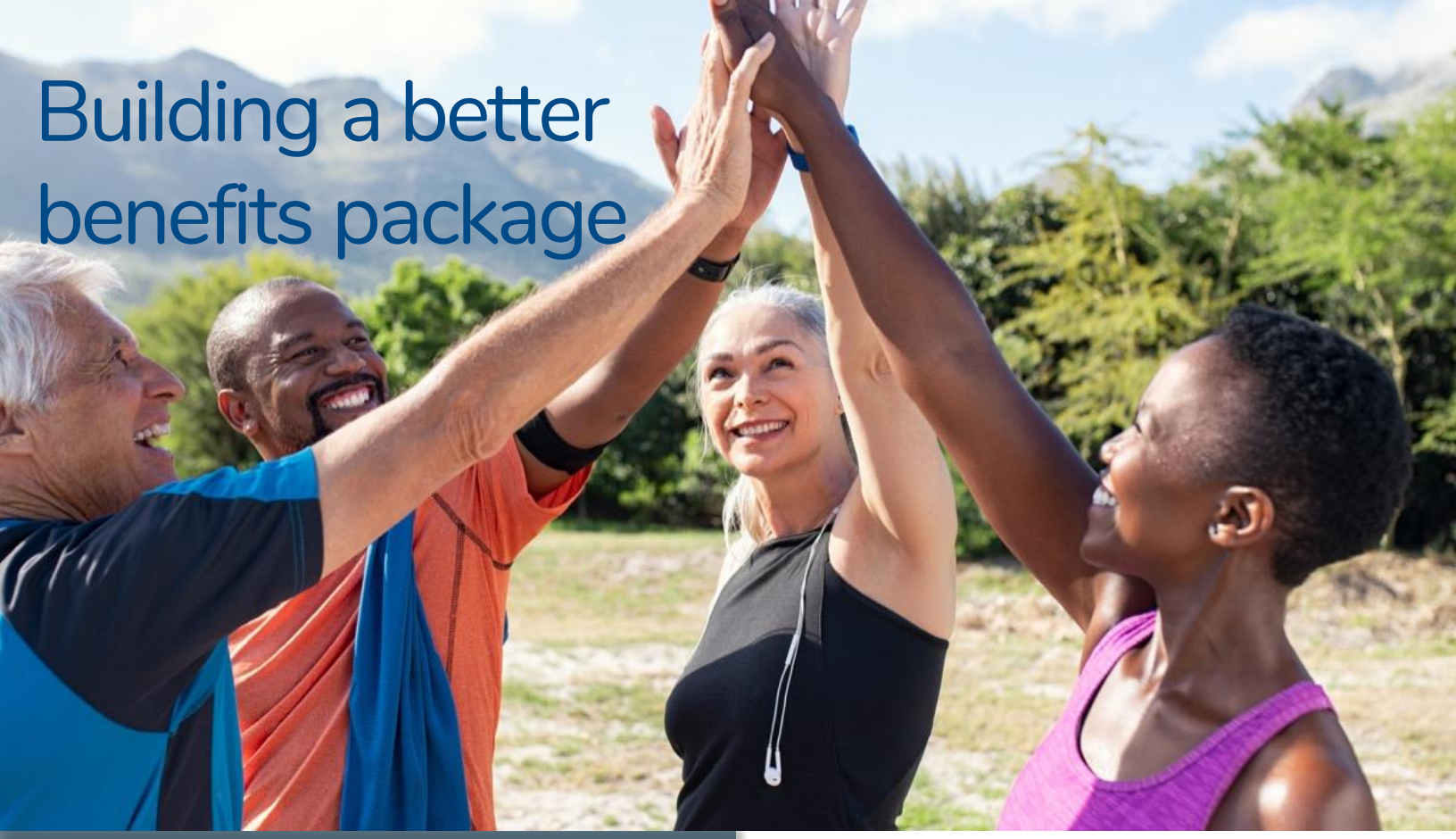
2022

BENEFITS GUIDE

July 1, 2022 – June 30,2023

Sterling Seacrest Pritchard

Building a better benefits package



Benefits to meet your individual needs

At The City of Forest Park, we know that our employees are crucial to our success. That's why we provide you with an excellent, diverse benefits package that helps protect you and your family now and into the future.

The benefits package includes a variety of coverages including Cigna Medical, Anthem Dental and Vision and Lincoln Life and AD&D coverage.

Effective July 1st, 2022, Employees have the option to enroll in one of three Cigna Medical plans.

Employees enrolled in one of our Cigna Medical plans are eligible for the City's Health Reimbursement arrangement (HRA) administered by MedCom. An HRA is an employer health benefit plan that reimburses employees for specified amounts of their out-of-pocket medical expenses

**This Benefits Guide outlines the health and welfare plans offered to you and your family. It contains general information and is meant to provide a brief overview. For complete details regarding each benefit plan offered, please refer to the individual plan documents as the information contained herein is for illustrative purposes. More details can be found in the plan specific Summary Plan Description(s) and/or Summary of Coverage. In the case of a discrepancy the plan specific documents will prevail.*

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ELIGIBILITY & ENROLLING

Who is Eligible to Join the Benefit Plan?

You and your dependents are eligible to join the City of Forest Park health and welfare benefit plans if you are a full-time employee regularly scheduled to work 30 hours per week. You must be enrolled in the plan to add dependent coverage.

Who is an Eligible Dependent?

- Your spouse to whom you are legally married
- Your dependent child under the maximum age specified in the Carriers' plan documents including:
    - Natural child
    - Adopted child
    - Stepchild
    - Child for whom you have been appointed as the legal guardian

***Your child's spouse and a child for whom you are not the legal guardian are not eligible.**

The Dependent Maximum Age Limits is up to age 26. The dependent does not need to be a full-time student; does not need to be an eligible dependent on parent's tax return; is not required to live with you; and may be unmarried or married.

Once the dependent reaches age 26, coverage will terminate on the last day of the birth month.

A totally disabled child who is physically or mentally disabled prior to age 26 may remain on the if the child is primarily dependent on the enrolled member for support and maintenance.

Annual Open Enrollment

Each year during the annual Open Enrollment Period, you are given the opportunity to make changes to your current benefit elections.

During Open Erollment, you may:

•Elect coverage

•Change to any Plan Option

•Enroll eligible dependents

•Drop covered dependents

•Discontinue coverage

When Do Benefits Become Effective?

Your benefits become effective on the first day of the month following 30 consecutive days as a full-time employee with The City of Forest Park.

Qualifying Event Changes

You are allowed to make changes to your current benefit elections during the plan year if you experience an IRS-approved qualifying change in life status. The change to your benefit elections must be consistent with and on account of the change in life status.

