City of Roswell
2024-2025 Benefits Enrollment Guide

TABLE OF CONTENTS

3	BENEFIT PLAN BASICS
4	GETTING ENROLLED
5	BENEFIT ELIGIBILITY
6	ENROLLMENT INSTRUCTIONS
7	MEDICAL PLAN COMPARISON & HOW TO FIND A DOCTOR
8	MEDICAL PLAN OPTIONS
10	PRESCRIPTION DRUG COVERAGE | Rx
11	EMPLOYEE WELLNESS
13	HEALTH SAVINGS ACCOUNTS (HSA)
15	FLEXIBLE SPENDING ACCOUNTS (FSA)
16	DENTAL BENEFITS
17	VISION BENEFITS
18	BASIC LIFE AND AD&D INSURANCE
19	DISABILITY BENEFITS
20	VOLUNTARY LIFE INSURANCE
22	SUPPLEMENTARY BENEFITS
24	EMPLOYEE ASSISTANCE PROGRAM (EAP)
25	GLOSSARY OF TERMS
26	CONTACT INFORMATION
27	WHEN SHOULD I CONTACT NFP

WELCOME

Benefits Menu | Open Enrollment

BENEFITS OFFERED

MY HEALTH

Medical | **Aetna**
Dental | **MetLife**
Vision | **Aetna**
Health Savings Accounts | **Health Equity**

MY LIFE

Life and AD&D | **MetLife**
Disability | **MetLife**
Accident | **Aflac**
Critical Illness **| Aflac**

MY PERKS

Wellness | **City of Roswell/Aetna**
Telehealth | **Aetna**
Employee Assistance Program | **FEI**

Your Open Enrollment Dates:

AUGUST 19, 2024 – AUGUST 30, 2024

ENROLLMENT REMINDERS

1. Review the information in this guide and benefit plan summaries.
2. You must complete your enrollment even if you are waiving coverage. **If you participate in HSA and/or FSA, you will have to elect your contributions for the new plan year.**
3. You will not be allowed to make changes after the open enrollment window closes, unless you experience a qualifying life event.

IMPORTANT

You must notify HR and change elections within 30 days of a life event.

Paying For Your Benefits

Some benefits are provided by the City at no cost to you whereas some costs are shared.
While you pay for the full cost of other coverages such as Voluntary Term Life, you still benefit from discounted group rates.

Benefit	Who Contributes?
Medical/Pharmacy	You and City of Roswell
Dental	You and City of Roswell
Vision	You
Basic Life and AD&D	City of Roswell
Voluntary Life and AD&D	You
Disability	City of Roswell
Supplemental Benefits	You

GETTING ENROLLED

Benefits Menu | Enrollment Instructions

BENEFITS OFFERED

MY HEALTH

Medical | **Aetna**
Dental | **MetLife**
Vision | **Aetna**
Health Savings Accounts | **Health Equity**

MY LIFE

Life and AD&D | **MetLife**
Disability | **MetLife**
Accident | **Aflac**
Critical Illness **| Aflac**

MY PERKS

Wellness | **Be Well Roswell**
Telehealth | **Aetna**
Employee Assistance Program | **FEI**

Your Benefit Period

OCTOBER 1, 2024 – SEPTEMBER 30, 2025

ENROLLMENT

All team members have access to our online benefits enrollment platform 24/7 where you have the ability to enroll, select or change your benefits online during the annual open enrollment period, new hire orientation, and for qualifying events.

- ✓ **Accessible 24/7;**
- ✓ **View all benefit plan options and your elections;**
- ✓ **View important carrier forms and links;**
- ✓ **Report a qualifying life event; and**
- ✓ **Make changes to beneficiary designations and more.**

ENROLLMENT INSTRUCTIONS:

1. Go to https://workforcenow.adp.com/
2. Enter your User ID
3. Enter your Password: **Last 4 of your SSN**
4. Follow instructions and enroll in your benefits
5. Once you save your elections, you will be able to download and print your confirmation.

READY TO ENROLL?

Go to https://workforcenow.adp.com/

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their *26th birthday this year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

ELIGIBILITY

Rules | Requirements

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are a full-time benefit eligible employee. Your coverage will be effective 1st of the month following your date of hire.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner; or
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains who is eligible for coverage under each benefit plan type:

Line of Coverage	
Spouses are eligible for:	**Medical/Rx, dental, vision, life, supplementary benefits**
Children are eligible for:	**Medical/Rx, dental, vision, life, supplementary benefits (eligible until age 26)**

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA continuation details can be found in the notices section of this employee benefit guide.

