

CITY OF TYBEE ISLAND

EMPLOYEE BENEFITS ENROLLMENT GUIDE FOR THE JULY 2015 - JUNE 2016 PLAN YEAR

CLASS 1 - ALL ACTIVE FULL-TIME EMPLOYEES

The following is a summary of the benefit package available to all employees in the above defined Class, working for the City of Tybee Island. We are providing this information to assist you and your family in making an informed decision regarding your healthcare coverage and other benefits during this annual enrollment period. For more specific details regarding the benefits, including any coverage limits and exclusions, you should consult the Certificate of Coverage issued for each benefit plan.

Please review all of your options in this packet and contact our Plan Administrator, Janice Elliott, Human Resources Manager, if you have any questions.

**SEE INSIDE FOR YOUR
2015-2016 BENEFITS &
PREMIUMS - EFFECTIVE
JULY 1, 2015**

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If You And/Or Any One Of Your Dependents Are Eligible For Medicare Or Will Become Eligible For Medicare In The Next 12 Months, A Federal Law Gives You More Choices About Your Prescription Drug Coverage. Please See Page 19 For More Details.

City of Tybee Island Employees Benefits Enrollment Instructions

City of Tybee Island is now conducting benefit enrollment online at www.benefitsconnect.net/cityoftybee

Online enrollment with Benefits Connect is simple, secure and can be done in a few minutes from any computer with internet access. After enrolling online, you will have access to your benefit information 24 hours a day, from any computer. For your security Benefits Connect is 128-bit encrypted and password protected. Follow the steps below to learn how to access the system and enroll.

What you need to get started...

During the enrollment process you will be asked to provide some basic information that you should have available.

- Your social security number
- Your dependent's social security numbers and birth dates

User Name and Password

Initially your user name and password are defaulted to a standard format. Upon completing your first login you will be prompted to change your password. Let's walk through a sample login.

Your **user name** is made up of the **first six letters of your last name**, followed by your **first initial** and the **last four numbers of your social security number**. The **initial password** for the system is your **social security number** (without dashes).

Example:

Employee Name: Matt Sample
Social Security Number: 949-12-1234

User Name: samplem1234
Password: 949121234

Apprize Enrollment Demo login

Please login below to enter the *benefitsCONNECT®* system.

Username:

Password:

First six of last name, first initial, last four of social security number

Social Security Number (no dashes)

Entering Personal Profiles

After your initial login, the system will take you to the PERSONAL INFORMATION section. Please complete all fields. **Bolded** fields are required, and must be completed.

When you have completed all of the fields, click *save & continue* to proceed to the next screen.

personal information

Please complete the 5-section enrollment process.

Click the "save" button at the bottom of the page after you've entered the profile information.

Fields in bold are required.

General Information

First Name

Middle Initial

Last Name

Title

Social Security No.

Government Visa No.

EEO Ethnic Code

EEO Job Category

Gender

Date of Birth date in format, mm/dd/yyyy

Contact Information

Street Address

Street Address 2

Entering Dependent Profiles

The system will now take you to the DEPENDENT INFORMATION section:

- To enter a spouse, click the icon under Spouse, enter information, and click *Save*.
- To enter a child, click the icon under Children, enter information, and click *Save*.
- To edit a dependent, click the pencil icon next to the dependent you want to edit, make changes, and click *Save*.
- Note: You only need to add dependents that you would like to enroll for coverage. You will choose which dependents to enroll for each plan when you reach the election screens.

When you are finished entering dependents, click *Save & Continue*.

please complete the 4-section enrollment process

dependent information

Please enter your dependent information.

Spouse or Domestic Partner
To add spouse or domestic partner information, click here.

Children
To add a child dependent, click here.

Ex-spouse
To add ex-spouse information, click here.

[back](#) [save & continue](#)

[Section 2 of 4]

Making Benefit Plan Elections

Next, the system will take you to the BENEFIT PLAN ENROLLMENT Section. Each benefit and your options will be displayed one by one.

- To enroll in a plan, check next to the plan, and check any dependents you want to cover. If applicable, indicate the amount for which you would like to enroll.
- To waive coverage, check next to *I waive enrollment*.
- For information about a plan, click *View Plan Outline of Benefits*.
- For plans provided by your company at no cost to you, enrollment is already checked.

Click *Save & Continue* after each benefit selection.

benefits plan enrollment

Please select a Medical plan.

All elections and changes are stored in an archive that can be viewed at any time, so there's never missing forms or lost information.

Available Medical Plans	Coverage	Your Cost
<input checked="" type="radio"/> Choice MCS7 Plan View Plan Outline of Benefits Provided by MEDICA Eligible on 4/1/2005 Cost is deducted on a pre-tax basis	<input checked="" type="checkbox"/> You <input checked="" type="checkbox"/> Sam (child)	\$92.31
<input type="radio"/> Comprehensive Major Medical Plan View Plan Outline of Benefits Provided by BLUE CROSS OF MINNESOTA Eligible on 4/1/2005 Cost is deducted on a pre-tax basis	<input type="checkbox"/> You <input type="checkbox"/> Sam (child)	
<input type="radio"/> I waive enrollment in all medical plans		

Election Summary
Costs shown are as of 4/1/2005

Medical
\$92.31

Denial
Long-term Disability
Basic Life
Voluntary Life
Health Care Reimbursement (125)

Bi-weekly Payroll Deduction
\$92.31

[back](#) [save & continue](#)

Completing Your Enrollment

Once you have gone through enrollment for each plan available, the system will take you to the CONSOLIDATED ENROLLMENT FORM page. This screen will show you a summary of the information you entered and the benefit elections you made.