IRS-approved qualifying life status changes include:

- Marriage, divorce or legal separation
- Birth or adoption of a child or placement of a child for adoption
- Death of a dependent
- Change in employment status, including loss or gain of employment, for your spouse or a dependent
- Change in work schedule, including switching between full-time and part-time status, by you, your spouse or a dependent
- Change in residence or work site for you, your spouse, or a dependent that results in a change of eligibility
- If you or your dependents lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP) coverage
- If you or your dependents become eligible for a state's premium assistance subsidy under Medicaid or CHIP
- Open Enrollment for a spouse or parent

If you have a life status change, you must notify Human Resources within 60 days for changes in life status due to a Medicare or CHIP event and within 31 days of the other events.

! *Please note, loss of coverage due to non-payment or voluntary termination of other coverage outside a spouse's or parent's open enrollment is **not** an IRS-approved qualifying life event and you do not qualify for a special enrollment period.*

MEDICAL BENEFITS

While a lot can go into choosing a health plan, these four quick check points are a good starting place.

WHAT TO CONSIDER	WHAT IT MEANS	HOW TO DECIDE
Deductible	The amount you pay before your health plan covers costs for medical services.	If you're likely to have surgery or a lot of medical care expenses, you may want a lower deductible, which is the amount you pay before your health plan covers costs.
Providers/ Provider Network	Your doctors - both primary care and specialists.	You may want to choose a plan where your provider is in-network to avoid extra costs.
Network	The hospitals, health care providers and labs that Cigna has negotiated lower rates with to provide health care services.	Some networks may be larger than others or may include different choices of providers in your local area. It's important to understand these differences when choosing a plan to meet your specific needs. Also, when you choose a plan, make sure your provider is part of the network associated with that plan.
Prescriptions	Any medications you take that have been prescribed by your doctor.	Different plans may have different copays or coinsurance for covered prescriptions. Review the plan to understand how your prescriptions are covered.

This year you have the option of choosing one of three unique benefit plans, each with it's own network.

LocalPlus In-Network

• In your local area, or when in any LocalPlus In-Network area, you must receive care from a health care provider or facility in this LocalPlus In-Network to receive in-network coverage.
• If you're away from home and need care, simply look for a participating LocalPlus In-Network doctor in the area. If you are in an area where a LocalPlus In-Network isn't available, you can use doctors or hospitals in our Away From Home Care feature for coverage at the in-network cost.
• If you're in an area where the LocalPlus In-Network is available and you choose to go outside the LocalPlus In-Network (or outside the Away From Home Care feature when LocalPlus isn't available), your care will not be covered by the plan (except in an emergency as defined by your plan documents).

Cigna Open Access Plus In-Network

• You don't need referrals for in-network specialists.
• Out-of-network services are not covered unless it's an emergency as defined by your plan documents.

Cigna Open Access Plus

• You don't need referrals to see specialists.
• You have coverage for out-of-network services, but you will have higher out-of-pocket costs and you may need to file a claim.

Search for in-network providers, procedures, cost estimates and more at mycigna.com

FINDING A DOCTOR IN OUR DIRECTORY IS EASY

SEARCH YOUR PLAN'S NETWORK IN FOUR SIMPLE STEPS

Step 1

Go to **Cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

(If you're already a Cigna customer, log in to **myCigna.com** or the myCigna® app to search your current plan's network. To search other networks, use the **Cigna.com** directory.)

Step 2

Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

Step 3

Answer any clarifying questions, and then verify where you live (as that will determine the networks available).

Step 4

Optional: Select one of the plans offered by your employer during open enrollment.

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

Search first. Then choose Cigna.

There are so many things to love about Cigna. Our directory search is just the beginning.

After you enroll, you'll have access to **myCigna.com** – your one-stop source for managing your health plan, anytime, just about anyplace. On **myCigna.com**, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

Questions? Call **866.494.2111**

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

Providers and facilities that participate in the Cigna network are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, see your plan documents.

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MEDICAL OPTION 1 – LOCALPLUS PLAN		
PLAN HIGHLIGHTS	**IN NETWORK – YOU PAY**	**OUT-OF-NETWORK – YOU PAY**
Deductible	$500 Individual | $1,500 Family	Not applicable
Coinsurance	0% after deductible	Not applicable
Annual Out-of-Pocket Maximum	$6,600 Individual | $13,200 Family	Not applicable
Primary Care Physician Office Visit	$20 copay	Not covered
Specialist Office Visit	$40 copay	Not covered
Urgent Telemedicine – MDLive	$0 copay	Not covered
Routine Telemedicine – MDLiive	$20 PCP copay | $40 Specialist copay *(Primary care, Behavioral care & Dermatology)*	Not covered
Preventive Care Services	Plan pays 100%	Not covered
Laboratory Diagnostics & X-Ray	Deductible, then 0%	Not covered
Complex Imaging Services (CT Scans, PET Scans & MRI's)	Deductible, then 0%	Not covered
Hospital Inpatient Care	Deductible, then 0%	Not covered
Outpatient Surgery	Deductible, then 0%	Not covered
Emergency Room	$250 copay	Paid as In-network
Urgent Care	$60 copay	Not covered
Prescription Drugs	You pay either a copay &/or coinsurance per the assigned prescription drug tier which can be found in the prescription drug formulary. This plan meets the CMS standard for creditable prescription drug coverage. **Quantity Limits:** Retail = 30-day supply Mail-Order = 90-day supply	
Tier 1 — Low-cost Generic and Brand-name Drugs*	Retail: $10 copay Mail Order: $25 copay	Not covered
Tier 2 —Higher-cost Generic and Brand-Name Drugs*	Retail: $25 copay Mail Order: $63 copay	Not covered
Tier 3 — High-cost Generic and Brand-name drugs *	Retail: $50 copay Mail Order: $125 copay	Not covered
Tier 4 — Specialty drugs	Retail: 20% coinsurance up to a $200 maximum Mail Order: Not available	Not covered

***When you request a brand name when a generic equivalent is available, you pay the brand name copay plus the difference in cost of the generic and brand name drug unless provider indicates "Dispense As Written - DAW"**

The prescription drug coverage provided by the Cigna OAPIN medical plan is expected to pay out as much as standard Medicare prescription drug coverage pays. This is important because members who enroll in a Medicare prescription drug plan after their initial eligibility period, may pay a higher premium (a penalty) if they were enrolled in a group health plan with non-creditable prescription drug coverage.

The HRA reimbursement will reduce your deductible back down to $0 for you and your covered dependents.

