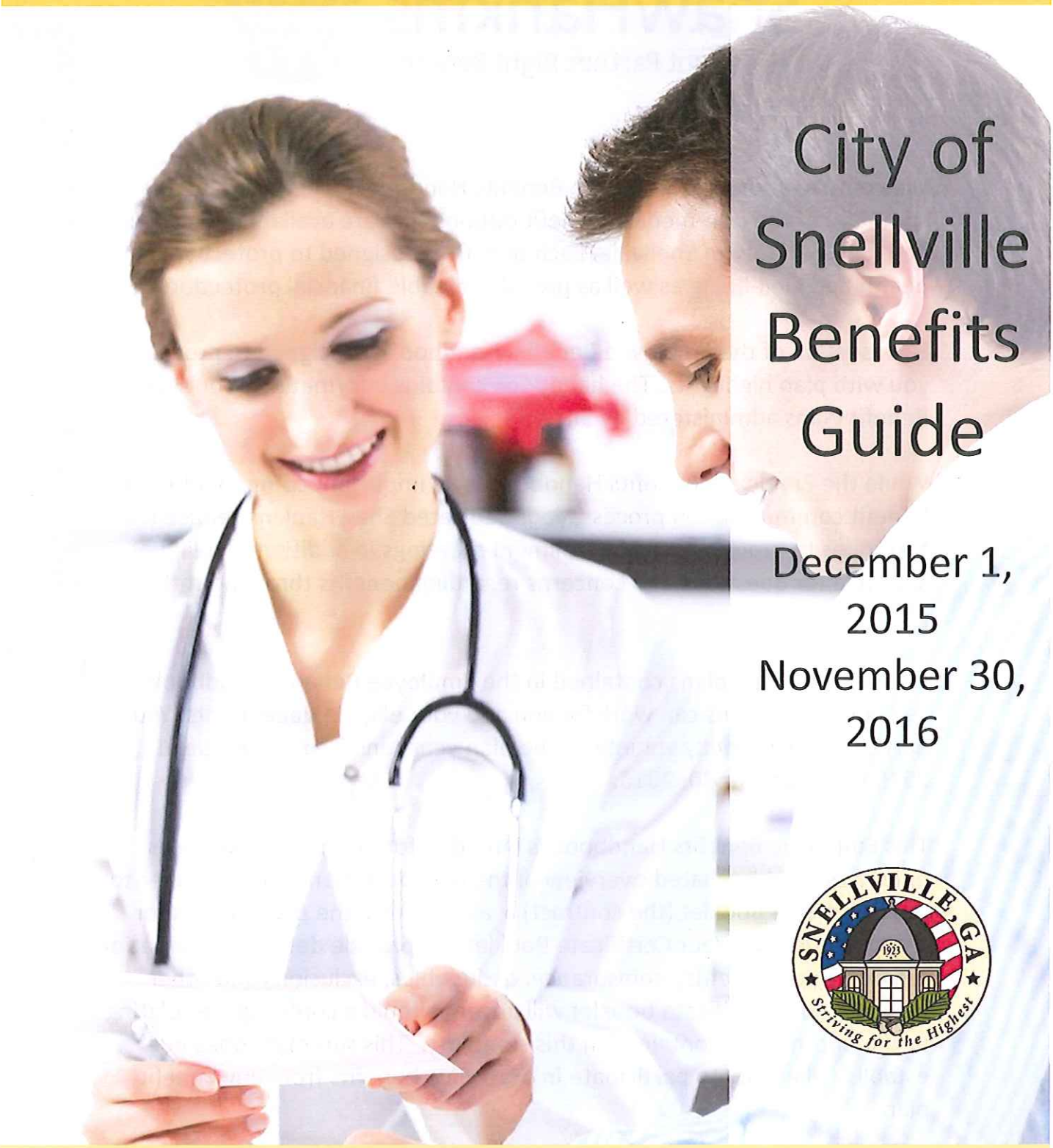

City of Snellville Benefits Guide

December 1, 2015
November 30, 2016

ShawHankins
Right Partner. Right Benefits.

Welcome to your new Employee Benefits Handbook. This guide is your summary of the non-medical benefit options that are available to eligible employees of City of Snellville. Each benefit is designed to protect your health and well-being as well as provide valuable financial protection.

Each section of the Employee Benefits Handbook is designed to provide you with plan highlights. The handbook contains information about your Benefit Plans administered by ShawHankins.

While the Employee Benefits Handbook is an important component in the benefit communication process, your dedicated ShawHankins service team continues to provide annual enrollment meetings in addition to being available for questions and concerns regarding benefits throughout the plan year.