- To complete the enrollment process, click *Finished*. You will then see a “SYSTEM FEEDBACK” screen.
- If you need to log off before completing enrollment, any data you entered will be saved. The next time you log on, you will be taken directly to the last saved screen.
- **Always make sure to log out upon completing any action on the system.**

During this annual enrollment period you will be required to make a benefit election for all the benefit Plans described in this Benefits Enrollment Guide, including those benefit Plans in which you are currently enrolled.

If you elect an amount of Voluntary Life insurance for you or your spouse that is subject to Evidence of Insurability, you will be required to print out the EOI Form for Lincoln Financial, complete the form and return the completed form to Midsouth Benefits before the end of our annual enrollment period.



THINGS YOU SHOULD KNOW ABOUT YOUR BENEFITS THROUGH CITY OF TYBEE ISLAND

Disclaimer

We provide benefits, to you, your spouse and dependents, for which you (and they) are eligible for and enrolled. The information in this Employee Benefits Enrollment Guide is intended to only provide you with a brief overview of certain administrative provisions, as well as some highlights of the benefits being offered by the City of Tybee Island (herein referred to simply as the City). *Please read this document carefully and do not hesitate to contact our Plan Administrator or our Account Managers with Midsouth Benefits if you have any questions.* It is your responsibility to understand your benefits and to ask questions if you need more information.

Please note that this document does not provide any substantive rights to benefits that are not included in the Insurer's Certificate of Coverage. The information in this document is not binding. If there are any discrepancies between the information in this Employee Benefits Enrollment Guide and the Insurer's Certificate of Coverage, the Insurer's Certificate of Coverage will prevail and govern how the benefits are provided and administered. The Certificates of Coverage provide more information about the Insurer's claims procedures, including information on how to file a claim.

The City reserves the right to terminate, modify, amend or eliminate any and all benefits under our Plan. The right to modify, amend or terminate also applies to any insurance contract between the City and the Insurer. Such actions may be taken without the consent of or prior notice to any person who claims rights or benefits under any of our group policies or plans.

Neither this document nor any other benefit plan document constitutes a contract of employment between you and the City, or any other arrangement indicating that you will be employed for any specific period of time.

Important info! Check it out.

Plan Changes Effective July 1, 2015, for our 2015-2016 Plan Year

As you review the information in this Guide, you will note a number of changes taking place.

- Although our Medical benefits will continue to be provided by Blue Cross Blue Shield, some benefits will be different, such as the maximum out-of-pocket amounts and the cost sharing under Prescription Drugs.
- Our Dental benefits will be provided through a new carrier, MetLife. We will continue to offer both a High and Low Option Dental Plan, however, some benefits within those Plans will change. For example, under the High Option Plan the maximum calendar year benefit will now be \$5,000, and the Plan will now include orthodontia benefits for adults.
- We are offering three new Vision Plans, all of which will be administered by Ameritas but utilize different provider networks (VSP and EyeMed Networks).
- We are also offering a brand new benefit plan; you can elect to enroll in a Short Term Disability Plan offered by Lincoln Financial. The premiums for this Plan will be paid 100% by you, the employee, and you may elect the level of coverage that best fits your financial needs.
- Beginning July 1st, Lincoln Financial Group will be the provider of all our group Life and Disability benefits.
- The maximum monthly benefit amount under our Long Term Disability Plan is increasing from \$5,000 to \$6,000.
- If you previously declined enrollment in our Voluntary Life Plan, now is your and your spouse's opportunity to enroll for a limited amount with no evidence of insurability required.
- If you and your spouses **are** currently enrolled in our Voluntary Life Plan, you will have an opportunity to increase the current benefits with no evidence of insurability required.
- There will be new premiums for all our existing group plans except the Voluntary Life Plan. See pages 34-37 of this Guide for your new premium deductions. Please note however, you could be subject to a premium increase under the Voluntary Life Plan if due to your age, you are now in a higher age bracket.
- Effective July 1st, if enrolled, we will start deducting your Dental and Vision premiums, in addition to the Medical, on a pre-tax basis. For more information on what this means for you, see page 10 of this Guide.

**THINGS YOU SHOULD KNOW ABOUT YOUR BENEFITS THROUGH
CITY OF TYBEE ISLAND - Continued**

Annual Enrollment Period

The benefits elected during this annual enrollment period will be for elections effective July 1, 2015. If you wish to change your elections made during this annual enrollment period, you must wait until the next annual enrollment period to make changes unless you experience a qualified Change in Status event. Please review the sections of this Benefits Enrollment Guide titled **Special Enrollment Opportunities** outlined on page 9 and **Pre-Tax Premium Contributions (Section 125 Plan)** on page 10 for more information.