MEDICAL OPTION 2 – OAPIN PLAN		
PLAN HIGHLIGHTS	**IN NETWORK – YOU PAY**	**OUT-OF-NETWORK – YOU PAY**
Deductible	$1,000 Individual | $3,000 Family	Not applicable
Coinsurance	0% after deductible	Not applicable
Annual Out-of-Pocket Maximum	$6,600 Individual | $13,200 Family	Not applicable
Primary Care Physician Office Visit	$25 copay	Not covered
Specialist Office Visit	$50 copay	Not covered
Urgent Telemedicine - MDLive	$0 copay	Not covered
Routine Telemedicine - MDLive	$25 PCP copay | $50 Specialist copay *(Primary care, Behavioral care & Dermatology)*	Not covered
Preventive Care Services	Plan pays 100%	Not covered
Laboratory Diagnostics & X-Ray	Deductible, then 0%	Not covered
Complex Imaging Services (CT Scans, PET Scans & MRI's)	Deductible, then 0%	Not covered
Hospital Inpatient Care	Deductible, then 0%	Not covered
Outpatient Surgery	Deductible, then 0%	Not covered
Emergency Room	$250 copay	Paid as In-network
Urgent Care	$60 copay	Not covered
Prescription Drugs	You pay either a copay &/or coinsurance per the assigned prescription drug tier which can be found in the prescription drug formulary. This plan meets the CMS standard for creditable prescription drug coverage. **Quantity Limits:** Retail = 30-day supply Mail-Order = 90-day supply	
Tier 1 — Low-cost Generic and Brand-name Drugs*	Retail: $10 copay Mail Order: $25 copay	Not covered
Tier 2 —Higher-cost Generic and Brand-Name Drugs*	Retail: $25 copay Mail Order: $63 copay	Not covered
Tier 3 — High-cost Generic and Brand-name drugs *	Retail: $50 copay Mail Order: $125 copay	Not covered
Tier 4 — Specialty drugs	Retail: 20% coinsurance up to a $200 maximum Mail Order: Not available	Not covered

***When you request a brand name when a generic equivalent is available, you pay the brand name copay plus the difference in cost of the generic and brand name drug unless provider indicates "Dispense As Written - DAW"**

The prescription drug coverage provided by the Cigna OAPIN medical plan is expected to pay out as much as standard Medicare prescription drug coverage pays. This is important because members who enroll in a Medicare prescription drug plan after their initial eligibility period, may pay a higher premium (a penalty) if they were enrolled in a group health plan with non-creditable prescription drug coverage.

The HRA reimbursement will reduce your deductible back down to $500 for you and down to $1,500 for you and your covered dependents.

MEDICAL OPTION 3 – OAP PLAN		
PLAN HIGHLIGHTS	**IN NETWORK – YOU PAY**	**OUT-OF-NETWORK – YOU PAY**
Deductible	$500 Individual | $1,500 Family	$1,000 Individual | $3,000 Family
Coinsurance	0% after deductible	30% after deductible
Annual Out-of-Pocket Maximum	$6,600 Individual | $13,200 Family	$6,600 Individual | $13,200 Family
Primary Care Physician Office Visit	$15 copay	Deductible, then 30%
Specialist Office Visit	$25 copay	Deductible, then 30%
Urgent Telemedicine - MDLive	$0 copay	Not covered
Routine Telemedicine - MDLive	$15 PCP copay | $25 Specialist copay *(Primary care, Behavioral care & Dermatology)*	Not covered
Preventive Care Services	Plan pays 100%	Deductible, then 30%
Laboratory Diagnostics & X-Ray	Deductible, then 0%	Deductible, then 30%
Complex Imaging Services (CT Scans, PET Scans & MRI's)	Deductible, then 0%	Deductible, then 30%
Hospital Inpatient Care	Deductible, then 0%	Deductible, then 30%
Outpatient Surgery	Deductible, then 0%	Deductible, then 30%
Emergency Room	$100 copay	Paid as In-network
Urgent Care	$60 copay	Deductible, then 30%
Prescription Drugs	You pay either a copay &/or coinsurance per the assigned prescription drug tier which can be found in the prescription drug formulary. This plan meets the CMS standard for creditable prescription drug coverage. **Quantity Limits:** Retail = 30-day supply Mail-Order = 90-day supply	
Tier 1 — Low-cost Generic and Brand-name Drugs*	Retail: $10 copay Mail Order: $25 copay	Retail: $10 copay Mail Order: $25 copay
Tier 2 —Higher-cost Generic and Brand-Name Drugs*	Retail: $25 copay Mail Order: $63 copay	Retail: $25 copay Mail Order: $63 copay
Tier 3 — High-cost Generic and Brand-name drugs*	Retail: $50 copay Mail Order: $125 copay	Retail: $50 copay Mail Order: $125 copay
Tier 4 — Specialty Drugs	20% coinsurance up to $200 maximum	20% coinsurance up to $200 maximum

***When you request a brand name when a generic equivalent is available, you pay the brand name copay plus the difference in cost of the generic and brand name drug unless provider indicates "Dispense As Written - DAW"**

The prescription drug coverage provided by the OAP medical plan is expected to pay out as much as standard Medicare prescription drug coverage pays. This is important because members who enroll in a Medicare prescription drug plan after their initial eligibility period, may pay a higher premium (a penalty) if they were enrolled in a group health plan with non-creditable prescription drug coverage.

The HRA reimbursement will reduce your deductible back down to $0 for you and your covered dependents.

Together, all the way.®

Cigna.

Whether you're taking medications now or in the future, it's important to know which medications your plan covers. Cigna makes it easy by providing up-to-date drug lists online.

Follow these simple steps to find out how your plan covers your medication(s).

1. Go to **Cigna.com/PDL.**
2. Scroll down until you see a pdf of the **Cigna Advantage 4-Tier Prescription List (all specialty medications covered on Tier4).**
3. Then look for your medication name. Medications are listed by the condition they treat, then listed alphabetically within tiers (or cost-share levels).

Your plan uses the **Cigna Advantage 4-Tier** prescription drug list

Cigna 90 Now Program

Consider using Express Scripts Pharmacy. They help make things easy by putting everything at your fingertips.

Home delivery is a convenient option when you're taking a medication on a regular basis. With just a few simple clicks of your mobile phone, tablet or computer, your important medications will be on their way to your door (or location of your choice). **To get started** using home delivery, go to **my.cigna.com/choosehomedelivery** and follow the online instructions for how to move your prescription from your retail pharmacy.

- **Easily order, manage and track your medications** on your phone or online
- Standard shipping at **no extra cost**
- Fill up to a **90-day supply** at one time
- **Helpful pharmacists** available 24/7
- **Automatic refills** and refill reminders so you don't miss a dose
- **Payment options** if you need help paying for your medications

To learn more, go to **Cigna.com/homedelivery**.