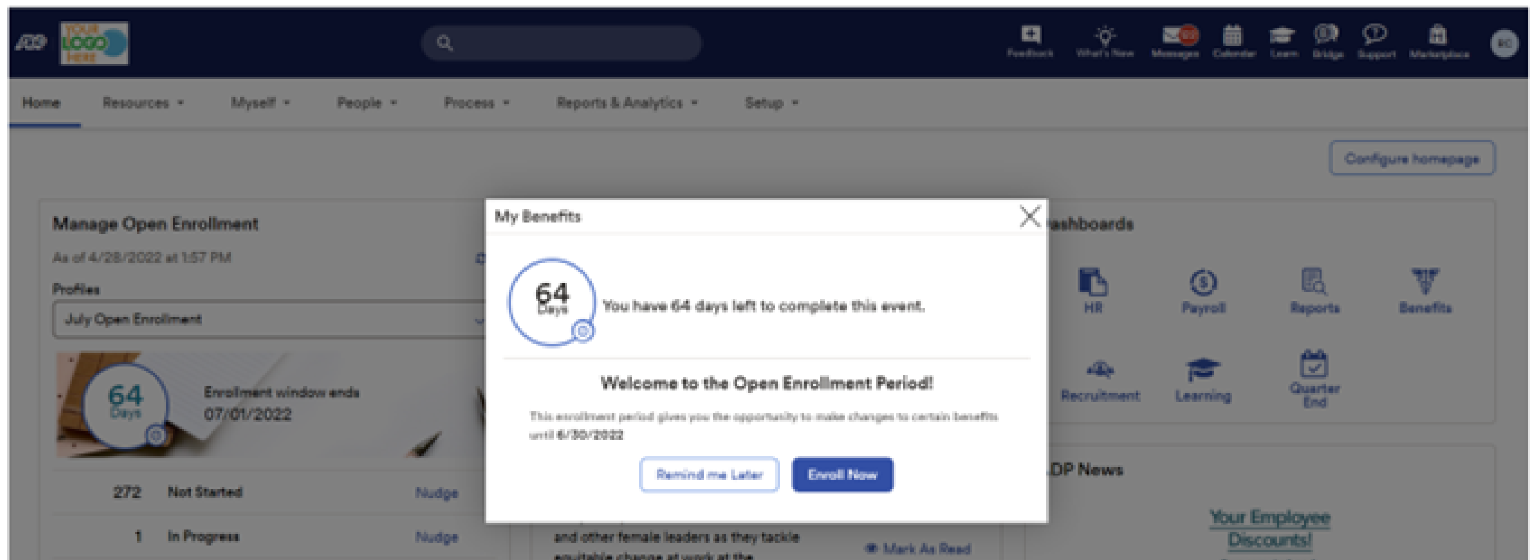
ENROLLMENT INSTRUCTIONS

Enrollment Portal | www.workforcenow.adp.com

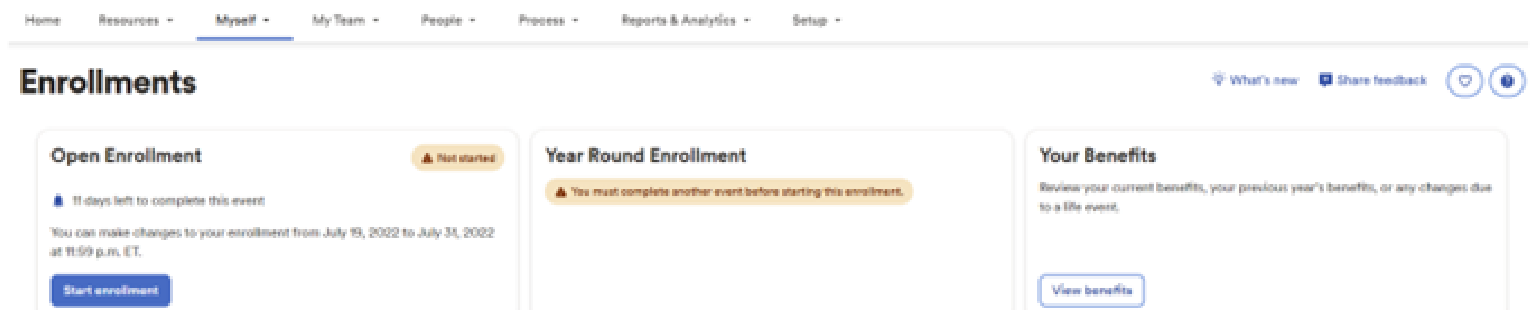
Open Enrollment Pop-up upon Login

Upon logging in, you will be presented with a pop-up showing important information about this Open Enrollment period. You can click **Enroll Now** or **Remind Me Later**.

Note*: This pop-up is displayed each time you log in during the Open Enrollment period. 24-hours after submitting your selections the pop-up will no longer display.*



Select **Enroll Now** will bring you to the **Myself > Benefits > Enrollments** screen where you can click **Start Enrollment**.



MEDICAL

Plan Comparison

	Aetna 2000 HSA	Aetna Traditional POS
Deductible (Individual/Family)	$2,000/$4,000	$1,000/$3,000
Embedded or Non-Embedded Deductible	Non-Embedded: There is no individual deductible. So, the overall family deductible must be reached, either by an individual or by the family, in order for the insurance company to pay for services at the contracted rates.	Embedded: Each family member has an individual deductible in addition to the overall family deductible. Meaning if an individual in the family reaches his or her deductible before the family deductible is reached, his or her services will be paid by the insurance company.
Eligible for HSA	Yes	No
Primary Care Cost	You pay 10% after deductible is met	You pay a $25 copay each visit
Out-of-pocket Maximum	$3,000/$6,000	$3,000/$6,000
Preventive Care Cost	Covered 100%	Covered 100%
Emergency Room Cost	You pay 10% after deductible is met	You pay 10% after deductible is met

How do I find an in-network provider?

As a guest on Aetna.com by following the instructions below:

1. Go to our Find a Doctor page.
2. Under "Guests," choose "Plan from an employer."
3. Enter your zip code and wait for the drop down to appear with your zip code and city . Select your zip and city that appears in the drop down. Set range of miles around home location (up to100-mile radius) and hit "Search".
4. Under "Select a Plan," type in the search bar or scroll to “Aetna Choice® POS II (Open Access)” and search. Make sure the plan name matches the Aetna plan name exactly as outlined above.
5. Search by provider name, provider type or you'll also have the option to search by various categories.

Once you have registered for your Aetna member account, the providers can be found under “Find Care” and they will all be in-network based on your plan!

If you are having trouble locating a provider, please reach out to Aetna member services by calling the number on the back of your ID card or you may also call NFP at 1-888-643-5995.

MEDICAL

Aetna | HSA 2000 Plan

	In-Network	Out-of-Network
This Plan Is Eligible For HSA		
DEDUCTIBLE		
Single Deductible	$2,000	$4,000
Two Person/Family Deductible	$4,000	$8,000
COINSURANCE *(applies after deductible is met)*		
Member Cost Share %	You pay 10%	You pay 30%
MEMBER COPAYMENT(S)		
Preventive Care/Routine Exams	Covered 100%; no deductible	You pay 30% after deductible
Primary Care (PCP) - Office Visit	You pay 10% after deductible	You pay 30% after deductible
Specialist - Office Visit	You pay 10% after deductible	You pay 30% after deductible
Urgent Care Facility	You pay 10% after deductible	You pay 30% after deductible
Emergency Room Visit	You pay 10% after deductible	Same as In-Network
OUT-OF-POCKET (OOP) MAXIMUM		
Single Maximum	$3,000	$8,000
Two Person/Family Maximum	$6,000	$16,000