Please review the plans contained in the Employee Benefits Handbook and see how these plans can work for you and your eligible dependents. Your participation is strictly voluntary. The plan year runs from December 1, 2015 to November 30, 2016.

This Employee Benefits Handbook is intended for orientation purposes only. It is an abbreviated overview of the plan documents. Please refer to the Certificate Booklet (the contract) available from the plan carriers for complete details. Your Certificate Booklet will provide detailed information regarding copayments, coinsurance, deductibles, exclusions and other benefits. The certificate booklet will govern should a conflict arise relating to the information contained in this summary. This summary does not establish eligibility to participate in or receive benefits from any benefit plan.

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New for 2016

- Medical coverage is now provided by Aetna
- Dental coverage is now provided by MetLife
- Vision is now provided by NVA with lower premiums
- Short Term Disability rate change
- HSA will move to Aetna Healthfund

Eligibility

Active employees of City of Snellville are classified as:

- Full Time

Eligible Dependents are classified as:

- Your legal spouse who resides in the United States
- Child/stepchild/legal dependent child less than 26 years of age
- If your dependent child is approaching 26 and is disabled, an application for continuation of dependent status must be made within 30 days of the child's 26th birthday.

Before You Enroll

NOTE: You are required to enroll in all Benefits. You must add any Dependents you wish to cover to the system at this year's annual enrollment.

To Begin:

1) From the "Home Page" click on the "Enroll Now" link, to begin the election process.
2) On the "Personal & Family Page", verify your information is accurate and "Add" all eligible dependents you wish to cover under any benefits.

HOW TO ENROLL

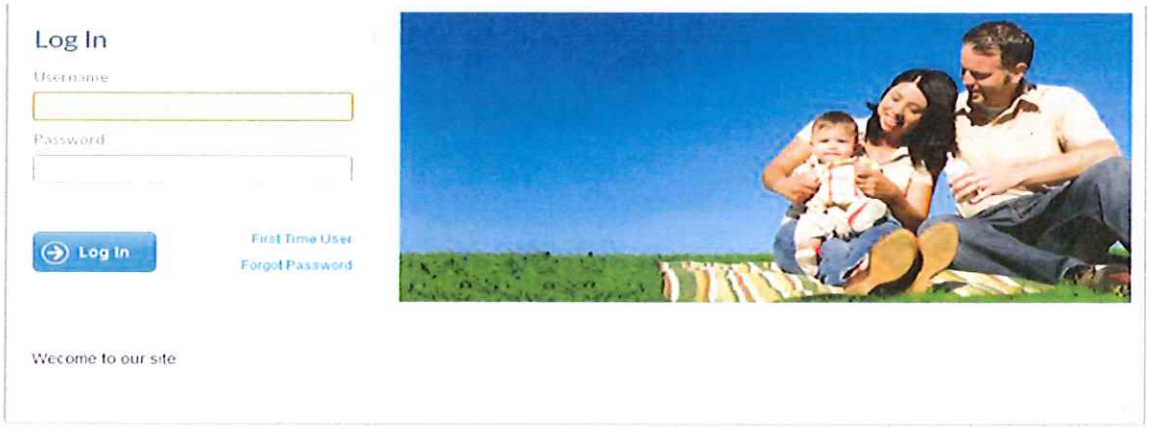
Go to www.cityofsnellville.bswift.com.

At this time, make sure to disable your pop up blocker.

At the enrollment website enter your Username and Password.

- Username is the first letter of your first name, last name and last four digits of your social security number (ex. jdoe1234).
- Password is the last 4 digits of your Social Security number (ex. 4567).

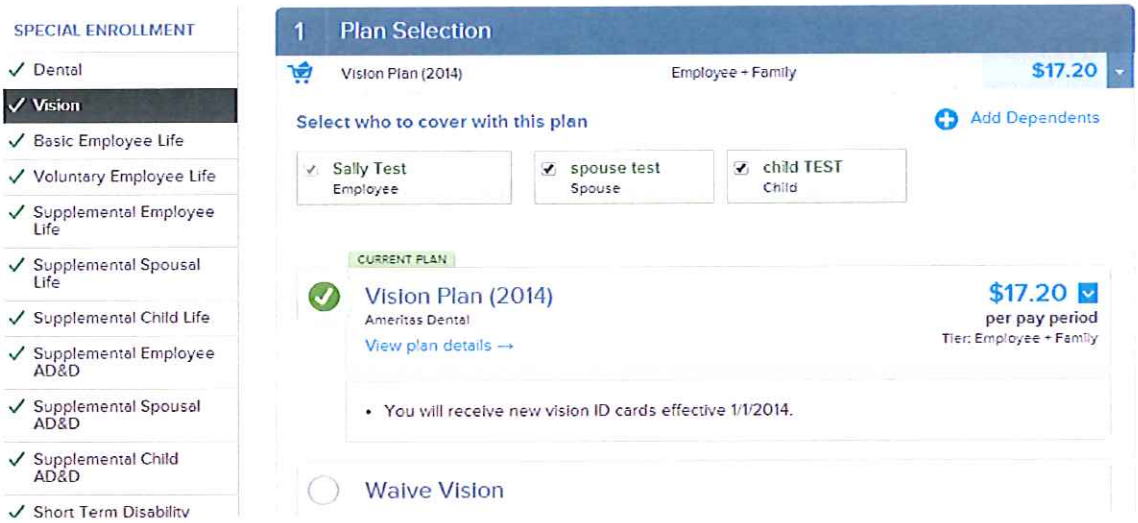
You will then be prompted to create a permanent password.