The information in this Benefits Enrollment Guide assumes that you have already met your Initial Eligibility Waiting Period and are enrolling for benefits outside of your initial 31 day eligibility enrollment period.

Some of our supplemental benefits and programs will not be included in this Guide, such as our Supplemental Insurances through Colonial or AFLAC, and Supplemental Retirement Plans. For information on these benefits/programs, please contact our Plan Administrator, or see page 40 of this Guide for the insurer/provider contact information.

During this annual enrollment period you will be required to make a benefit election for all the benefit Plans described in this Benefits Enrollment Guide, including those benefit Plans in which you are currently enrolled.

If you elect an amount of Voluntary Life insurance for you or your spouse that is subject to Evidence of Insurability, you will be prompted to print out the EOI Form available online for Lincoln Financial, complete the form and return the completed form to Midsouth Benefits before the end of our annual enrollment period. All EOI forms should be mailed to:

Lee Ann Sharpton
Midsouth Benefits
4994 Lower Roswell Road, Suite 5
Marietta, Georgia 30068

IMPORTANT TO KNOW!



Your Eligibility and Enrollment for Benefits

To be eligible for benefit elections during this annual enrollment period, you must be an active, full-time employee or a COBRA Beneficiary. Full-time means actively at work on the City's regular work schedule for the class of employees to which you belong, and working a minimum of 30 hours per week for the City. However, under the medical plan, full-time means working, on average, at least 30 hours of service per week (or 130 hours of service per month).

If you are a COBRA Beneficiary, your benefit election will be limited to the benefit plan(s) under which you are receiving COBRA continuation of coverage.

Your Dependents' Eligibility and Enrollment for Benefits

If you are eligible and enrolled or enrolling for the coverage, the following family members are also eligible for enrollment during this annual enrollment period:

For the Medical Plan: a) your lawful spouse, and b) your child(ren) up to the age of twenty-six (26), regardless of student status, residency or marital status.

For the Dental, Vision and Voluntary Life Plans: a) your lawful spouse, and b) your child(ren) up to the age of twenty-six (26), regardless of student status. Note, a child must be at least 14 days old to be eligible for benefits under the Voluntary Life Plan.



NOTE: If you experience a qualified change in status event, you may be able to enroll or change your benefit election under the Medical, Dental and Vision Plans before the next annual enrollment period under a Special Enrollment Opportunity. A Special Enrollment Opportunity may also apply if you or your dependents declined enrollment in the Medical or Dental Plan due to having other similar coverage and that other coverage is lost due to certain circumstances. See the **Special Enrollment Opportunities** section on page 9 and the **Pre-Tax Premium Contributions (Section 125 Plan)** section on page 10 for more information.

An individual who is a child of a covered employee shall be enrolled for coverage under the group health, dental and/or vision plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO). You or your dependent may contact our Plan Administrator for more information on the City's procedures for determining whether a child support order is a *qualified* medical support child order (QMCSO) or NMSO.



NOTE: Under no benefits may a person be insured as both an employee and a dependent. And if both parents are employees of the City, a dependent child may be covered for benefits under only one parent. *It is your responsibility to notify our Plan Administrator when a covered dependent is no longer eligible for coverage.*



Coverage Effective Date

If you are electing coverage, for which you are eligible for, during this 2015 annual enrollment period, your coverage or any change in coverage will be effective on the later of:

- 1) The first day of the new Plan Year (July 1, 2015);
- 2) The first day of the month following or coinciding with the date the carrier approves your Evidence of Insurability (EOI), if EOI is required; or
- 3) The date you satisfy the requirement under the Deferred Effective Date, if a Deferred Effective Date applies. (see **NOTE** below)

The above assumes you pay the required premium, when your contribution towards the premium is required. This also assumes that you have already met your Initial Eligibility Waiting Period and are enrolling for benefits outside of your initial 31 day eligibility enrollment period.

If you are electing coverage, for which your dependent is eligible for, during an annual enrollment period, their coverage or any change in coverage will be effective on the later of:

- 1) The date your coverage for the same benefit plan becomes effective;
- 2) The first day of the new Plan Year (July 1, 2015);
- 3) The first day of the month following or coinciding with the date the carrier approves their Evidence of Insurability (EOI), if EOI is required; or
- 4) The date your dependent satisfies the requirement under the Deferred Effective Date, if a Deferred Effective Date applies. (see **NOTE** below)

This too assumes you pay the required premium, when your contribution towards the premium is required.



NOTE: A deferred effective date will not apply to any election for medical or vision benefits, nor to any Plan of benefits in which you or your dependents are currently enrolled. However, a deferred effective date will apply to any elected increase in the Voluntary Life benefits. The deferred effective date may vary by Plan, so for more information contact our Account Manager with Midsouth Benefits.

If you are not actively at work on the day that your Life, Disability or Dental insurance, or any newly elected increase in the insurance, would otherwise first become effective, then your insurance or increase in insurance may be subject to a Deferred Effective Date. This applies even if you elect this coverage or increase during an annual enrollment period. The term "Actively At Work" means an employee's full-time performance of all customary duties of his/her occupation at their normal place of work. Unless disabled on the prior workday or on the day of absence, an employee will be considered Actively At Work on the following days: a Saturday, Sunday or holiday which is not a scheduled workday; a paid vacation day, other scheduled or unscheduled non-work day; or an excused or emergency leave of absence (except a medical leave).

