage. According to the law, you have 60 days from the date you are notified of your rights, or the date you would lose coverage because of one of the events described above, to inform the plan administrator that you want continuation coverage.

If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end. COBRA continuation coverage is not available to any covered individual if coverage is lost due to termination of employment for gross misconduct.

If you choose continuation coverage, the employer is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided with the plan to similarly situated employees or family members. Any changes made to the health plan for similarly situated employees or family members also will apply to the individual who chooses COBRA continuation coverage. The terms of the coverage are governed by the plan documentation, which is available upon request from the plan administrator in the event you have misplaced your documentation.

The law requires that you are given the opportunity to maintain continuation coverage for up to three years unless you lost group health coverage because of a termination of employment (except for gross misconduct) or reduction in hours. If such termination or reduction of hours is the reason for your loss of coverage, the required continuation coverage period is up to 18 months. These 18 months may be extended to 36 months if other events (such as death, divorce or the employee's Medicare entitlement) occur during the 18-month period. If the covered employee became entitled to Medicare less than 18 months before a qualifying event that is termination of employment or reduction of hours, then qualified beneficiaries, other than the covered employee, may receive continuation coverage for up to 36 months measured from the covered employee's Medicare entitlement.

The 18-month continuation coverage period applicable to termination (except for gross misconduct) or to reduction of hours may be extended to up to 29 months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time within the first 60 days of continuation coverage. In order to extend the 18-month period, a qualified beneficiary must notify the plan administrator within 60 days of the determination by the Social Security Administration and before the end of the 18-month continuation period.

If the above requirements are satisfied, the continuation coverage for all qualified beneficiaries may continue for up to an additional 11 months beyond the end of the initial 18-month period. A higher monthly premium (150 percent of the applicable premium used to determine regular COBRA rates) will be required. The plan administrator also must be notified within 30 days after the date of any final determination of the Social Security Administration that the disability no longer exists, if such a determination is made before the end of the 29-month continuation coverage period. Continuation coverage will be cut for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees
- The premium for your continuation coverage is not made on time
- You become covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition you have
- You become entitled to Medicare
- In the case of the 29-month continuation of coverage period for the disabled, the disability ends

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the plan administrator reserves the right to terminate your COBRA coverage retroactively if you are ineligible.

Under the law, you may have to pay all or part of the premium, plus a 2 percent administration fee, for your continuation coverage. As explained above, higher rates apply to the 11-month extension due to disability. There is a grace period of 30 days for payment of the regularly scheduled premium. In addition, upon the expiration of the 18-month or 36-month continuation coverage period, you are allowed to enroll in an individual conversion plan if conversion is provided from the terms of the health plan.

HIPAA Special Enrollment Right

During the enrollment period, if you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, enroll yourself or your dependents in the health plan, provided you request enrollment within 30 days after your other coverage ends. To retain your right for special enrollment, you may be required to certify during enrollment, in writing, that you are covered by another health plan. In addition, if you have a new dependents a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires all group health plans that provide medical and surgical benefits for a mastectomy must also provide certain other related benefits. A participant or beneficiary who is receiving benefits for a mastectomy that is covered by a health plan and elects breast reconstruction is entitled to receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

The coverage will be provided in a manner determined in consultation with the attending doctor and the patient. The coverage will be subject to the same annual deductible, coinsurance, copay and other conditions and limitations otherwise applicable under the health plan. If you have any questions about coverage for these benefits, contact the health insurance carrier.

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 Benefits Division (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.

Newborns' and Mothers' Health Protection

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

NOTES

IMPORTANT CONTACT INFORMATION

Medical Plans
- **Cigna**
  www.myCigna.com
  1-800-244- 6224

Health Savings Accounts
- **HSA Bank**
  www.hsabank.com
  1-800-357-6246

Dental Plan
- **Cigna**
  www.myCigna.com
  1-800-244-6224

Life Insurance
- **Cigna**
  www.Cigna.com
  Claims: 1-800-362-4462

Disability
- **Cigna**
  www.Cigna.com
  Claims: 1-800-362-4462

Vision Plan
- **EyeMed**
  www.eyemed.com
  1-866-723-0514

Flexible Spending Accounts
- **Admin America**
  www.adminamerica.com
  770-992-5959
  claims@adminamerica.com
  customerservice@adminamerica.com

Supplemental Insurance
- **Aflac**
  Bart Irby
  404-932-2643
  barton_irby@us.aflac.com

- **Cincinnati Life**
  Haley Gustavel and Jordan Gustavel
  770-536-2218
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