Coverage Tier	Bi-Weekly Employee Cost	City Pays Bi-Weekly	Monthly Premium
Employee Only	$40.00	$271.16	$675.48
Employee + Spouse	$62.00	$589.56	$1,411.72
Employee + Child(ren)	$56.97	$522.89	$1,256.37
Employee + Family	$81.02	$841.78	$1,999.38

***Above rates do no include tobacco and/or spousal surcharges or Wellness credits.**

Surcharge	Bi-Weekly Cost
Employee Tobacco User	$50.00
Spouse Tobacco User	$50.00
Dependent Over 18 Tobacco User	$50.00
Spousal Surcharge (If your spouse is covered under your plan in lieu of their own Employer plan)	$50.00

MEDICAL

Aetna | Traditional POS Plan

	In-Network	Out-of-Network
DEDUCTIBLE		
Single Deductible	$1,000	$4,000
Two Person/Family Deductible	$3,000	$8,000
COINSURANCE *(applies after deductible is met)*		
Member Cost Share %	You pay 10%	You pay 30%
MEMBER COPAYMENT(S)		
Preventive Care/Routine Exams	Covered 100%; no deductible	You pay 30% after deductible
Primary Care (PCP) - Office Visit	$25 copay per visit; no deductible	You pay 30% after deductible
Specialist - Office Visit	$60 copay per visit; no deductible	You pay 30% after deductible
Urgent Care Facility	$60 copay per visit; no deductible	You pay 30% after deductible
Emergency Room Visit	You pay 10% after deductible	Same as In-Network
OUT-OF-POCKET (OOP) MAXIMUM		
Single Maximum	$3,000	$8,000
Two Person/Family Maximum	$6,000	$16,000

Coverage Tier	Bi-Weekly Employee Cost	City Pays Bi-Weekly	Monthly Premium
Employee Only	$83.38	$297.50	$825.23
Employee + Spouse	$158.68	$634.02	$1,717.51
Employee + Child(ren)	$144.17	$569.41	$1,546.10
Employee + Family	$213.54	$878.44	$2,365.96

***Above rates do no include tobacco and/or spousal surcharges or Wellness credits.**

Surcharge	Bi-Weekly Cost
Employee Tobacco User	$50.00
Spouse Tobacco User	$50.00
Dependent Over 18 Tobacco User	$50.00
Spousal Surcharge (If your spouse is covered under your plan in lieu of their own Employer plan)	$50.00

PRESCRIPTION DRUGS

Rx | Plan Comparison

TRADITIONAL DRUGS

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 | Highest copay: In this category are nonpreferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay. **Make sure to check for mail order discounts that may be available.**

SPECIALTY DRUGS

TIER 4 | Lowest (Preferred) specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than non-preferred specialty drugs in tier 5.

TIER 5 | Highest (Non-preferred) specialty drug copay: These drugs have the highest copay for specialty drugs, usually because there may be a more cost-effective generic or preferred brand available.

Rx Copays	Aetna HSA 2000	Aetna Traditional POS
TIER 1 (Value / Generic)	Retail: $10 copay Mail Order: $25 copay After medical deductible has been met	Retail: $10 copay Mail Order: $20 copay
TIER 2	Retail: $35 copay Mail Order: $87.50 copay After medical deductible is met	Retail: $35 copay Mail Order: $70
TIER 3	Retail: $60 copay Mail Order: $150 copay After medical deductible is met	Retail: $60 copay Mail Order: $120 copay
TIER 4	$60 copay After medical deductible is met	You pay 20% up to $200
TIER 5	$60 copay After medical deductible is met	You pay 20% up to $200

WHERE CAN I FIND A DRUG LIST?

Once enrolled, you can log into the Aetna member website to search for drugs currently on the formulary or see if a drug is covered through Aetna's public formulary by taking the following steps:

Go to: www.aetna.com/individuals-families/find-a-medication

Scroll down and choose the plan year and plan. Choose a plan year: 2024 / Choose a plan: "Aetna Standard Plans"

Click "View Plan" to continue

On this page, you can find the drug guide that includes the most commonly covered drugs under your plan, quarterly plan change guides, and more coverage details.

To easily search for a specific drug:

Follow steps #1-3 above

Click on "Find a covered drug"

Type the drug name you are looking for in the search bar and select the drug with proper dosage in the drop down and hit "Search".

Select the drug from the list that appears. On this page, you can see the formulary status and if there are any notes or restrictions (i.e. quantity limits).

Save Money With Generic (Tier 1) Drugs

Ask your doctor if it's appropriate to use a generic drug rather than a brand.

Generic drugs are less expensive, and according to the FDA, they contain the same active ingredients and are identical in dose, form and administrative method as a brand name.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER - Many drugs are available in a 90-day supply, rather than the 30-day retail supply. Typically, you will pay less if you choose to get a mail order 90-day supply.

GoodRx - There are many tools online that you can use in order to save on prescription costs. One being GoodRx.com, an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR – Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times, there are generic or different manufacturers that will save you money at the pharmacy.

EMPLOYEE WELLNESS PROGRAM

Be Well Roswell | Employee Perks

The Employee Wellness Program promotes the health, safety, and well-being of the EXTRAORDINARY employees of the City of Roswell!

Additional Programs include:

- CORE Wellness Center
- $40 Bi-Weekly Wellness Credit**
- Diabetes supplies for Wellness Program Participants
- Wellness Lunch and Learns
- Employee Reward Program
- Men's Basketball League
- Softball League
- COR Fitness Reimbursement for BJCAB Gym

For questions regarding wellness contact:
Hydee Weis
770-594-6109
hweis@roswellgov.com

Wellness credits for the 10/01/2024-09/30/2025 plan year will be based on completion of an annual physical between 10/1/2023-08/31/2024.

WELLNESS PROGRAMS

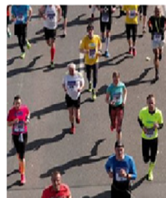
SmartDollar

SmartDollar is a free benefit for City of Roswell Employees, designed to help you get on track, stay motivated, and reach your financial goals. Participation is voluntary, and the program is confidential and secure.

The City of Roswell's Employee Wellness Program promotes and supports the health, safety, and well-being of our extraordinary staff! By offering in-house programs and classes, the Employee Wellness Program aims to inspire staff to make healthy lifestyle choices that will help them be the best they can be for themselves, their families, and their community.