If your dependent is in a Period of Limited Activity on the date that their newly elected Life insurance, or any increase in such insurance, would otherwise be effective, then the Life insurance for that dependent may be subject to a Deferred Effective Date. This applies even if you elect coverage during an annual enrollment period. A Period of Limited Activity means the dependent is confined in a health care facility; or whether confined or not, and is unable to perform the regular and usual activities of a healthy person of the same age and sex.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requires that organizations follow certain privacy practices regarding your protected personal health information (PHI). PHI is defined as your individually identifiable health information that is created or received by the City's various welfare benefit Insurers. You have specific rights with respect to the use and disclosure of your PHI. The Plan and its insurers are required by law to maintain the privacy of medical information about you and your covered dependents, and to provide you with notice about their legal duties and privacy practices with respect to this information. When applicable, you will find the Insurer's Notice of their Privacy Practices for Protected Health Information within the Certificate of Coverage.

COBRA Rights - Continuation of Coverage

When you initially enroll in our Medical, Dental or Vision Plan, you should receive an Initial/General COBRA Notice outlining your (and your enrolled dependents') rights under COBRA. You will also receive a COBRA Election Notice when your and/or your enrolled dependents lose coverage for these plans due to certain circumstances. For more information on your rights under COBRA, you should contact our Plan Administrator or you may contact our COBRA administrator, by calling 1-866-800-2272 or send an email to Cobraservices@benefitadminsolutions.com.

Special Enrollment Opportunities

HIPAA Special Enrollment Rights

If you declined enrollment in our Group Medical Plan or our Group Dental Plan for yourself and/or for your dependents (including your spouse) solely because of having other health or dental insurance or group health or dental coverage, you may be able to enroll yourself and/or your dependents in the Plan available through the City during a Special Enrollment Period if you and/or your dependents have: a) exhausted COBRA benefits, b) lost eligibility for that other coverage (the term "lost eligibility" includes (1) a loss of coverage due to legal separation, divorce, death, no longer in a class eligible for benefits, termination of employment, or reduction in the number of hours of employment; or (2) in the case of coverage offered through an HMO, loss of coverage because the employee or dependent no longer lives or works in the HMO's service area and no other option is available; or c) as related to medical coverage, stop receiving employer contributions towards the cost of that other coverage. However, you must request enrollment within 31 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 one of these events: marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Medical Plan during a Special Enrollment Period. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If properly enrolled, coverage will be effective on the date of the event, provided all premium contribution requirements have been met.

Medicaid and CHIP Special Enrollment/Special Enrollee Rights

Eligible employees and dependents may also enroll in the dental and/or the Medical Plan prior to the next annual enrollment period under two additional circumstances: 1) your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or 2) your or your dependent becomes eligible for a premium subsidy (state premium assistance program) under Medicare or CHIP. Your or your dependent must request the Special Enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of becoming eligible for the premium subsidy.

If you apply within 60 days of the date Medicaid or CHIP coverage is terminated or within 60 days of the date the Member is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start no later than the first day of the month following receipt of your enrollment request.

For more information on Medicaid and the Children's Health Insurance Program (CHIP) and the availability of premium subsidies in your state, see page 41 of this Guide.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO)

If you are required by a court order to provide coverage for a dependent child, you will be permitted to enroll the dependent child without regard to annual enrollment season restrictions. An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO). You or your dependent may contact our Plan Administrator for more information on the City's procedures for determining whether a child support order is a *qualified* medical support child order (QMCSO) or NMSO. This information is available free of charge.

To elect benefits or make a benefit election change as allowed under the Special Enrollment Rights, contact our Plan Administrator.

Special Enrollment Opportunities - Continued

❑ Pre-Tax Premium Contributions (Section 125 Plan)



Your portion of your Medical, Dental and Vision premiums will automatically be paid with dollars deducted from your pay on a pre-tax basis unless you submit in writing to our Plan Administrator that you want these premiums deducted on an after-tax basis. With this pre-tax feature, your premium contributions are subtracted from your gross pay before taxes are determined. By doing this, your taxable pay is reduced so you pay less in taxes. However, you should be aware that premiums deducted on a pre-tax basis will also reduce your Social Security and Medicare wages for benefit purposes in the future. Because this pre-tax feature impacts what you pay in taxes, the IRS has specific regulations that affect when you can make changes to your election for these Plans.

Once the election period is over, your elections under the Medical, Dental and/or Vision coverage for yourself and your dependents **cannot** be changed during the Plan Year unless you experience a qualified Change in Status event. If you experience a qualified Change in Status event, you may change certain elections so long as the election change is on account of and consistent with the Change in Status event. A change in a benefit election is considered “consistent with a change in status” only if the change in status results in the employee, spouse, or dependent gaining or losing eligibility for coverage under our Plan or, the same type of coverage sponsored by the spouse’s or dependent’s employer, and the change in your benefit election corresponds with such a gain or loss of coverage.

Listed below are some events that **may** enable you to change elections mid-year. The definition of a qualifying Change in Status event may vary by insurer and benefit plan. You should consult the Insurer’s Certificate of Coverage or contact our Plan Administrator to determine whether or not your change in status is considered a qualifying event.