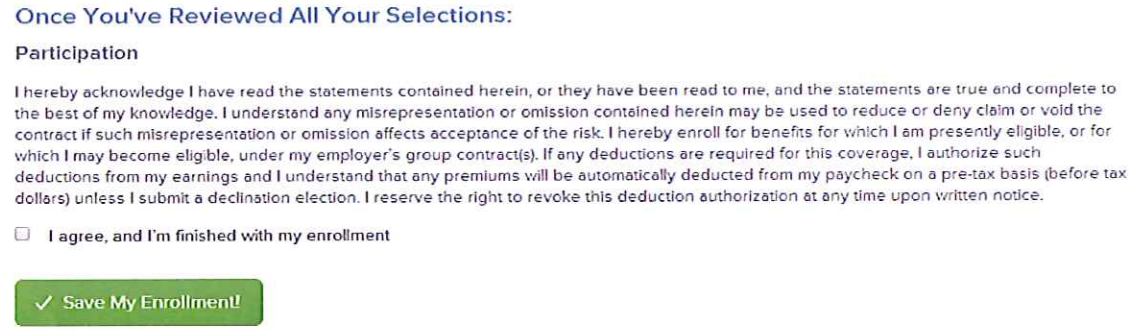
3) To make a plan selection, select the button beside the newly elected plan. if you are covering dependents, make sure to "Select" them by checking off next to their name under Select who to cover with this plan. Then press "Next" at the bottom of the screen.

Annual Enrollment Period: Begins 11/4/2015 and ends at MIDNIGHT on 11/8/2015

Before You Enroll (cont'd.)



4) Once you have reviewed and completed your enrollment, click on "I Agree and I am finished with my enrollment", then click on "Save My Enrollment".



5) You will now be taken to the final confirmation page to either print or email.

Failure to enroll within the above time period will result in the forfeiture of your eligibility for enrollment until the beginning of the next plan year.

Qualifying Events (refer to your 2015 Summary Plan Description - Special Enrollment Rights)

» Contact ShawHankins by calling 800-994-7429 to speak with an enroller regarding enrollment.
» You must enroll within 30 days from the effective date of your qualifying event.

Medical Plan - POS

PROVIDED THROUGH AETNA

Benefits	Aetna GA 51-100 OAMC 4000 100 (Option 1)	
	In-Network	Out-of-Network
Office Visits (PCP/Specialist)	$35/$75	70% After Deductible
Preventive Care	100%	70% After Deductible
Annual Deductible	$4,000 Single $8,000 Family	$8,000 Single $16,000 Family
Coinsurance	100%	70%
Out-of-Pocket Maximum (Includes Deductible)	$6,600 Single $13,200 Family	$19,000 Single $38,000 Family
In-Patient Hospital Copay	$250 After Deductible	N/A
Inpatient Hospital Coinsurance	100% After Deductible	70% After Deductible
Outpatient Hospital Copay	$250 After Deductible	N/A
Outpatient Hospital Coinsurance	100% After Deductible	70% After Deductible
Urgent Care	$75	70% After Deductible
Emergency Room	$500	$500
Prescriptions		
Tier 1 (Preferred Value/ Generic)	$3/$15	$3/$15
Tier 2	$45	$45
Tier 3	$75	$75
Tier 4	30% to $250	30% to $250
Mail-Order	2.5 x retail	2.5 x retail
Rates Per Pay Period		
Employee	$50.00	
Employee + Spouse	$120.00	
Employee + Child(ren)	$120.00	
Family	$150.00	