FITNESS COMPETITION/RACE REIMBURSEMENT

Full-time City employees can apply for reimbursement of up to $25 per race/fitness competition; up to 2 races per fiscal year, until the fund is exhausted.



weight watchers

The cost to participate is $20.00 per month. The City pays 50% of your fee. If you attend 10 meetings in a calendar quarter, you can be reimbursed for your portion of the fee for that quarter.

FREE FITNESS CLASSES

Group fitness classes are offered on a weekly basis. They are held at varying times and locations throughout the City.

- Boot Camp
- Cardio Fusion
- Yoga
- Walking

WELLNESS WEDNESDAY

Each quarter, HR will go to different locations around the City and provide fresh fruit and health snack options on Wednesdays.

AND MORE!

EMPLOYEE WELLNESS CENTER

Services | Costs

Want to save money on doctor visits and lab work? Use the City of Roswell Wellness Center!

Wellness visits, physicals, and screenings are FREE!

Sick visits, such as illness or minor injuries, are only $25.00.

Lab work is also included at no extra charge!

Make an appointment online today:
www.members.eversidehealth.com

For questions regarding wellness contact:
Hydee Weis
770-594-6109
hweis@roswellgov.com

WELLNESS CENTER

Want to save money on doctor visits and lab work? Use the City of Roswell Wellness Center! This convenient, on-site wellness center is close to work, reducing the time it takes to address healthcare issues. The center can provide health services to all full-time City employees, Elected Officials, and part-time employees covered on the medical insurance plan. Wellness visits, physicals, and screenings are FREE! Sick visits, for illness or minor injuries, are only $25.00.

WHERE is it?

- At the Waller Park Recreation Center building at 250 Oak Street

WHEN can I visit?

- Monday 8:30am-2:30pm, Tuesday and Thursday 8:30am-3:30pm (closed 11:30am-12pm & COR holidays).
- Call 770-817-6070, press 1 for the appointment line or 2 to be transferred directly to the wellness center during their normal business hours. Walk-Ins accepted if an appointment time is available.
- You can also make an appointment online by going to https://members.eversidehealth.com/. You can also send a message to the center staff and view your health records through the portal.
- Virtual Visits are also available.

HOW do I pay?

- CORE Wellness Center is an in-network provider. If enrolled in Medical, the cost of your appointment will be applied to your deductible, but payment is expected at time of service.

WHAT information is shared?

- The City does NOT have access to your private health information.

Services Provided:

Acute Care

Illnesses, Minor Injuries, and Skin Conditions

- Cold/Flu
- Sinus Infections
- Sore Throat/Strep

$25

Preventative Care

Vaccines, Education, Wellness

- Screenings
- Lab Work
- Wellness Coaching
- Vaccinations
- Physicals

FREE

Disease Management

Treatment plans, follow-up for chronic conditions

- Allergies and Asthma
- Diabetes
- High Blood Pressure
- High Cholesterol
- Weight Management

$0-$25

Medications

Due to recent regulatory guidance concerning dispensing in the State of Georgia, the Wellness Center is no longer able to dispense medication. However, all medications which were previously dispensed can be filled at local pharmacies for **FREE**! Speak to NP Mimi Phan at your next visit for more details.

HEALTH SAVINGS ACCOUNT

HSA | HealthEquity

ENROLLED IN THE HSA ELIGIBLE HEALTH PLAN?

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax-free, and no matter what, the money in the account is yours!

A Health Savings Account (HSA) is a tax-free savings account owned by you is 100% vested from day one, and let's you build up savings for future needs. The funds may be used to pay for qualifying healthcare expenses not covered by insurance or any other plan for yourself, your spouse, or tax dependents. You decide how much you would like to contribute, when and how to spend the money on eligible expenses, and how to invest the balance.

**Some employees may have HSA through Optum or another bank.*

UNDERSTANDING YOUR HSA

- Pre-tax contributions are deducted through payroll and deposited into your HSA account;
- You can use your HSA available funds to pay for qualified medical expenses tax-free;
- HSA funds can be used for non-eligible expenses but will be subject to regular income taxes and a 20% excise tax penalty.
- Unused funds remain in your account for future use and roll over each calendar year;
- HSAs remain with you even if you change health plans or companies. If you open an HSA and later become ineligible to make contributions, you can still use your remaining funds; and
- You can change your HSA contribution at any time during the plan year for any reason.

2024 | HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts.

HSA Contribution Limits	
Employee	$4,150
Two Person/Family	$8,300
HSA "Catch-Up" Contributions	
Age 55 or older	$1,000 a year
Employer HSA Contribution	
Employee	$750
Two Person/Family	$1,500
Contribution Maximum (after employer contribution)	
Employee	$3,400
Two Person/Family	$6,800

HEALTH SAVINGS ACCOUNT

Eligibility | Eligible Expenses

HSA ELIGIBILITY REQUIREMENTS

To have an HSA and make contributions to the account, you must meet several basic qualifications.

- ✓ To be eligible to open and contribute to an HSA, you must have coverage under a qualified High Deductible Health Plan (HDHP).
- ✓ Participants cannot be covered by any other health insurance plan (this exclusion does not apply to certain other types of insurance, such as dental, vision, disability or long-term care coverage);
- ✓ Participants cannot participate in a Healthcare FSA or spouse/domestic partner's Healthcare FSA or Health Reimbursement Account (HRA).
- ✓ Participants cannot be enrolled in Medicare or Medicaid.
- ✓ You cannot be eligible to be claimed as a dependent on someone else's tax return.
- ✓ You have not received Department of Veterans Affairs Medical benefits in the past 90 days, unless the Veteran has a disability rating. (*There may be additional special circumstances, check with your tax preparer*).

MAINTAINING RECORDS

To protect yourself in the event that you are audited by the IRS, keep records of all HSA documentation and itemized receipts for at least as long as your income tax return is considered open (subject to an audit), or as long as you maintain the account, whichever is longer.

The IRS requires HSA funds to be used for qualified expenses only. If you use HSA funds for non-eligible expenses, you will be subject to regular income taxes and an additional 20% excise tax penalty.