- Change in your employment status or the employment status of your spouse or dependent (i.e., full-time to part-time, termination, commencement of employment)
- Change in your or your spouse’s or your child’s place of work or place of residence
- Change in your legal marital status
- Entitlement by you, your spouse or dependent for Medicare or Medicaid
- Utilization of Special Enrollment Rights under HIPAA
- Your spouse or child is eligible to enroll in or drop coverage from his or her employer’s group health plan due to that employer’s annual enrollment period
- Change in your number of dependents
- You, your spouse or dependent satisfies or ceases to satisfy dependent Eligibility Requirement for a benefit
- Significant change in cost of coverage or significant change in level of coverage being offered

When you become eligible to make a change in your election(s), you must complete a *Mid-Year Election Due To Change In Status* form and submit it to our Plan Administrator within 31 days of the actual date of your status change event. You may obtain the appropriate form from our Plan Administrator .



If you do not wish to have your insurance premiums deducted on a pre-tax basis, you must submit a written request to our Plan Administrator prior to the start of each Plan Year. Our Plan Administrator will provide you with the appropriate form for submitting such a request.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Effective Jan. 1, 2014, the health care reform law created an online marketplace for purchasing health insurance coverage. This marketplace is referred to as a Health Insurance Marketplace, or an Exchange. In the Marketplace, you can find and compare different health insurance plans. You are not required to purchase insurance coverage through the Marketplace. City of Tybee Island is currently continuing to offer health coverage to eligible employees.

If you purchase coverage through a Marketplace, you may be eligible for a federal subsidy that lowers your monthly premiums or reduces your cost sharing. However, to receive these federal savings, you cannot be eligible for the health plan coverage that is offered through your employer that is both "affordable" and provides "minimum value." Also, keep in mind that you may only enroll in a health insurance plan through the Marketplace during an open enrollment period or a special enrollment period.

The availability of coverage through the Marketplace does not affect your eligibility for coverage through the City. However, if you purchase health insurance through the Marketplace instead of enrolling in the health plan through the City, you will lose the City's contribution to the employer-sponsored health coverage. Also, while contributions to the health coverage through the City are excluded from your income for tax purposes, your payments for Marketplace coverage are made on an after-tax basis.

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new **Health Insurance Marketplace**.

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.

The 2015 open enrollment period for health insurance coverage through the Marketplace began on Nov. 15, 2014, and ended on Feb. 15, 2015. Individuals must have enrolled or changed plans prior to Dec. 15, 2014, for coverage starting as early as Jan. 1, 2015. After Feb. 15, 2015, you can get coverage through the Marketplace for 2015 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year (9.56 percent for 2015), 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. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about the health care coverage offered by the City, please review the information pertaining to our Medical Plan in this Enrollment Benefits Guide and the Insurer's Certificate of Coverage, or contact our Plan Administrator.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

**BLUE CROSS BLUE SHIELD OF GA
MEDICAL PLAN OAP5 2K/0 6.6K A
CONTRIBUTORY PLAN**



If this summary of benefits conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions, pre-authorization requirements or waiting periods, please refer to the Certificate of Coverage for this Plan.

On page 16 of this Guide you will find information on **Other Medical Plan Provisions** applicable to this Plan. Please be sure to review the information under that section as well.

This group medical plan does not qualify as a “grandfathered health plan” under the Patient Protection and Affordable Care Act. Benefits provided under this medical plan are fully-insured by BlueCross BlueShield/Anthem for the City of Tybee Island.

All benefits are subject to the calendar year deductible, except those with in-network copays, unless otherwise noted. All calendar year maximum visit/day limits are combined between in-network and out-of-network unless otherwise noted. In addition to copays, members are responsible for the deductibles and any applicable coinsurance. Members are also responsible for all costs over the plan maximums. Some services may require pre-certification before services are provided.

When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copays, deductibles and/or applicable coinsurance.

This Plan uses the Blue Open Access POS Network

Deductibles, Coinsurance and Maximums	In-Network Benefit	Out-of-Network Benefit
Calendar Year Deductible* <ul style="list-style-type: none"> ▪ Individual ▪ Family 	\$2,000 \$6,000	\$4,000 \$12,000
Coinsurance	Member pays 0% Plan pays 100%	Member pays 30% Plan pays 70%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible) <ul style="list-style-type: none"> ▪ Individual ▪ Family 	\$6,600 \$13,200	\$19,800 \$39,600
Lifetime Maximum	Unlimited	Unlimited
<p><i>*Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member’s deductible amount also goes toward the Family deductible and out-of-pocket maximum. Not everyone has to meet his or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses. The following do not apply to the out-of-pocket maximums: non-covered items, plan premiums, any balance billing due to Out-of-Network services. The medical copays on this plan will apply toward the out-of-pocket maximums.</i></p>		
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures) <ul style="list-style-type: none"> ▪ Primary Care Physician (PCP)* ▪ OB/GYN ▪ Specialist Physician 	\$25 copayment \$25 copayment \$50 copayment	Member pays 30% after deductible
*Also applies to services rendered at Retail Health Clinics		

Continued on next page.