Medical Plan - HSA

Benefits	Aetna GA 51-100 OAMC 4000 EQHD (Option 2)	
	In-Network	Out-of-Network
Office Visits (PCP/Specialist)	Deductible Applies First; $25/$50	Deductible Applies First; 70%
Preventive Care	100%	70%
Annual Deductible	$4,000 Single $8,000 Family	$8,000 Single $16,000 Family
Coinsurance	100%	70%
Out-of-Pocket Maximum (Includes Deductible)	$6,450 Single $12,900 Family	$19,000 Single $38,000 Family
In-Patient Hospital Copay	N/A	N/A
In-Patient Hospital Coinsurance	Covered in Full After Deductible	70% After Deductible
Outpatient Hospital Copay	N/A	N/A
Outpatient Hospital Coinsurance	Covered in Full After Deductible	70% After Deductible
Urgent Care	Covered in Full After Deductible	70% After Deductible
Emergency Room	$300 After Deductible	$300 After Deductible
Prescriptions		
Tier 1 (Preferred Value/ Generic)	$3/$15	$3/$15
Tier 2	$35	$35
Tier 3	$65	$65
Tier 4	30% to $250 max	30% to $250 max
Mail-Order	2.5 x retail	2.5 x retail
*Deductible Must Be Met Before Copays Apply		

Rates Per Pay Period	
Employee	$0.00
Employee + Spouse	$0.00
Employee + Child(ren)	$0.00
Family	$0.00

Medical Plan – HSA (con.)

An HSA is a health savings account that allows you to set aside funds on a tax-free basis for qualified medical expenses now or after you retire. HSAs roll over from year to year and may be invested and earn tax-free investment dollars. They are a great way for you to save money for health care costs now or in the future, as well as become more involved in your health care decisions.

There are many advantages to an HSA:

Tax advantages—You can have your HSA contributions deducted from your paycheck on a pre-tax basis or you can write them off as a deduction on your federal and state tax returns.

Saving advantages—The HSA is your account, and the funds roll over every year for future health care expenses and/or retirement (on a taxable basis at this time). You earn interest on the money in your account, too.

Investment advantages—Multiple investment options are available.

Medical Plan – HSA (con.)

Upon renewal, Coventry Consumer Choice℠ (C3) customers will have the Aetna HealthFund One-to-One funding options, Powered by PayFlex®. Here are some FAQs to help better understand what that means to you and your employees.

Renewing with an Aetna consumer-directed health care product

Q: Why is Aetna moving the health reimbursement arrangement (HRA), health savings account (HSA) and flexible spending account (FSA) administration from C3 to PayFlex?

A: Aetna and Coventry Health Care are now one company. Our combined organization is one of the nation's largest health care benefits companies. With access to even more resources and innovative technology, you and your employees can more actively manage your health.

We have been working together to offer our customers locally focused products that provide high quality, affordable health plans and services.

Aetna brings to our financial product portfolio, PayFlex, one of the nation's leading account-based third-party administrators for the HRA, HSA and FSA. With PayFlex, we'll be able to offer innovative solutions for all your account needs. This includes a stacked funding or savings account with more than one tax-advantaged account (e.g., an FSA, a limited purpose flexible spending account [LPFSA], or an HRA); employee web portal access for online account management; a mobile application; and an employer portal for reports and other plan administration needs.

Q: Will the process be a seamless experience?

A: One of our goals is to minimize disruption to the people who use our products and services. The PayFlex implementation team will work with the plan sponsor and their broker, if applicable, to make the transition as seamless as possible.

Q: How will members be impacted?

A: Members will be enrolled in a new HRA, FSA or HSA with PayFlex. Once enrolled, they can use their new member portal at **www.payflexwallet.com**. A mobile app is also available for members to download and manage their account.

Claims

Q: How can a member submit a manual claim?

A: For any eligible claim that did not cross over from the medical plan, the member may file a manual claim online at **www.payflexwallet.com**. They'll also be able to fax or mail it to the address listed on the claims form.

Q: Will a member's Aetna medical claims information be sent?

A: Yes. Medical and pharmacy claims are sent nightly. And the eligible claims are automatically reimbursed to the member on a weekly basis.

Account balances

Q: What will happen to HRA members' run-out claims or rollover dollars with C3?

A: If applicable, C3 will adjudicate their run-out claims. After the end of the run-out period, if the member has rollover dollars, C3 will transfer those remaining balances to PayFlex.

Run-out claims for FSA groups who elect a grace period or carryover will be administered on our new platform.

Q: What will happen to a member's account balance during the transition?

A: If the medical plan year and the FSA plan year are the same, members will continue to submit any remaining claims to C3 during the run-out period unless they have an FSA carryover or grace period. If they have an FSA carryover or grace period, account balances will be transferred to PayFlex during the transition. PayFlex will administer the run-out in order to coordinate claims reimbursement with the carryover or grace period benefit. There will be a short period of time where prior year claims reimbursements will be held until after the transition is completed.