ELIGIBLE HSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limb
- Automobile modifications for a physically handicapped person
- Birth control pills
- Blood pressure monitoring device
- Braille books & magazines
- Chiropractic care
- Christian science practitioner
- COBRA premiums
- Contact lenses & related materials
- Crutches
- Dental treatment
- Dentures
- Diagnostic services
- Drug addiction treatment
- Eye examination
- Eyeglasses & related materials
- Fertility treatment
- Flu shot
- Guide dog or another animal aide
- Hearing aids
- Hospital services
- Immunization
- Insulin
- Laboratory fees
- Laser eye surgery
- Long-term care premiums or expenses
- Medical testing device
- Nursing services
- Obstetrical expenses
- Organ transplant
- Orthodontia (not for cosmetic reasons)
- Oxygen
- Physical exam
- Physical therapy
- Prescription drugs
- Psychiatric care
- Retiree medical insurance premiums
- Smoking cessation program
- Surgery
- Transportation for medical care
- Weight loss program
- Wheelchairs and more*.

A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

FLEXIBLE SPENDING ACCOUNT

FSA | HealthEquity

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire plan year **(October 1st through September 30th)**. The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at **www.irs.gov.**
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at **www.fsastore.com.**

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | $3,850 (single) | $7,750 (family)

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general-purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

LIMITED PURPOSE FSA | ADDITIONAL REQUIREMENTS

- If you open or contribute to a Health Saving Account (HSA), you may only enroll in a Limited Purpose FSA.
- If you enroll in a HDHP (High Deductible Health Plan) and elect a Health FSA, you will automatically be enrolled in the Limited Purpose FSA.
- A limited purpose FSA will reimburse you for dental and vision expenses, but you cannot claim the same expense on both the FSA and HSA Accounts.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to $5,000 annually in pre-tax dollars if you are single, or $2,500 if you are married and file taxes separately from your spouse. If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

"USE IT" OR "LOSE IT"

*"Unused" FSA funds do not roll over from year to year. **If you don't use the funds in your account by December 14th, 2025, you'll lose them.***

IMPORTANT: PAYING FOR ELIGIBLE SERVICES & EXPENSES

Visit the FSA Store at **www.FSAstore.com,** where you can purchase FSA-eligible products without a prescription online.

Although you do not need to file for reimbursement when using your FSA debit card, you may be required to submit documentation, so be sure to save your receipts.

If you use a personal form of payment to pay for eligible expenses out-of-pocket, you can submit an FSA claim form along with your original receipts for reimbursement.

*ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:

1. **'Care'** for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. **'Care'** for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. **'Care'** for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

'Care' is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

DENTAL

Plan Options | MetLife

COMMON TERMS

PRE-TREATMENT ESTIMATE

If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE

You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS

Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

You have the freedom to select the dentist of your choice; however, when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

	Core Plan	Buy-Up Plan
PLAN FEATURES		
Network Details	**PDP Plus Network**	**PDP Plus Network**
Benefit Period	**Calendar Year**	
DEDUCTIBLE		
Single	**$50**	
Two Person	**$100**	
Family	**$150**	
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive or Ortho services)	
COVERED SERVICES		
TYPE A: Preventive Services *Routine oral exams and cleanings, x-rays (bitewing), sealants & fluoride treatments*	**Covered at 100%**	**Covered at 100%**
TYPE B: Basic Services *Periodontics (surgical & non-surgical), endodontics (root canals), oral surgery, fillings, prosthetic maintenance*	**Covered at 90%**	**Covered at 90%**
TYPE C: Major Services *Prosthodontics, crowns, inlays/onlays, dentures, implants & bridges*	**Covered at 50%**	**Covered at 50%**
TYPE D: Orthodontia Services	**Covered at 50%**	**Covered at 50%**
OUT-OF-NETWORK BENEFITS		
	Negotiated Fee Schedule/Amount	**R&C 90th Percentile**
ANNUAL MAXIMUM		
Maximum Benefit *Allowed per Benefit Period*	**$2,250 per covered individual**	
Lifetime Orthodontia	**$1,500**	

Dental Bi-Weekly Cost		
Coverage Tier	**Core Plan**	**Buy-Up Plan**
Employee Only	$0.00	$4.98
Employee + Spouse	$12.44	$19.92
Employee + Child(ren)	$13.03	$19.90
Employee + Family	$24.88	$34.82

How do I find an In-Network Provider?

This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on www.MetLife.com under "Find a Dentist". Choose the network based on the plan type you are choosing.

VISION

Coverage Overview | Aetna

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

	IN-NETWORK *AETNA VISION PREFERRED*	OUT-OF-NETWORK PROVIDER
PLAN FEATURES		
Vision Exam	**$0** copay	Reimbursement up to **$40**
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	**$20** copay	Reimbursement up to **$25**
Bifocals	**$20** copay	Reimbursement up to **$40**
Trifocals	**$20** copay	Reimbursement up to **$56**
Frames	**$0** Copay; **$130** Allowance**, 15% off balance over allowance	Reimbursement up to **$65**
COVERED SERVICES		
Contact Lenses (Conventional)	**$0** Copay; **$130** Allowance**, 15% off balance over allowance	Reimbursement up to **$104**
Contact Lenses (Medically Necessary)	Covered In Full	Reimbursement up to **$200**
Contact Lens Evaluation Fitting	$40 copay	Not Covered
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months
Contacts	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months *(contacts in lieu of frames/lenses)*

Vision Semi-Monthly Cost	
Employee Only	$2.91
Employee + Spouse	$5.53
Employee + Child(ren)	$5.82
Employee + Family	$8.56

Please note that the costs in the enrollment portal will be based on a bi-weekly pay schedule (26 pay periods)

Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating In-Network provider?

Find providers, manage your benefits and view your ID card at AetnaVision.com

BASIC LIFE

Coverage Overview | MetLife

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary**. A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

BASIC LIFE INSURANCE

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost	
Coverage Amount	**Employees:** Benefit of 3x your salary up to $450,000 **Spouses:** Flat $5,000 benefit **Children:** Flat $2,500 benefit
Accidental Death and Dismemberment (AD&D)	Amount equal to your Life benefit
Benefit Reduction Schedule	Your insurance will reduce to: – 65% of the original amount at age 65 – 50% of the original amount at age 70 – 35% of the original amount at age 75

ADDITIONAL PLAN PROVISIONS

Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

DISABILITY

Short-Term | Long-Term

SHORT-TERM DISABILITY (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs.