BLUE CROSS BLUE SHIELD OF GA
MEDICAL PLAN - Continued
CONTRIBUTORY PLAN



Covered Services	In-Network Benefit	Out-of-Network Benefit
Preventive Care Services for Children and Adults (preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits) <ul style="list-style-type: none"> ▪ Well-child care, immunizations ▪ Periodic health examinations ▪ Annual gynecology examinations ▪ Prostate screenings 	Member pays 0% (not subject to deductible)	Member pays 30% after deductible (deductible waived through age 5)
Maternity Physician Services <ul style="list-style-type: none"> ▪ Prenatal and post natal care ▪ Global obstetrical care (prenatal, delivery and postpartum services) 	\$25 copay per visit, first visit only Member pays 0% after Deductible	Member pays 30% after deductible Member pays 30% after deductible
Telemedicine Services	\$25 PCP copayment or \$50 Specialist copayment	Member pays 30% after deductible
Telehealth Services – Online Physician Visit	\$25 PCP copayment	Member pays 30% after deductible
Allergy Services <ul style="list-style-type: none"> ▪ Office visits, testing and the administration of allergy injections ▪ Allergy injection serum 	\$25 PCP copayment or \$50 Specialist copayment Member pays 0% after deductible	Member pays 30% after deductible Member pays 30% after deductible
Office Surgery (surgery and administration of general anesthesia)	Member pays 0% after deductible	Member pays 30% after deductible
Office Therapy Services <ul style="list-style-type: none"> ▪ Physical Therapy and Occupational Therapy: 20-visit benefit period maximum combined ▪ Speech Therapy: 20-visit benefit period maximum ▪ Chiropractic Care/Manipulation Therapy: 20-visit benefit period maximum 	\$25 copayment	Member pays 30% after deductible
Other Therapy Services (chemotherapy, radiation therapy, cardiac rehabilitation and respiratory/pulmonary therapy)	Member pays 0% after deductible	Member pays 30% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 0% after deductible	Member pays 30% after deductible
Urgent Care Services	\$60 copayment	Member pays 30% after deductible
Emergency Room Services <ul style="list-style-type: none"> ▪ Life-threatening illness or serious accidental injury only ▪ The ER copayment will be waived if admitted to the hospital 	\$150 copayment; then member pays 0%	\$150 copayment; then member pays 0%

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BLUE CROSS BLUE SHIELD OF GA
MEDICAL PLAN - Continued
CONTRIBUTORY PLAN



Covered Services	In-Network Benefit	Out-of-Network Benefit
Outpatient Facility Services <ul style="list-style-type: none"> Surgery facility/hospital charges Diagnostic x-ray and lab services Physician services (anesthesiologist, radiologist, pathologist) 	Member pays 0% after deductible	Member pays 30% after deductible
Inpatient Facility Services <ul style="list-style-type: none"> Daily room, board and general nursing care at semi-private room rate, ICU/CCU charges; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care Physician services (anesthesiologist, radiologist, pathologist) 	Member pays 0% after deductible	Member pays 30% after deductible
Skilled Nursing Facility <ul style="list-style-type: none"> 30-day benefit period maximum 	Member pays 0% after deductible	Member pays 30% after deductible
Mental Health/Substance Abuse Services (*services must be authorized by calling 1-800-292-2879) <ul style="list-style-type: none"> Inpatient mental health and substance abuse services* (facility and physician fee) Office mental health and substance abuse services (physician fee) Outpatient mental health and substance abuse services (facility fee) 	Member pays 0% after deductible \$25 copayment Member pays 0% after deductible	Member pays 30% after deductible Member pays 30% after deductible Member pays 30% after deductible
Home Health Care Services <ul style="list-style-type: none"> 120-visit benefit period maximum 	\$25 copayment	Member pays 30% after deductible
Hospice Care Services <ul style="list-style-type: none"> Inpatient and outpatient services covered under the hospice treatment program 	Member pays 0% (not subject to deductible)	Member pays 30% after deductible
Durable Medical Equipment (DME)	Member pays 0% after deductible	Member pays 30% after deductible
Ambulance Services (covered when medically necessary)	Member pays 0% after deductible	Member pays 0% after deductible
Prescription Drugs (Option A) Note: If a member receives a brand name drug that falls on Tier 2 or Tier 3 that has a generic equivalent available, the member pays the Tier 1 copay, plus the difference in cost between the brand drug and generic drug. This applies even when physician indicates DAW (dispense as written) or obtains an authorization.		
<ul style="list-style-type: none"> Retail Drugs - Tier 1 (30 day supply) 	\$15 copayment	
<ul style="list-style-type: none"> Retail Drugs - Tier 2 (30 day supply) 	\$35 copayment	
<ul style="list-style-type: none"> Retail Drugs - Tier 3 (30 day supply) 	\$60 copayment	
<ul style="list-style-type: none"> Retail Drugs - Tier 4 (Specialty Drugs) (30-day supply) 	Member pays 20%, up to a \$300 maximum per prescription drug	

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BLUE CROSS BLUE SHIELD OF GA
MEDICAL PLAN - Continued
CONTRIBUTORY PLAN