If the medical plan year and the FSA plan year do not renew at the same time, then C3 will transition your FSA administration to PayFlex when the medical plan renews. PayFlex will take over for the remainder of your FSA plan year, including the handling of an FSA carryover or grace period, if applicable. There will be a short period of time where claims reimbursements will be held until after the transition is completed.

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Idaho and Wyoming, by Aetna Health of Utah Inc. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156.

Medical Plan – HSA (con.)

Q: What will happen to a member's HealthEquity[4] account balance?

A: All new employer funding and member payroll contributions will be deposited into the member's PayFlex HSA. Plan sponsors can then sign up to send any employer contributions and member payroll contributions to the new PayFlex HSA through the PayFlex employer portal at **www.wealthcareadmin.com/default.aspx**.

Since an HSA is owned by the member, the member must decide whether or not they want to close their account with HealthEquity and transfer those funds to their new PayFlex HSA.

If a member chooses to maintain their account with HealthEquity, they will begin paying a $3.95 monthly account maintenance fee.

Q: Will the member be charged an account closure fee when they transfer their account from HealthEquity to PayFlex?

A: Yes. The member will be charged a $25 account closure fee from HealthEquity when they transfer their funds to PayFlex.

Contributions

Q: Will a plan sponsor be able to contribute to a member's HSA account like they do today?

A: The plan sponsor will need to set up their contribution schedule through the PayFlex employer portal at **www.wealthcareadmin.com/default.aspx**. PayFlex will then generate an automated withdrawal to debit the plan sponsor's bank account according to their contribution schedule.

Q: How long does it take for members to get their debit card?

A: PayFlex mails the debit card to members within 7 – 10 days of their account activation.

Q: Will a member be able to make post-tax contributions to the HSA?

A: Yes. The member can make post-tax contributions to their HSA from their linked personal bank account through the member portal at **www.payflexwallet.com**.

Q: How can a member withdraw funds from their HSA?

A: Members can use the member portal at **www.payflexwallet.com** to make withdrawals for eligible expenses that they paid for using personal funds. Or they can use their PayFlex[3] Wallet debit card to pay their provider directly. We recommend that members wait until Aetna processes the claim before they pay the provider. This will ensure the member only pays what they owe.

Account information

Q: How long will a plan sponsor and member have access to their C3 HRA or FSA for prior plan year information?

A: Plan sponsors will have access to Online Account Management™ (OAM) until the end of the C3 run-out period. Members will have access for 106 days after their C3 end date.

Q: How long will a plan sponsor and member have access to prior plan HealthEquity HSA information?

A: They will have access to their prior year information through **www.healthequity.com** indefinitely.

Q: Will members need to name a new beneficiary?

A: Yes. Current beneficiary information will not be transferred from HealthEquity to PayFlex. Beneficiary information will need to be added through the member portal at **www.payflexwallet.com**.

Q: Will the investment options change?

A: Yes. The investment options will change based on what PayFlex offers. In addition, the minimum balance required for the ability to invest with PayFlex is $1,000. For HealthEquity, it was $2,000.

Q: Is PayFlex the HSA custodian or is there another bank involved?

A: PayFlex has a nonbank trustee license and is the HSA custodian.

Q: Can a plan sponsor offer a health care flexible spending account (HCFSA) or LPFSA along with an Aetna HRA or HSA?

A: Yes. PayFlex can support either an HCFSA or an LPFSA in conjunction with the HRA and HSA. Both accounts are serviced on the same platform. The plan sponsor can determine which account pays first.

Contact information

Q: Will the toll-free number or customer service hours change?

A: Yes. PayFlex's customer service number is **1-855-384-8249**. Customer service representatives are available Monday – Friday, 7 a.m. to 7 p.m. CT. Members may also access their account information anytime at **www.payflexwallet.com**.

Q: Who does the plan sponsor or broker contact with questions about the HRA or HSA?

A: They can call the implementation team at **1-855-462-3056**.

Medical Plan – HSA (con.)

Eligible Expenses

You can use your HSA to pay for covered medical expenses that apply toward your qualified high-deductible health plan annual deductible amount. Additionally, you can pay for other qualified medical expenses such as:

Dental treatments

Eye exams, glasses and contact lenses

Laser vision correction

Long-term care

Mental health care

Acupuncture

Medications (with a prescription)

COBRA coverage

Qualified long-term care insurance

Medicare premiums

Who is eligible for an HSA?

Any individual who: (1) is covered under a QHDHP on the first day of the month; (2) is not also covered by any other health plan, including a spouse's plan that is not a QHDHP (except for plans providing certain limited types of coverage); (3) is not enrolled in Medicare; (4) may not be claimed as a dependent on another person's tax return; and (5) is not covered by his or her own or someone else's health care Flexible Spending Account (excluding an HSA-compatible Flexible Spending Account, which is used for dental and vision expenses only).