Visit Cigna.com/PDL from any computer or mobile device. Try it today!

GoodRx

PRESCRIPTION ALTERNATIVES

Find the lowest price on prescriptions right from your phone or iPad.

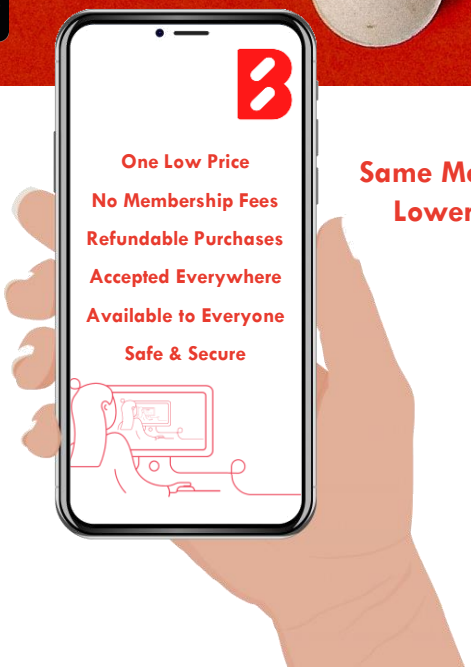
Our free, easy-to-use mobile apps feature:

- Instant access to the lowest prices for prescription drugs at more than 75,000 pharmacies
- Coupons and savings tips that can cut your prescription costs by 50% or more
- Side effects, pharmacy hours and locations, pill images, and much more!

Available on the App Store

ANDROID APP ON Google play

BLINK HEALTH



Same Medication Lower Price.

Lowest Rx Prices, Every Day

- Choose local pickup to save at a pharmacy near you.
- Choose home delivery for fast, free shipping to your door.
- No commitments.

SAVINGS IS EASY

1. Order online

Select how to get your meds and pay online to save.

2. Get Your Medication

FREE LOCAL PICKUP

Show your proof of purchase. Pay nothing at the pharmacy.

OR

FREE HOME DELIVERY

Get your medication delivered with free shipping.

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care[1] from MDLIVE.®

It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options —available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait —or travel —for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE®

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost[2] to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology[4]

Fast, customized care for skin, hair and nail conditions —no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

Cigna®

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Offered by: Cigna Health and Life Insurance Company or its affiliates.

3 easy steps to connect to care

Virtual care visits are convenient and easy.
To schedule an appointment:

Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE

Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.

Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®

Cigna®

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

A SMARTER WAY TO BETTER **HEALTH**

It's Your Health. Get Involved

Your health is a work in progress that needs your consistent attention and support. Each choice you make for yourself and your family is part of an ever-changing picture. Taking steps to improve your health such as going for annual physicals and living a healthy lifestyle can make a positive impact on your well-being.

It's up to you to take responsibility and get involved, and we are pleased to offer programs that will support your efforts and help you reach goals.

Preventive Health Care Services

Preventive care includes services like checkups, screenings and immunizations that can help you stay healthy and may help you avoid or delay health problems. Many serious conditions such as heart disease, cancer, and diabetes are preventable and treatable if caught early. It's important for everyone to get the preventive care they need.

See the following pages for the services and supplies considered preventive care under most health plans. Coverage for services recommended specifically for "men" or "women" is provided based on the anatomical characteristics of the individual and not necessarily the gender of the individual as indicated on the claim and/or an enrollment form

Understanding What's Covered

Generally speaking, if a service is considered preventive care, it will be covered at 100%. If it's not, it may still be covered subject to a copay, deductible or coinsurance. The Affordable Care Act (ACA) requires that services considered preventive care be covered by your health plan at 100% in-network, without a copay, deductible or coinsurance. To get specifics about your plan's preventive care coverage, call the customer service number on your member ID card. You may want to ask your doctor if the services you're receiving at a preventive care visit (such as an annual checkup) are all considered standard preventive care.

If any service performed at an annual checkup is as a result of a prior diagnosed condition, the office visit may not be processed as a preventive visit and you may be responsible for a copay, coinsurance or deductible. To learn more about the ACA or preventive care and coverage, visit **www.healthcare.gov**.

Wellness exams

SERVICE	GROUP	AGE, FREQUENCY
Well-baby/well-child/well-person exams, including annual well-woman exam (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	● ● ●	• Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months • Additional visit at 2–4 days for infants discharged less than 48 hours after delivery • Ages 3 to 21, once a year • Ages 22 and older, periodic visits as doctor advises

Routine immunizations covered under preventive care

SERVICE	SERVICE
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP, Tdap, Td)	Meningococcal (meningitis)
Haemophilus influenzae type b conjugate (Hib)	Pneumococcal (pneumonia)
Hepatitis A (Hep A)	Poliovirus (IPV)
Hepatitis B (Hep B)	Rotavirus (RV)
Human papillomavirus (HPV)	Varicella (chickenpox)
Influenza vaccine	Zoster (shingles)
Measles, mumps and rubella (MMR)	

You may view the immunization schedules on the CDC website: **cdc.gov/vaccines/schedules/**.

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Abnormal blood glucose and type 2 diabetes screening/counseling	● ●	Adults ages 40–70 who are overweight or obese; women with a history of gestational diabetes mellitus
Anxiety screening	●	Adult and adolescent women including pregnant and postpartum women
Aspirin to prevent cardiovascular disease and colorectal cancer; or to reduce risk for preeclampsia[1]	● ●	Adults ages 50–59 with risk factors; Pregnant women at risk for preeclampsia
Autism screening	●	18, 24 months
Bacteriuria screening	●	Pregnant women
Bilirubin screening	●	Newborns before discharge from hospital
Breast cancer screening (mammogram)	●	Women ages 40 and older, every 1–2 years
Breast cancer-discussion of benefits/risks of preventive medication	●	Women at risk
Breast-feeding support/counseling, supplies[2]	●	During pregnancy and after birth
Cervical cancer screening (Pap test) HPV DNA test alone or with Pap test	●	Women ages 21–65, every 3 years Women ages 30–65, every 3 years
Chlamydia screening	●	Sexually active women ages 24 and under and older women at risk
Cholesterol/lipid disorders screening[1]	● ● ●	• Screening of children and adolescents ages 9–11 years and 17–21 years; children and adolescents with risk factors ages 2–8 and 12–16 years • All adults ages 40-75
Lung cancer screening (low-dose computed tomography)	● ●	Adults ages 50 to 80 with 20 pack year smoking history, and currently smoke, or have quit within the past 15 years. Computed tomography requires precertification