Prescription Drugs (Option A) - Continued	
<ul style="list-style-type: none"> ▪ Home Delivery Maintenance Drugs – Tier 1 (90 day supply) 	\$15 copayment
<ul style="list-style-type: none"> ▪ Home Delivery Maintenance Drugs – Tier 2 (90 day supply) 	\$70 copayment
<ul style="list-style-type: none"> ▪ Home Delivery Maintenance Drugs – Tier 3 (90 day supply) 	\$180 copayment
<ul style="list-style-type: none"> ▪ Home Delivery Maintenance Drugs – Tier 4 (Specialty Drugs) (30 day supply) 	Member pays 20%, up to a \$300 maximum per prescription drug

Retail and Home Delivery maintenance drug coverage is provided at one of four tier levels in accordance with the Formulary Drug List. **Members must file a claim form for reimbursement when using an out-of-network pharmacy and reimbursement will be based on what a participating pharmacy would receive.** Specialty drugs can only be obtained from a Specialty Pharmacy. See below for Tier definitions.

Prescription Drug Tier Definitions

Tier 1 - These drugs have the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.

Tier 2 - These drugs will have a higher copayment than tier 1 drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

Tier 3 - These drugs will have a higher copayment than tier 2 drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single source brand drugs, or multi-source brands drugs.

Tier 4 - Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier will contain Specialty Drugs.

Summary of Limitations and Exclusions

Your *Certificate Booklet* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Non-emergency use of the emergency room
- Removal/extraction of impacted teeth
- Private duty nursing
- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and radiation for head and neck cancer
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational

See Certificate Booklet for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your Certificate of Coverage for a complete explanation of covered services, limitations and exclusions.

This Plan uses the Blue Open Access POS Network.



OTHER MEDICAL PLAN PROVISIONS INCLUDE:

Patient Protection Act

❑ Choice of Primary Care Physician

BCBS generally allows the designation of a Primary Care Physician (PCP), but you are not required to make such a designation under our 2015-2016 Plan. You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to the website, www.bcbsga.com. For children, you may designate a pediatrician as the PCP.

❑ Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.bcbsga.com.

❑ Emergency Care

Medically Necessary services will be covered whether the care is rendered by an In-Network Provider or an Out-of-Network Provider. Emergency Care rendered by an Out-of-Network Provider will be covered as an In-Network service, however the Member may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Coinsurance, Copayment or Deductible. For more information on how Emergency Care and Emergency Services are covered under our medical plan, consult the insurer's Certificate of Coverage.

Preventive Services

Preventive Care Services, as outlined in the insurer's certificate of coverage, shall meet requirements as determined by federal and state law. Many preventive care services are covered by this plan with no Deductible, Copayments or Coinsurance from the Member when provided by an In-Network Provider. Covered Services fall under four broad categories as shown below:

- A. Services with an "A" or "B" rating from the United States Preventive Services Task ;
- B. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- C. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- D. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration

You may call Customer Service using the number on your Medical ID Card for additional information about these services or visit the BCBS website at www.bcbsga.com/health-insurance/health-and-wellness/preventive-care. You can also view the federal government's web sites, <http://www.ahrq.gov/clinic/uspstfix.html>, <http://www.cdc.gov/vaccines/recs/acip/> and <http://www.healthcare.gov/center/regulations/prevention.html>. You should always confirm with BCBS what preventive services are covered by your Plan before scheduling services.

Women's Health and Cancer Rights Act

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient. The Women's Health and Cancer Rights Act requires that all health insurance plans that cover mastectomy also cover the following medical care:

- 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;
- Prosthesis 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 the medical plan and described on pages 12-15 of this Guide.

Affordable Care Act Requirements

Our medical plan provides the **minimum essential coverage** and meets the **minimum value standards** for the benefits provided, as required under the Affordable Care Act.

Continued on next page.

OTHER MEDICAL PLAN PROVISIONS INCLUDE - Continued:

Mental Health Parity and Addiction Equity Act

A group health plan that provides mental health and substance abuse benefits cannot impose special caps or limits on these benefits. Treatment limits and cost sharing, including deductibles, co-pays, coinsurance, and out-of-pocket expenses cannot be more restrictive than the most common or frequent rules that apply to all other medical and surgical benefits provided under the plan.

Newborns' and Mothers' Health Protection Act

Under federal law, our medical plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than forty-eight hours following vaginal delivery, or less than ninety-six (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 forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, our medical plan may not require that a Provider obtain authorization from the insurer before prescribing a length of stay which is not in excess of forty- eight (48) hours for a vaginal delivery or ninety-six (96) hours following a cesarean section.



You don't want to miss this info on LiveHealth Online!

Now you can get the health care you need without all the hassle



Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.*

With LiveHealth Online, you get:

- “ Immediate doctor visits through live video.
- “ Your choice of U.S. board-certified doctors.
- “ Help at a cost that is same as your office visit copay or \$49 per visit, subject to deductible and coinsurance, depending on your health plan benefits.
- “ Private, secure and convenient online visits.

What are the qualifications of the doctors you consult via LiveHealth Online?

- “ U.S. board-certified.
- “ Average 15 years practicing medicine.
- “ Mostly primary care physicians.
- “ Specially trained for online visits.