Short-Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

LONG-TERM DISABILITY (LTD)

Serious illnesses or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months – even years.

Long-Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

PLAN FEATURES	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Cost of Coverage	**City of Roswell Pays Your Premium**	**City of Roswell Pays Your Premium**
Elimination Period *This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.*	Benefits begin on the **30th day of an accident** and the **30th day of an illness (including pregnancy)**	Your elimination period is **180 days** (if elected, this will be the benefit duration of Short-Term Disability)
Benefit Duration *The maximum number of weeks you can receive benefits while you are sick or disabled.*	**Payments may last up to 22 weeks** You must be sick or disabled for the duration of the waiting period before you can receive a benefit payment.	**Payments will last for as long as you are disabled** You must be sick or disabled for the duration of the elimination period before you can receive a benefit payment.
Coverage Amount	Covers **66.667% of your weekly income,** up to a maximum benefit of **$1,500 per week.**	Covers **66.667% of your monthly income,** up to a maximum benefit of **$7,500 per month.**
What's covered?	**A variety of conditions and injuries.** Typical claims would include pregnancy, injuries, joint, back and digestive disorders.	**A variety of conditions and injuries.** Typical claims would include cancer, back disorders, injuries and poison, cardiovascular, joint disorders.
Definition of Earnings	**Base Salary** *(excludes commissions and bonuses)*	**Base Salary** *(excludes commissions and bonuses)*
ADDITIONAL PLAN PROVISIONS		
Benefit Payment Frequency	**Weekly benefit** may be reduced or offset by other sources of income.	**Monthly benefit** may be reduced or offset by other sources of income.
Pre-Existing Condition Limitation	None	Pre-existing Condition means a Sickness or accidental injury for which the employee: • Received medical treatment, consultation, care, or services; or • Took prescription medication or had medications prescribed in the 3 months before insurance or any increase in the amount of insurance under the certificate takes effect. We will not pay benefits, or any increase in benefit amount due to an elected increase in the amount of insurance for a Disability that results for a Pre-existing Condition, if the employee has been Actively at Work for less than 12 consecutive months after the date their Disability insurance or the elected increase in the amount of such insurance takes effect under the certificate.

Certain exclusions and any pre-existing condition limitations may apply. Please refer to the Provider's detailed benefit summary for details.

VOLUNTARY LIFE

Coverage Options

VOLUNTARY **LIFE INSURANCE**

Employees have the opportunity to enroll in supplemental life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents. Rates will be calculated in the enrollment portal when enrolling in coverage.

PLAN OPTIONS			
Cost of Coverage	Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.		
Coverage Options	**Employee Coverage** Choose in $10,000 increments up to the lesser of 5x your annual salary or $500,000	**Spouse Coverage** Choose in $5,000 increments up to the lesser of 100% of the amount you elect for yourself or $250,000	**Dependent Coverage** Choose a flat amount of $5,000 or $10,000
Do I have to take a health exam to get coverage?	If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.		
Guaranteed Issue	**Employee** $200,000	**Spouse** $50,000	**Dependent** $10,000

PLAN PROVISIONS		
Cost Calculation	Age Rated Benefit (Spouse Life based on employee's age)	
Benefit Reduction Schedule	**The voluntary life benefit will not reduce at any age**	**The voluntary life benefit will not reduce at any age**
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.	
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.	

*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). **This year, current participants can increase elections up to $100,000 for themselves and/or $25,000 for spouses without proof of good health. Late entrants or new participants can elect up to $100,000 for themselves and/or $25,000 for spouses without proof of good health.**

Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

VOLUNTARY LIFE

Coverage Costs

VOLUNTARY **LIFE INSURANCE**

Employees have the opportunity to enroll in supplemental life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents. Please see the instructions below to calculate your cost. Rates will also be calculated in the enrollment portal when enrolling in coverage.

Monthly Rate per $1,000			
Age	Employee & Spouse Rate	AD&D Rate	Total Monthly Rate
<30	$0.060	$0.021	$0.081
30-34	$0.080	$0.021	$0.101
35-39	$0.090	$0.021	$0.111
40-44	$0.147	$0.021	$0.168
45-49	$0.275	$0.021	$0.296
50-54	$0.430	$0.021	$0.451
55-59	$0.705	$0.021	$0.726
60-64	$1.008	$0.021	$1.029
65-69	$1.740	$0.021	$1.761
70 +	$2.600	$0.021	$2.621
Child Life w/ AD&D	$5,000 benefit = $1.42	$10,000 benefit = $2.83	Per Month

Spouse rates are calculated based on the employee’s age.

To calculate your deduction, please use one of the formulas below:

Semi-Monthly: _________÷ 1,000 x _______ x 12 ÷ 24 = Total Deduction

Bi-Weekly: _______ ÷ 1,000 x _______ x 12 ÷ 26 = Total Deduction

Example: John is 54 and elects $200,000 of Voluntary Life w/ AD&D for himself.

200,000 ÷ 1,000 = 200 x $0.451 = 90.20 x 12 = 1,082.40 ÷ 24 = $45.10 Total Deduction

Please note the costs in the enrollment portal will be based on a bi-weekly pay schedule (26 pay periods)

SUPPLEMENTARY BENEFITS

Accident | Aflac

Accident Insurance

A serious injury can cost you a lot of money – not only in medical bills but in things like income from lost work hours. Some injuries are minor, but others are debilitating and require significant medical care. If you get hurt, accident insurance pays you money that you can use to cover personal expenses, bills, and out-of-pocket medical costs.

Who Gets Paid?

You get paid. When you have a covered accident or injury, your health insurance company pays your doctor or hospital, but your accident insurance company pays you.

What's Covered?

Not all accidents are "qualifying injuries." The kinds of accidents that are covered can vary by plan, but accident insurance plans typically cover things like:

If you have a covered injury, accident insurance can help you pay for things like:

- Emergency Room Visits
- Ambulance Transportation
- Emergency Helicopter Transportation
- Hospital Admissions & Per Diem Charges
- Intensive Care & Rehabilitation Unit Care
- Diagnostic Exams
- Follow-up Treatments
- Physical Therapy

What it Doesn't Cover

Accident insurance will not typically cover things like check-ups or hospitalization due to illness. Accident insurance will not cover you for injuries suffered before you purchased the plan.