Medical Plan – HSA (con.)

Why should I consider getting an HSA?

You may save money in the short and long-term by:

Deducting 100% of your HSA contributions from your taxable federal income.

Having the money in your HSA earn interest and/or gains on a tax-free basis.

Paying no penalties or taxes when you use your HSA to pay for qualified medical expenses.

Having a qualified high-deductible HSA-eligible health insurance plan, which typically has a lower premium than a plan with a lower deductible.

Owning the money in the HSA, so you can keep it if you move, change jobs or locations. Like an IRA, the account belongs to you, not your employer. But unlike an IRA, your employer can contribute to your HSA.

In addition, you may invest your funds. You must have a minimum of $2,000 in your HSA before you invest funds.

If you elect the HSA Medial Plan, the city will contribute to your HSA twice a month --- $30 Employee Only or $60 for Employee + 1 or more.

Maximum contributions for 2016 are as follows:

Individual: $3,350

Family: $6,750

Note: These limits apply to all combined contributions from any source, except rollover funds.

Dental Plan

PROVIDED THROUGH METLIFE

Coverage Type	In-Network	Out-Of-Network
Type A: Oral Exams, Full Mouth X-Rays, Bitewing X-Rays, Cleanings, Fluoride Applications, Sealants, Space Maintainers	100%	100%
Type B: Amalgram & Composite Fillings, Repairs, Endodontics Root Canal , Periodontal Surgery, Periodontal Scaling & Root Planing, Periodontal Maintenance, Oral Surgery, Oral Surgery, Other Oral Surgery, Emergency Palliative Treatment, General Anesthesia	80%	80%
Type C: Crowns/Inlays/Onlays , Prefabricated Crowns, Bridge, Dentures, Consultations, Implant Services	50%	50%
Class IV: Orthodontia	50%	50%
Deductible Amount Per Calendar Year *(Deductible applies to all benefits except Diagnostic & Preventive Services or Orthodontic Services)*	$50 Individual $150 Family	$50 Individual $150 Family
Annual Maximum Benefit Per Enrollee	$5,000	$5,000
Orthodontia Lifetime Maximum: per individual	$1,500	$1,500

Tier of Coverage	Per Pay Period
Employee Only	$0.00
Employee + Spouse	$5.00
Employee + Children	$5.00
Employee + Family	$10.00

Vision Benefits

PROVIDED THROUGH NVA

Benefit	In-Network	Out-of-Network	Frequency
Vision Exam	Covered 100% After $10 Copayment	(Reimbursed Amounts) Up to $35	Once every 12 months
Lenses	Standard Glass or Plastic Covered 100% After $20 Copayment	Single Up to $25 Bi-focal Up to $45 Tri-focal Up to $75 Lenticular Up to $75	Once every 12 months
Contact Lenses Elective	Covered up to $130 Retail Allowance (15% Discount on Conventional or 10% Discount on Disposable, off remaining balance over $130)	Up to $105	Once every 12 months (in lieu of lenses or frames)
Medically Necessary	100%	$210	
Evaluation & Fitting	100%	Daily Wear: $20/ Extended Wear $30	
Frames	$130 Retail Allowance	Up to $65 maximum amount	Once every 12 months

***Please see your benefits portal for a list of providers.**

Tier of Coverage	Per Pay Period
Employee Only	$2.00
Employee + Spouse	$4.00
Employee + Children	$5.00
Family	$7.00

Basic Life & AD&D

PROVIDED THROUGH LINCOLN

Term Life Insurance provides valuable financial protection for your family. City of Snellville is pleased to offer $50,000 of Basic Life Insurance & $100,000 AD&D Coverage.

You are eligible to enroll in the Basic Life and AD&D Insurance program underwritten by Lincoln.

This enrollment period is an annual opportunity to increase coverage or elect life insurance if you do not already have coverage. Your premium will be based on the coverage amount you elect and your age. *Voluntary* premiums will be paid through the convenience of payroll deduction.

Benefit Coverage – Full Time Sworn Police Officers	
Life	$50,000
AD&D	$150,00
Benefit Coverage – All Other Full Time Employees	
Life	$50,000
AD&D	$100,000
Benefit Reduction	**Employee**
Benefits Will Reduce:	35% at age 65; An additional 25% of original amount at age 70; An additional 15% of original amount at age 75; Benefits terminate at retirement
Additional Benefits	
See Understanding Your Benefits Page:	Accelerated Death Benefit Conversion Seatbelt Benefit – Air Bag Benefit – Common Carrier Benefit