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions *(continued)*

SERVICE	GROUP	AGE, FREQUENCY
Congenital hypothyroidism screening	🟢	Newborns
Critical congenital heart disease screening	🟢	Newborns before discharge from hospital
Contraception counseling/education (including fertility awareness-based methods); contraceptive products and services[1, 3, 4]	🔴	Women with reproductive capacity
Dental application of fluoride varnish to primary teeth at time of eruption (in primary care setting)	🟢	Children to age 6 years
Dental caries prevention Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride[1]	🟢	Children older than 6 months
Depression screening/Maternal depression screening	🔵🔴🟢	Ages 12–21, All adults, including pregnant and postpartum women
Developmental screening	🟢	9, 18, 30 months
Developmental surveillance	🟢	Newborn, 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
Fall prevention in older adults (physical therapy)	🔵🔴	Community-dwelling adults ages 65 and older with risk factors
Folic acid supplementation[1]	🔴	Women planning or capable of pregnancy
Genetic counseling/evaluation and BRCA1/BRCA2 testing	🔴	Women at risk •Genetic counseling must be provided by an independent board-certified genetic specialist prior to BRCA1/BRCA2 genetic testing •BRCA1/BRCA2 testing requires precertification
Gestational diabetes screening	🔴	Pregnant women
Gonorrhea screening	🔴	Sexually active women age 24 years and younger and older women at risk
Healthy diet and physical activity counseling	🔵🔴🟢	Ages 6 and older - to promote improvement in weight status; Overweight or oactbese adults with risk fors for cardiovascular disease
Hearing screening (not complete hearing examination)	🟢	All newborns by 2 months. Ages 4, 5, 6, 8, 10. Adolescents once between ages 11–14, 15–17 and 18–21
Hemoglobin or hematocrit	🟢	12 months
Hepatitis B screening	🔵🔴🟢	Pregnant women; adolescents and adults at risk
Hepatitis C screening	🔵🔴	Adults ages 18–79
High blood pressure screening (outside clinical setting)[2]	🔵🔴	Adults ages 18 and older without known high blood pressure
HIV Preexposure Prophylaxis (PrEP) for prevention of HIV infection[1] HIV PrEP related services (HIV screening, kidney function testing, hepatitis B & C screening, pregnancy testing, sexually transmitted infection screening / behavioral counseling, adherence counseling)	🔵🔴🟢	Individuals at risk
HIV screening and counseling	🔵🔴🟢	Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women (adolescent/adult), annually
Intimate partner/interpersonal violence screening	🔴	All women (adolescent/adult)
Lead screening	🟢	12, 24 months
Metabolic/hemoglobinopathies (according to state law)	🟢	Newborns

🔵 = Men 🔴 = Women 🟢 = Children/adolescents

Health screenings and interventions *(continued)*

SERVICE	GROUP	AGE, FREQUENCY
Osteoporosis screening	●	Age 65 or older (or under age 65 for women with fracture risk as determined by a Clinical Risk Assessment Tool). Computed tomographic bone density study requires precertification
Colon cancer screening[1]	●●	The following tests will be covered for colorectal cancer screening, ages 45 and older: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually • Flexible sigmoidoscopy every 5 years • Flexible sigmoidoscopy every ten years + annual FIT • Double-contrast barium enema (DCBE) every 5 years • Colonoscopy every 10 years • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - Requires prior authorization • Stool-based deoxyribonucleic acid (DNA) test (i.e., Cologuard) every 1–3 years
Obesity screening/counseling	●●●	Ages 6 and older, all adults
Ocular (eye) medication to prevent blindness	●	Newborns
Oral health evaluation/assess for dental referral	●	6, 9 months. Ages 12 months, 18 months-6 years for children at risk
PKU screening	●	Newborns
Perinatal depression preventive counseling	●	Pregnant and postpartum women with risk factors
Preeclampsia screening (blood pressure measurement)	●	Pregnant women
Prostate cancer screening (PSA)	●	Men ages 45 and older or age 40 with risk factors
Rh incompatibility test	●	Pregnant women
Sexually transmitted infections (STI) counseling	●●●	Sexually active women, annually; sexually active adolescents; and men at increased risk
Sexually transmitted infections (STI) screening	●	Adolescents ages 11–21
Sickle cell disease screening	●	Newborns
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation	●●●	Ages 6 months – 24 years
Syphilis screening	●●●	Individuals at risk; pregnant women
Tobacco use cessation: counseling/interventions[1]	●●	All adults[1]; pregnant women
Tobacco use prevention (counseling to prevent initiation)	●	School-age children and adolescents
Tuberculosis screening	●●●	Children, adolescents and adults at risk
Ultrasound aortic abdominal aneurysm screening	●	Men ages 65–75 who have ever smoked
Unhealthy alcohol use and substance abuse screening	●●●	All adults; adolescents age 11–21
Unhealthy drug use screening	●●	All Adults
Urinary incontinence screening	●	Women
Vision screening (not complete eye examination)	●	Ages 3, 4, 5, 6, 8, 10, 12, and 15 or as doctor advises

● = Men ● = Women ● = Children/adolescents

Cigna Motivate*Me* Program®

Motivate*Me* is an incentive program that helps you change unhealthy behaviors and rewards you for it. And that's important, because taking healthy actions will help reduce your risk of illness, disease and costly medical treatment. With Motivate*Me*, you'll work toward achieving real results that mean a real, healthy change for you.

Take care with things like a health assessment or biometric screening and you may earn awards,* such as lower plan premiums or deposits into your health fund account or paycheck. The more you do, the more you earn. Of course, the best reward is your good health.

A uniquely personalized experience

Anyone who's ever tried to undo a bad habit or maintain a new, healthy one knows how hard it can be. It takes time, determination and, sometimes, your own personal cheering section.

To help make it easy, our health coaches and customer service representatives will be there to support you throughout – online or by phone. We'll remind you about which health and wellness activities and programs you're eligible for, suggest helpful online resources like our Motivate*Me* incentive page, and encourage you – from start to finish.

I'm ready. How do I start?

Visit **myCigna.com** > Incentive Awards Program

There, you'll find:

- A list of available healthy actions and goals
- Details on how to get started
- Instructions on how to earn and redeem your rewards

Download on the App Store | GET IT ON Google Play | Available at amazon

You can also view your incentives information by downloading the myCigna Mobile App.**

*Incentive awards may be subject to tax; you are responsible for any applicable taxes. Please consult with your personal tax advisor for assistance.

TAKE CARE.
GET REWARDED.

Get rewarded for the healthy actions you take. The more you do, the more you earn.