Coverage Tier	Semi-Monthly Premium
Employee Only	$7.24
Employee + Spouse	$12.78
Employee + Child(ren)	$15.78
Employee + Family	$21.32

Please note that the costs in the enrollment portal will be based on a bi-weekly pay schedule (26 pay periods)

$50 WELLNESS BENEFIT Per Covered Individual

For Screenings such as: blood tests, Chest X-rays, Stress tests, Colonoscopies, Mammograms, and other tests listed in your policy.

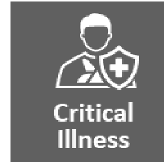
SUPPLEMENTARY BENEFITS

Critical Illness | Aflac

Employee Non-Tobacco Monthly Premiums			
Age	$10,000	$20,000	$30,000
18-24	$3.43	$6.87	$10.30
25-29	$4.11	$8.23	$12.34
30-34	$5.18	$10.36	$15.54
35-39	$6.44	$12.88	$19.32
40-44	$8.67	$17.34	$26.02
45-49	$12.26	$24.52	$36.78
50-54	$17.60	$35.19	$52.79
55-59	$24.48	$48.97	$73.45
60-64	$35.15	$70.31	$105.46
65-69	$52.22	$104.45	$156.67
70+	$79.38	$158.77	$238.15

Spouse Non-Tobacco Monthly Premiums			
Age	$5,000	$10,000	$15,000
18-24	$1.72	$3.43	$5.15
25-29	$2.06	$4.11	$6.17
30-34	$2.59	$5.18	$7.77
35-39	$3.22	$6.44	$9.66
40-44	$4.34	$8.67	$13.01
45-49	$6.13	$12.26	$18.39
50-54	$8.80	$17.60	$26.39
55-59	$12.24	$24.48	$36.72
60-64	$17.58	$35.15	$52.73
65-69	$26.11	$52.22	$78.34
70+	$39.69	$79.38	$119.08

Please note that the costs in the enrollment portal will be based on a bi-weekly pay schedule (26 pay periods)

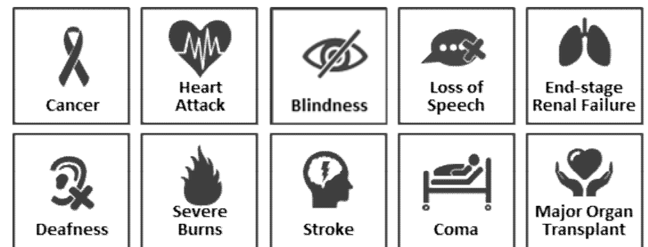


Critical Illness Insurance

How would you pay your bills if you were suddenly diagnosed with cancer and couldn't work? Critical illness insurance doesn't' pay your medical bills. It pays you if you're diagnosed with a covered illness. The benefit is paid directly to you and is your choice how to spend it.

What's Covered?

Critical illness can vary widely from one another. Some may focus on a single specific diagnosis, while others may provide you with coverage for a range of possible diagnoses, such as:



COVERAGE OPTIONS

- Employees can choose up to $30,000 in $10,000 increments
- Elect up to 50% of the employee amount in increments of $5,000 for spouses

What is the Cost of Critical Illness Insurance?

Depending on your age, your Tobacco user status, and how much coverage you want, the cost of critical illness insurance can vary significantly.

Please note that the rates on the tables to the left reflect only the non-tobacco user rates. If you are a tobacco user, your rates will be slightly higher. You will be able to see that reflected in the enrollment system upon enrolling.

$50 WELLNESS BENEFIT Per Covered Individual

For Screenings such as: blood tests, Chest X-rays, Stress tests, Colonoscopies, Mammograms, and other tests listed in your policy.

EMPLOYEE ASSITANCE PROGRAM

EAP | FEI

Welcome to your **Employee Assistance Program** (EAP). By accessing its information, resources and referrals, you can find the support you need to become your best—in all facets of life. Your member portal and app provide access to information and resources, including many expanded services, such as health and lifestyle assessments, soft skills courses and a discount marketplace. Services are free, confidential and available to you and your family members. When you use your EAP, everyone benefits. We have stronger employees, families, workplaces and communities. **We're here for you: 24/7/365.**

Here's a closer look at your benefits:

Short-Term Counseling

Up to 6 sessions per issue per year to help you:

- Alleviate emotional stress
- Enhance interpersonal relationships
- Tackle family/parenting challenges
- Deal with substance misuse
- Manage strong feelings
- Build on personal strengths
- Navigate life transitions
- Work through grief and loss

Life Coaching

Up to 6 sessions per year to help you:

- Define your goals and plan a strategy
- Achieve personal and professional goals
- Manage life transitions
- Improve stress and time management
- Overcome obstacles
- Strengthen relationships
- Improve communication
- Manage multiple projects and demands

Work-Life Benefit

Unlimited consultations and referrals for:

- Childcare
- Adoption
- Elder care
- Dependent care
- K -12 & higher education resources
- Medical Advocacy
- Personal Assistant

Legal Benefit

One session per issue:

- Bankruptcy, foreclosure
- Home sale/purchase or lease agreement
- Separation or divorce
- Adoption
- Child custody/child support
- Free simple will
- Traffic, civil or criminal matters
- Elder law
- Legal document review
- Simple dispute resolution

Financial Benefit

One consultation per issue:

- Manage expenses and debt
- Prepare a realistic budget
- Deal with tax-related questions
- Plan for retirement
- Identity theft solutions
- Invest in a college education
- Student loan coaching
- Home purchase education
- Credit report review

Contact FEI Behavioral Health
Call: 800-824-4372
Visit: myassistanceprogram.com/fei
Code: roswell

FEI WORKFORCE RESILIENCE
An AllOne Health Company

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

IMPORTANT CONTACT INFORMATION

Have Questions?

Please see the chart below for provider customer service phone numbers and website addresses.

If you need any other assistance, contact HR.