Voluntary Life & AD&D

PROVIDED THROUGH LINCOLN

Benefit Amount		
Employee	$10,000 increments to the greater of $500,000 or 5x salary	
Spouse	$5,000 increments to $250,000 not to exceed .5x employee salary	
Children (6 months+)	$10,000	
Guarantee Issue		
Employee	$100,000 (New Hire Only) Current Employees Can Pick Up New Coverage or Increase Their Coverage Up to $20,000 (no EOI) to the Maximum GI of $100,000.	
Spouse	$10,000 Spouse Can Pick Up New Coverage to $10,000 (no EOI)	
Children	$10,000 (EOI)	
Reduction Schedule		
Benefits Reduced to	65%	Age 65
	40%	70
	25%	75
	10%	80
Coverage Termination		
Employee	Retirement	
Spouse	Earliest Age of 70 or Retirement	

Voluntary Life & AD&D (con.)

Age	Employee Rate	Spouse Rate
<20	0.070	0.070
20-24	0.070	0.070
25 – 29	0.070	0.070
30 – 34	0.080	0.080
35 – 39	0.110	0.110
40 – 44	0.170	0.170
45 – 49	0.270	0.270
50 – 54	0.520	0.520
55 – 59	0.820	0.820
60 – 64	0.960	0.960
65 – 69	1.730	1.730
70 – 74	3.390	3.390
75 -79	9.120	9.120
80+	20.800	20.800
AD&D Rate Per $1,000		
	0.045	0.045

Child Rate per $1,000
$.20

Short Term Disability

PROVIDED THROUGH LINCOLN

Benefits	Coverage
Benefit Percentage	60%
Maximum Weekly Benefit	$1,500
Elimination Period	Accident – 14 Days Sickness – 14 Days
Duration of Benefits	11 Weeks
Pre-Existing Condition Limitation	3/6

Rate per $10 of Weekly Benefit
$0.495

***Employee can add Short Term Disability, but will be subject to a 3/6 Pre-Existing Condition Limitation**

Long Term Disability

PROVIDED THROUGH LINCOLN

****This benefit is provided at no cost to you. Your employer pays 100% of the premium.***

Benefits	Coverage
Benefit Percentage	60%
Benefit Minimum	$50
Benefit Maximum	$6,000
Elimination Period	90 Days
Own Occupation Period	24 Months
Benefits Duration	Later of age 65 or SSNRA

Contract Features	Coverage
Mental & Nervous	2 Years
Alcohol & Drug	2 Years
Limited Conditions	2 Years
Self-Reported Limitation	No Limitation

Accident

PROVIDED THROUGH AFLAC

Benefits	Coverage
Accidental Death	
Employee	$50,000
Spouse	$25,000
Children	$5,000
Burns	
2nd Degree	$100-$1,000
3rd Degree	$1,000-$20,000
Skin Grafts for 2nd & 3rd Degree Burn	N/A
Catastrophic Accident Dismemberment	
Employees <65	Up to $25,000
Spouse < 65	Up to $10,000
Children	Up to $5,000
Emergency & Initial Care	
Doctor's Office Initial Visit	$75-$125
Emergency Room Treatment	$200
Diagnostic Exam	$200
Follow Up Doctor Visits	$30 (6 max)
Hospitalization	
Hospital Admission	$1,000
Hospital Stay	$200 per day
Hospital (ICU)	$400 per day
Surgery	Up to $600
Ambulance	
Ground	$200
Air	$1,000

Tier of Coverage	Monthly Cost
Employee Only	$19.63
Employee + Spouse	$29.42
Employee + Children	$34.41
Family	$44.20

Group Critical Illness with Cancer

PROVIDED THROUGH AFLAC

Covered Conditions	Cancer, Carcinoma in Situ (25%), Heart Attack, Coronary Artery Bypass Surgery (25%), Stroke, End Stage Renal (Kidney) Failure, Major Organ Transplant, Paralysis, Coma, Loss of Sight, Loss of Hearing, Loss of Speech, Burns, Mitral valve replacement or repair, aortic valve replacement or repair, surgical treatment of abdominal aortic aneurysm, 10% for various heart procedures (angioplasty, stent, etc.)
Initial Diagnosis Employee Spouse Child(ren)	 $20,000 $10,000 $10,000
Benefit Reduction	50% at age 70
Waiting Period	30 Days
Portability	Included
Wellness Benefit Employee & Children Spouse	 $50 per year $50 per year

Tier of Coverage	Monthly Cost
Employee Only	$19.63
Employee + Spouse	$29.42
Employee + Children	$34.41
Family	$44.20

Group Critical Illness with Cancer (con.)