Goal type	Description	Award type	Timing
Get a personalized health assessment	A confidential questionnaire that asks you about your health and well-being and provides a personalized assessment of your current health.	$25 Gift Card	Visit myCigna.com to complete by **6/30/2023** to earn your reward.
Complete my annual physical (preventive exam)	A preventive exam that's used to reinforce good health, address potential and chronic problems.	$50 Gift Card	Complete your annual physical or OBGYN exam by **6/30/2023** to earn your reward.
Get my annual OB/GYN exam (preventive exam)	A preventive exam that can identify early ovarian and cervical cancers, HPV (human papillomavirus), breast cancer and more.	$50 Gift Card	Complete your annual physical or OBGYN exam by **6/30/2023** to earn your reward.
Complete 9 lessons of the 16-week Cigna Diabetes Prevention Program	More than 1 out of 3 people are at risk for diabetes. Are you? This online program, available through Cigna, in collaboration with Omada, helps you make lifestyle changes that can reduce risks. Get started now.	$50 Gift Card	Visit myCigna.com and complete a 1-minute screening questionnaire to see if you're eligible to participate in this program.
Get connected! Have fun and earn rewards on Apps & Activities	Explore popular health devices and apps to help you stay motivated and challenge yourself. Earn 1,000 points and get an award.	$20 Gift Card per goal; max 3 goals.	Visit myCigna.com to complete by **6/30/2023** to earn your reward.

For all participants - 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 Cigna by calling the number on the back of your ID card and they will work with you and, if you wish, with your doctor.

For participants who may have an impairment - If you are unable to participate in any of the program events, activities or goals, because of a disability you may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards. For work-site accommodations please contact your employers Human Resources department. For accommodations with online, phone or other Cigna programs, please contact Cigna by calling the number on the back of your ID card.

CITY OF FOREST PARK HRA
HEALTH REIMBURSEMENT ARRANGEMENT

Employees enrolled in one of our Cigna Medical plans are eligible to participate in the City of Forest Park Health Reimbursement Arrangement (HRA) administered by MedCom.

An HRA is an employer health benefit plan that reimburses employees for specified amounts of their out-of-pocket medical expenses. You don't have to report your participation in an HRA on your tax return. The amount your employer is willing to reimburse you for medical expenses through an HRA is not considered taxable income, nor are the actual amounts reimbursed, as long as you put the money toward qualified medical expenses

How the HRA works

Services are rendered by a health professional

↓

The claim is submitted to Cigna by the service provider

↓

Cigna processes the claim and sends an Explanation of Benefits (EOB) to the member.

↓

If the EOB shows the charges for the services rendered went toward your In-Network Deductible Submit the EOB to MEDCOM

↓

Reimbursement is issued by Medcom and a check is sent to the member

No expense is too small.

It is simple to file your claim for reimbursement as illustrated on this page. You can submit your claim to Medcom on their website portal, by e-mail or download their app to your smartphone.

MedCom, our HRA administrator, will often be able to verify your claim automatically, but sometimes you'll need to submit an itemized bill from your healthcare provider to substantiate your claim.

Medical Plan	In-Network Deductible	HRA Reimbursement	Your Deductible Expense
LocalPlus	$500 Individual $1,500 Family	$500 Individual $1,500 Family	**$0**
OAPIN	$1,000 Individual $3,000 Family	$500 Individual $1,500 Family	**$500 Individual** **$1,500 Family**
OAP	$500 Individual $1500 Family	$500 Individual $1,500 Family	**$0**

DENTAL BENEFITS

The City of Forest Park provides eligible employee a dental plan administered by Anthem. Enrolled employees may elect coverage for their dependents. Dependent children are covered up to age 26, regardless of student status.

The dental plan provides In-Network and Out-of-Network benefits. By using in-network dentist you will have lower out-of-pocket expenses. Anthem dentists have agreed to accept as payment in full a discounted fixed fee schedule for the services they perform and will never collect more than the MetLife fee for the procedure performed—no 'balance billing.' You have freedom of choice to use an out-of-network provider. Keep in mind that out-of-network providers can balance bill you for charges above the allowed amount covered by MetLife.

To find a dentist, log on to www.anthem.com or download the Anthem app on your smart phone.

Waiting periods may apply to coverage if not enrolled during initial enrollment period (late entrant).

	DENTAL PPO	
BENEFITS	IN-NETWORK (You Pay)	OUT-OF-NETWORK (You Pay)
Deductible (waived for Preventive)		
Individual	$50	$50
Family	$150	$150
Calendar Year Maximum		
Per inured person	$1,500	$1,500
Diagnostic & Preventive		
Exams, X-Rays, Cleanings, Fluoride Treatment, Sealants	100% (deductible waived)	100% (deductible waived)
Basic Services		
Fillings, Simple Extractions, Endodontics, Periodontics, Oral Surgery	80% after deductible	80% after deductible
Major Services		
Crowns, Inlays, Outlay, Dentures, Bridges, Implants	50% after deductible	50% after deductible
Orthodontia (Coverage for both Child & Adult)	50% to lifetime a maximum of $2,000	50% to a lifetime maximum of $2,000
How are Claims paid?	Negotiated Fee Schedule	90th UCR

VISION BENEFITS

Anthem

Your eyes deserve the best care to keep them healthy year after year. Regular eye examinations may determine your need for corrective eyewear and may also detect general health problems in their earliest stages. Our Vision plan through Anthem BlueCross BlueShield provides coverage and discounts for supplies and materials such as eyeglasses and contact lenses.

Eligible employees may elect coverage for themselves, a spouse and eligible dependent children. Dependent children are covered up to age 26, regardless of student status.

Services	In Network	Out Of Network
Eye Exam:		
Routine Exam with Dilation	$10 Copay	$30 allowance
Standard Contact Lens fit and follow-up	$55 Copay	Discount available
Frames:		
Any available frame at provider location	$130 frame allowance 20% off balance over allowance	$45 allowance
Standard Plastic Lenses:		
Single	$20 Copay	$25
Bifocal	$20 Copay	$40
Trifocal	$20 Copay	$55
Lens Options for Children Up to Age 19:		
Standard Scratch Resistant Coating	$0	Not covered
Standard Polycarbonate	$0	Not covered
Transition lenses	$0	Not covered
Contact Lenses: (Material Only)		
Conventional or Disposable	$130 allowance	$105 allowance
Medically Necessary	Paid in full	$210 allowance
Frequency:		
Examination	12 months	
Frames	24 months	
Eyeglass Lenses	12 months*	
Contact Lenses	12 months*	

*You can elect contact lenses in lieu of eyeglass lenses. You can not purchase both in the same 12-month period.