CONTACT INFORMATION

Provider	Contact
NFP Benefit Enrollment, General Questions, Claims	1-888-643-5995 NFPsecustomerservice@nfp.com
Aetna Medical/Rx │Vision	1-855-281-8858 www.aetna.com
MetLife Dental	1-800-275-4638 www.metlife.com/mybenefits
MetLife Life/Disability	1-800-300-4296 www.metlife.com
HealthEquity Health/Flexible Savings Accounts	866-346-5800 memberservices@healthequity.com
AFLAC Accident│Critical Illness	800-433-3036 www.aflacgroupinsurance.com
Optum Bank Health Savings Account	1-866-234-8913 www.optum.com
City of Roswell Benefits Portal	www.cityofroswellgabenefits.com

Why Would I Contact the NFP Service Center?

Order ID Cards: We can contact the insurance carrier directly and have your replacement card in ten to fifteen business days.

Claim Resolution and Research: We can help you understand your Explanation of Benefits (EOB) as well as contact the insurance carriers on your behalf. We can assist in appealing a denied claim or help you request a Prior Authorization (PA) from your physician as may be required by your medical carrier. We can also help you file out-of-network claims and assist with reimbursement if you require medical assistance while traveling outside of the United States.

Locate In-Network Providers: Staying in network saves everyone money. Our service center can help you locate in-network providers for medical, dental and vision coverage whether you are at home or away.

Request Copies of Any Necessary Forms: Medical claim forms, out-of-network claim forms, evidence of insurability forms, short and long term disability claim forms and any other applicable forms are always available if the need should arise.

Understanding Your Benefits: We can assist you with questions regarding deductibles, copayments and coinsurance. We can explain waiting periods, elimination periods and eligibility rules.

Explain Qualifying Events: Most benefit plans require that you have a Qualifying Event (like marriage, birth of a child or other life event) to make a change in your election anytime other than during open enrollment. We work with your employer to ensure that your change follows the rules of the plan, that your request is allowed within the appropriate timeframes, and that your give proper documentation of the event.

Annual Enrollment Information: We can provide details about when open enrollment begins and ends and if your plan designs or payroll deductions are changing.

Enrollment Assistance: The service center representative can walk you through every step of the enrollment process. Whether it's an online enrollment or paper enrollment form, your service center representative is available to help.

Confirmation Statements: We can provide copies of your online enrollment confirmation statement or a copy of your paper enrollment form at any time.

The service center is available from 8:30 a.m. to 5:00 p.m. Monday through Friday to assist you. We have an after-hours voice mailbox and your call will be returned the next business day.

1-888-643-5995
NFPsecustomerservice@NFP.com

Disclosure Notice – Prescription Drug and Medicare Notice

Important Notice from the City of Roswell About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Roswell has determined that the prescription drug coverage offered by the Aetna HDHP and the Aetna POS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current City of Roswell coverage will not be affected.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the City of Roswell benefit plan during an open enrollment period under the City of Roswell benefit plan.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

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

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

From: October 1, 2024-September 30, 2025

Contact: Erica Deigh – Compensation and Benefits Manager

Phone Number: 770-594-6503

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

Disclosure Notice – Continued

Unless otherwise noted, a paper copy is available, free of charge, by calling NFP at 1-888-643-5995.

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION 125 PRE-TAX BENEFIT AUTHORIZATION NOTICE:
Before-tax deductions will lower the amount of income reported to the federal government. This may result in slightly reduced Social Security benefits. If you do not enroll eligible dependents at this time, you may not enroll them until the next open enrollment period. You may not drop the coverage you elected until the next open enrollment period. You may only make a change or drop coverage elections before the next open enrollment period under the following circumstances:
A change in marital status, or
A change in the number of dependents due to birth, adoption, placement for adoption or death of a dependent, or
A change in employment status for myself or my spouse, or
Open enrollment elections for my spouse, or
A change in dependents eligibility, or
A change in residence or worksite.
Any change being made must be appropriate and consistent with the event and must be made within 30 days of when the event occurred. All changes are subject to approval by your Employer/Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE:
The Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breast, prostheses, and complications resulting from a mastectomy, including lymph edema.

NEWBORNS' ACT DISCLOSURE:
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.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION: This Notice describes how the Plan(s) may use and disclose your protected health information ("PHI") and how you can get access to your information. The privacy of your protected health information that is created, received, used or disclosed by the Plan(s) is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice is available on the web at: www.roswell.bswift.com. A paper copy is also available, free of charge, by calling your Employer or NFP at 1-888-643-5995. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan."

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS*:* On April 7, 1986, a federal law was enacted (Public Law 99272, Title X) requiring that most employers sponsoring 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 under the plan would otherwise end. If you or your eligible dependents enroll in the group health benefits available through your Employer, you may have access to COBRA continuation coverage under certain circumstances. Therefore, your plan makes available to you and your dependents the General Notice Of COBRA Continuation Coverage Rights. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The full Notice is available on the web at: www.roswell.bswift.com. A paper copy is also available, free of charge, by calling your Employer or NFP at 1-888-643-5995. Please note the participant is responsible for providing a copy to their spouse/dependents covered under the group health plan.

SUMMARY OF BENEFITS AND COVERAGE (SBC): As an employee, the group health (medical) benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC) which summarizes important information about any health coverage option in a standard format to help you compare across options. The SBC is available on the web at www.roswell.bswift.com. A paper copy is also available, free of charge, by calling your Employer or NFP at 1-888-643-5995. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan.

HEALTH INSURANCE MARKETPLACE NOTICE (a.k.a. Exchange Notice): When key parts of the health care law took effect in 2014, a new way to buy health insurance became available through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, the Marketplace notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer. This notice is available on the web at www.roswell.bswift.com. A paper copy is also available, free of charge, by calling your Employer.

Disclosure Notice – CHIP

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	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA Medicaid
GA 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	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)	**KANSAS Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA 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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

To see if any other states have added a premium assistance program since January 31, 2023, 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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

NFP Corp. and its subsidiaries do not provide legal or tax advice. Compliance, regulatory and related content is for general informational purposes and is not guaranteed to be accurate or complete. You should consult an attorney or tax professional regarding the application or potential implications of laws, regulations or policies to your specific circumstances.

This Benefit Enrollment Guide Is Provided By:

NFP © 2021. All rights reserved.