Weekly Rates with Cancer per $20,000		
Age	Non-Tobacco	Tobacco
,25	$19.977	$29.597
25-29	$19.977	$29.597
30-34	$30.160	$48.187
35-39	$30.160	$48.187
40-44	$59.583	$119.297
45-49	$59.583	$119.297
50-54	$97.457	$188.847
55-59	$97.457	$188.847
60-64	$153.487	$299.563
65-69	$153.487	$299.563
70+	Not Available	Not Available

Tier of Coverage	Monthly Cost
Employee Only	$20.50
Employee + Spouse	$40.30
Employee + Children	$29.21
Family	$49.01

Hospital Indemnity

Hospital Confinement	$1,000 per insured per calendar year for confinement
Daily Hospital Confinement	$200 per day (max 18 days)
Hospital Intensive Care	$200 per day (max 18 days)
Childbirth	Covered (pregnancy is a pre-existing condition is conceptions was before the coverage effective date)
Pre-Existing Condition Period	12/12

Disclosure Notices

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

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. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. (Both you and your spouse should take the time to read this notice carefully.) If you are an employee of City of Snellville, and covered by the City of Snellville's Group Health Plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).
If you are the spouse of an employee covered by the City of Snellville Group Health Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the
City of Snellville Group Health Plan for any of the following four reasons:

(1) The death of your spouse;
(2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the City of Snellville;
(3) Divorce or legal separation from your spouse; or
(4) Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the City of Snellville Group Health Plan, he or she has the right to continuation coverage if group health coverage through the City of Snellville Group Health Plan is lost for any of the following reasons:

(1) The death of the employee;
(2) A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with the City of Snellville;
(3) The employee's divorce or legal separation;
(4) The employee becomes entitled to Medicare; or
(5) The dependent child ceases to be a "dependent child" under the City of Snellville Group Health Plan.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the City of Snellville Group Health Plan within 30 days of the date of the event. City of Snellville has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement.
Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.
When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage.
If you do not choose continuation coverage on a timely basis, your group health insurance coverage will end. Not choosing continuation coverage may cause a break in your continued coverage, and any such break of more than sixty-three days may cause loss of coverage portability.
If you choose continuation coverage, City of Snellville is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 month period may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare, entitlement) occur during that 18-month period. Also, if you or your spouse gives birth to or adopts a child while on continuation coverage, you will be allowed to change your coverage status to include the child.
In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security disability purposes) as of the termination or reduction in hours of employment, or within sixty days thereafter. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18month period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.
However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

(1) City of Snellville no longer provides group health coverage to any of its employees;
(2) The premium for continuation coverage is not paid on time;
(3) The qualified beneficiary becomes covered under another group health plan after electing to participate in a continuation coverage plan.
(4) The qualified beneficiary becomes entitled to Medicare after electing to participate in a continuation coverage plan.
(5) The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Group Health Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.
Under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. (At the end of the 18-month, 29 month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided under City of Snellville Group Health Plan.)
If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact ShawHankins, LLC at 770-382-0951.

Disclosure Notices (con.)

Newborns' and Mothers' Health Protection Act
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).

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 July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com **Phone: 1-855-692-5447**	**Website:** http://dch.georgia.gov/ **- Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)** **Phone: 404-656-4507**
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ **Phone (Outside of Anchorage): 1-888-318-8890** **Phone (Anchorage): 907-269-6529**	**Website: http://www.in.gov/fssa** **Phone: 1-800-889-9949**
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf **Medicaid Customer Contact Center: 1-800-221-3943**	**Website: www.dhs.state.ia.us/hipp/** **Phone: 1-888-346-9562**
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ **Phone: 1-877-357-3268**	**Website: http://www.kdheks.gov/hcf/** **Phone: 1-800-792-4884**

Disclosure Notices (con.)

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

Disclosure Notices (con.)

Notice of 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 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).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 and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Gabriela Downs at 770-985-3507

General Notice of Pre-existing Condition Exclusion

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to ShawHankins at 201 West Main Street Cartersville, Ga 30120 or 770.382.0951.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Initial Notice

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 was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: available under the plan design for office/specialist visit and inpatient/outpatient copay/coinsurance your specific group health plan. If you would like more information on WHCRA benefits, call your Plan Administrator Gabriela Downs at 770-985-3507

Disclosure Notices (con.)

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

Notes

Notes

Contacts

Name	Contact	Phone
Benefits Administrator	ShawHankins	800-994-7429
Human Resources	Main Number	770-985-3507
Medical	Aetna	888-250-2309
HSA	Aetna	855-384-8249
Dental	MetLife	800-942-0854
Vision	NVA	800-672-7723
Basic Life & AD&D	Lincoln	800-487-1485
Voluntary Life & AD&D	Lincoln	800-487-1485
Short Term Disability	Lincoln	800-487-1485
Long Term Disability	Lincoln	800-487-1485
Accident	AFLAC	800-992-3522
Critical Illness	AFLAC	800-992-3522