LIFE AND AD&D BENEFITS

EMPLOYER PAID BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

The City of Forest Park provides full-time employees with Basic Term Life and Accidental Death & Dismemberment (AD&D) benefits administered through Lincoln Financial. These benefits are provided at no cost to all eligible full-time employees.

The Basic Term Life and AD&D benefit amount is equal to $20,000.

Employees must submit an application for the Basic Life & AD&D coverage within 30 days after their hire date to receive the employer paid benefits.

Value Added Programs

The following programs are provided to you through Lincoln Financial at **no cost:**

LifeKeys Services

- Helps you meet life's challenges
- Will preparation
- Identity theft assistance
- For your beneficiaries—services to assist for up to one year after a loss - counseling, financial services, support with day-to-day concerns, legal support
- Guidance Resources online

To access LifeKeys services: call 855-891-3684 or visit: **Lincoln4Benefits.com** (WebID = LifeKeys)

TravelConnect Service

- Whether traveling for business or leisure, any time you are more than 100 miles from home, TravelConnect services are available 24 hours a day, seven days a week.
- Services include: Medical evacuation, family member transportation, transportation after stabilization, repatriation, medical assistance

To use the TravelConnect services, call MEDEX at 410-453-6330 and provide them with ID number 322541.

Reminder: Make sure that your beneficiary designation is up to date. See HR if any changes are needed.

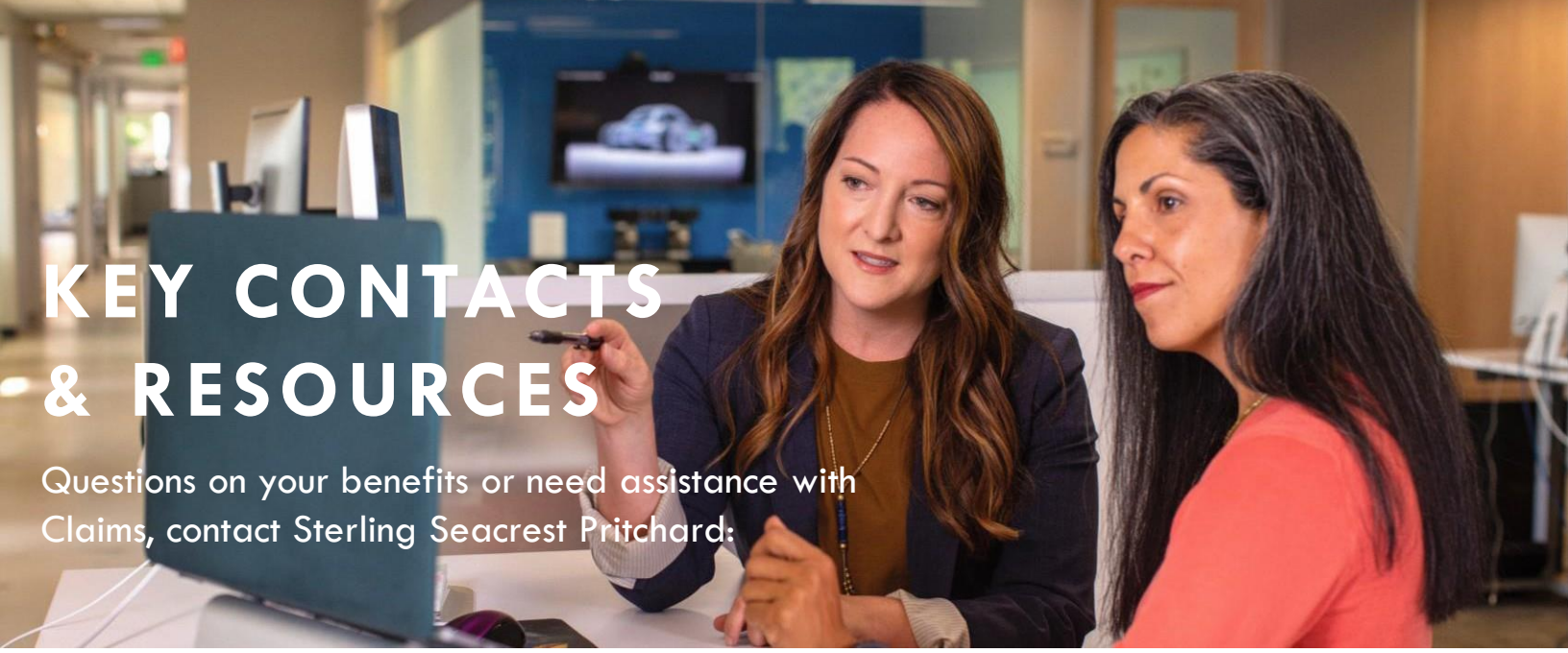
- ✓ If you fail to keep your beneficiaries up to date or make a mistake in documenting them, someone other than who you intended may receive your assets or policy proceeds. This is why carefully designating and remembering to update beneficiaries is so important.
- ✓ Your beneficiary can be a person, a charity, a trust, or your estate.
- ✓ Children under age 18 can be named as a primary or contingent beneficiary. However, if you were to die while they are still minors, the proceeds may be sent in their name to the legal guardian of the minor child's estate. If you want the payout used for their benefit while they are still children, you may want to set up a trust or custodial arrangement.

CONTRIBUTIONS

The City of Forest Park contributes to the cost of medical coverage for all eligible employees. For an additional premium employees can add dependent coverage. Please refer to the chart below for your 2022-2023 payroll deductions.

Weekly Payroll Deductions

Benefit Plan	Employee Only	Employee + 1	Family
Medical Option 1 Local Plus & Dental	$0.00	$10.50	$13.00
Medical Option 2 OAPIN & Dental	$10.00	$17.00	$20.00
Medical Option 2 OAP & Dental	$24.00	$62.00	$81.50
Vision Plan	$0.00	$1.00	$2.56
Life/AD&D	The City of Forest Park pays 100%of the premium		



KEY CONTACTS & RESOURCES

Questions on your benefits or need assistance with Claims, contact Sterling Seacrest Pritchard:

Your Employee Support Contact

LAURA STORMONT
SENIOR ACCOUNT ANALYST

678-538-2896
lstormont@sspins.com

NEED HELP WITH A CLAIM
BE SURE TO HAVE THE FOLLOWING INFORMATION WHEN CALLING:

Subscriber ID #
Date of Service
Name of Patient
Name of Doctor, Facility or Hospital
Copy of Bill or Explanation of Benefits (EOB)

Benefit	Company	Phone	Website
Medical Coverage	Cigna	866-494-2111	www.mycigna.com
Dental	Anthem Blue Cross Blue Shield	877-330-5973	www.bcbsga.com
Vision	Anthem Blue Cross Blue Shield	866-723-0515	www.bcbsga.com
Life/AD&D	Lincoln Financial	800-423-2765	www.lfg.com
Telemedicine	MDLive	888-726-3171	www.mycigna.com
Health Reimbursement Account (HRA)	MedCom	800-523-7542 Option 1	www.medcom.net

IMPORTANT INFORMATION

This guide provides a summary of you employee benefits rights and regulations as determined by Federal and State Laws. Information included in this guide includes the following:

- **Special Open Enrollment Rights**
- **General Notice of the Cobra Continuations Rights (COBRA)**
- **Newborns' and Mothers Health Protection Act**
- **Premium Assistance under Medicaid and CHIP**
- **Women's Health and Cancer Rights Act**
- **The Generic Information Nondiscrimination Act of 2008 (GINA**
- **PPACA Compliant Plan Notice**
- **USERRA NOTICE**
- **Health Insurance Marketplace Notice**
- **Notice of Creditable Prescription Drug Coverage – CMS**
- **HIPAA Privacy Notice**

SPECIAL OPEN ENROLLMENT RIGHTS

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. A special enrollment period is a time outside of the annual open enrollment period during which you and your family have a right to sign up for health coverage. In the Marketplace, you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days. Some events will require additional documentation to be submitted with the application at the time of enrollment. **You should read this notice even if you plan to waive coverage at this time.**

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment **within 30 days** after the marriage, birth, or placement for adoption.

Loss of Other Coverage

If you are declining coverage 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 toward your or your dependents' other coverage). However, you must request enrollment **within 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment **within 60 days** of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact HR.

IMPORTANT INFORMATION

COBRA Continuation of Coverage

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. For additional information regarding COBRA qualifying events, how coverage is provided and actions required to participate in COBRA coverage, please see your Human Resources department.

Newborns' and Mothers' Health Protection Act

The group health coverage provided complies with the Newborns' and Mothers' Health Protection Act of 1996. Under this law 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 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).

Premium Assistance under Medical and CHIP

If you or your children are eligible for Medicaid or CHIP (Children's Health Insurance Program) and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help you pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Please see Human Resources for a list of state Medicaid or CHIP offices to find out more about premium assistance.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy , you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Genetic Information Nondiscrimination Act - GINA

The Genetic Information Nondiscrimination Act (GINA) prohibits health benefit plans from discriminating on the basis of genetic information in regards to eligibility, premium and contributions. This generally also means that private employers with more than 15 employees, its health plan or "business associate" of the employer, cannot collect or use genetic information, (including family medical history information). The once exception would be that a minimum amount of genetic testing results make be used to make a determination regarding a claim.

You should know that GINA is treated as protected health information (PHI) under HIPAA. The plan must provide that an employer cannot request or require that you reveal whether or not you have had genetic testing; nor can your employer require that you participate in a genetic test. An employer cannot use any genetic information to set contribution rates or premiums.

IMPORTANT INFORMATION

PPACA Compliant Plan Notice

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

If your employer offers health coverage that meets the "minimum value" plan standard, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. The "minimum value" plan standard is set by the Affordable Care Act. Your health plans offered by [Company] are ACA compliant plans (surpassing the "minimum value" standard), thus you would not be eligible for the tax credit offered to those who do not have access to such a plan.

NOTE: If you purchase a health plan through the marketplace instead of accepting health coverage offered by your employer, then you will lose the employer contribution to the employer offered coverage. Also, this employer contribution, as well as your employee contribution to employer offered coverage, is excluded from income for Federal and State income tax purposed.

USERRA Notice

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services. In addition to the rights that you have under COBRA, you (the employee) are entitled under USERRA lo continue the coverage that you (and your covered dependents, if any) had under the [Company] plan.

You Have Rights Under Both COBRA and USERRA. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the attached COBRA Election Notice also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

USERRA Definitions

"Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

"Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System.

Duration of USERRA Coverage

General Rule: 24-Month Maximum. When a covered employee takes a leave for service in the uniformed services, USERRA coverage for the employee (and covered dependents for whom coverage is elected) can continue until up to 24 months from the date on which the employee's leave for uniformed service began. However, USERRA coverage will end earlier if one of the following events takes place:

A premium payment is not made within the required time; You fail to return to work or to apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

HEALTH INSURANCE MARKETPLACE

PART A: GENERAL INFORMATION

Under the provisions of the 2014 Affordable Health Care Act there is there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Lindsey Peterson.

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

HEALTH INSURANCE MARKETPLACE

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employee Name The City of Forest Park	**4. Employee Identification Number (EIN)** 58-6002562	
5. Employer Address 745 Forest Parkway	**6. Employer Phone Number** 404-608-2347	
7. City Forest Park	**8. State** GA	**9. Zip Code** 30297
10. Who can we contact about health coverage at this job? Shalonda Brown		
11. Phone Number (if different from above)	**12. Email Address** Sbrown@forestparkga.org	

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

As your employer, we offer a health plan to:

All employees. Eligible employees are:

☑ *Active full-time employees working 30 or more hours a week.*

Some employees. Eligible employees are:

☐

With respect to dependents:

We do offer coverage. Eligible dependents are:

☑ *Spouses and children up to age 26.*

☐ **We do not offer coverage.**

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

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

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

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

CREDITABLE

Medicare.gov

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

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

- 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.

- The City of Forest Park has determined that the prescription drug coverage offered by the Cigna OAPIN and Cigna OAP Option 2 LFP medical plans are, 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.

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

If you are eligible for Medicare, you can retain your existing group coverage and choose not to enroll in a Medicare prescription drug plan, or you can enroll in a Medicare prescription drug plan as a supplement to, or in lieu of, the group coverage. If you enroll in a Medicare prescription drug plan and keep your existing group coverage, you and your eligible dependents will be eligible to receive all of the group plan's prescription drug benefits. Your group health plan will coordinate benefits with the Medicare drug plan. Your Medicare prescription drug plan will be the primary payee on prescription drug claims and your group health plan will be the secondary payee on prescription drug claims.

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.

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 Forest Park 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.

For more information about this notice or your current prescription drug coverage, contact your carrier.

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).

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 The City of Forest Park changes. You also may request a copy of this notice at any time.

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).

IMPORTANT INFORMATION

Notice of Privacy Provision

This Notice of Privacy Practices (the "Notice") describes the legal obligations of [Company] (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health or condition;
- The provision of health care to you; or
- The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact your Human Resources department. The full privacy notice is available with your Human Resources Department.

The City of Forest Park

Sterling Seacrest Pritchard

Stronger Together