When can you use LiveHealth Online?

As always, you should call 911 with any emergency. Otherwise, you can use LiveHealth Online whenever you have a health concern and don't want to wait. Doctors are available 24 hours a day, seven days a week, 365 days a year. Some of the most common uses include:

- “ Cold and flu symptoms such as a cough, fever and headaches
- “ Allergies
- “ Sinus infections
- “ Family health questions

Start a conversation now.

Just enroll for free at livehealthonline.com or on the app, and you're ready to see a doctor.

Not available with HRA plans and plans purchased through the Connecticut Health Insurance Marketplace known as Access Health CT.

*As legally permitted in certain states.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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MEDICARE PART D NOTICE FOR PRESCRIPTION DRUG COVERAGE -DISCLOSURE NOTICE

PLEASE READ THIS SECTION CAREFULLY IF YOU ARE ENROLLING OR ALREADY ENROLLED IN OUR MEDICAL PLAN, and share this notice with your spouse, or any other dependent if they are eligible for Medicare and participate in our Group Medical Plan. If you or a dependent are Medicare eligible, the following information may apply to you. This is information about your current prescription drug coverage through the City of Tybee Island and options under Medicare's prescription drug coverage. If you are considering joining a Medicare drug plan, you should compare the prescription drug coverage available under the City's medical plan, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. There are two important things you need to know about the drug coverage available under the City's medical plan and Medicare's prescription drug coverage:

First, 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.

Second, BCBS has determined the prescription drug coverage offered under the City's medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the City's prescription drug coverage through BCBS 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.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through 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.

If you decide to join a Medicare drug plan, your current coverage through the City will not be affected. Your current coverage through the City pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you will still be eligible to receive all of your current medical and prescription drug benefits through the City. You cannot drop your prescription drug coverage through the City without losing ALL your medical benefits through the City. If you decide to drop your current prescription drug (and medical) coverage through the City and enroll in Medicare prescription drug coverage, if still eligible for our benefits, you may enroll back into a medical plan offered by the City during an annual open enrollment period, or earlier if you qualify for Special Enrollment Rights. Please see pages 14-15 of this document for a description of the current prescription drug coverage.

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 through the City and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the Plan Administrator with the City. 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 changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information 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).

To receive a personalized Creditable Coverage Notice for proof that you have maintained your creditable coverage through the City, contact our Plan Administrator.

METLIFE
DENTAL BASE (LOW) OPTION PLAN
CONTRIBUTORY PLAN



You have the option to select enrollment in one of two different dental plans. The Plan described below is called the Base (Low) Option Plan. The City of Tybee Island will pay 100% of the cost for employee only coverage under this Plan. If you want the additional coverage available under the Buy Up (High) Option Plan, you will pay the difference in the premium cost. This Plan offers a lower Calendar Year Maximum Benefit than the Buy Up (High) Option Plan, and does not cover Orthodontia. Your premiums for this Plan will be lower than those under the Buy Up (High) Option Plan.

Dental Benefits*		In-Network Benefits	Out-of-Network Benefits
Calendar Year Maximum Benefit – Per Person (Benefits paid under Preventive, Basic and Major Services apply towards the calendar year benefit maximum)			\$1,500
Calendar Year Deductible (Deductible applies only to Basic and Major Services) Per Person Family Maximum			\$50 \$150
Preventive Services Routine Oral Exams Prophylaxis (cleaning) Bitewing X-rays Fluoride Treatment		Full Mouth X-rays Other X-rays Sealants Space Maintainers	Based on allowable charges Plan will pay 100% You will pay 0%
Basic Services Restorative Fillings Endodontic (root canal) Simple Extractions Periodontics		Emergency Palliative Treatment	Based on allowable charges Plan will pay 80% You will pay 20%
Major Services Inlays, Onlays, Crowns Dentures Repairs Complex Extractions		Implants Bridges General Anesthesia Other Oral Surgery	Based on allowable charges Plan will pay 50% You will pay 50%
Orthodontic Services (Adult & Child) Diagnostic, Treatment			Not covered
Orthodontic Lifetime Maximum Benefits – Per Person			Not applicable
MetLife’s Allowable Charges (Applies to Preventive, Basic and Major Services)		Based on PPO Negotiated Fees	Based on Reasonable & Customary for your area at the 90 th percentile
Benefit Period – Your benefits are based on a Calendar Year. Calendar Year runs from January 1 through December 31			
Understanding Your Dental Plans The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist’s actual charge); or "Usual Charge" (the dentist’s usual charge for the same or similar services); or "Customary Charge" (the 90th Percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).			
*Frequency and age limits may apply. Continued on page 22 of this Guide.			

METLIFE
DENTAL BUY UP (HIGH) OPTION PLAN
CONTRIBUTORY PLAN



You have the option to select enrollment in one of two different dental plans. The Plan described below is called the Buy Up (High) Option Plan. This Plan offers a higher Calendar Year Maximum Benefit than the Base (Low) Option Plan, and includes coverage for Orthodontia on both adults and children. Your premiums for this Plan will be higher than those under the Base (Low) Option Plan.

Dental Benefits*		In-Network Benefits	Out-of-Network Benefits
Calendar Year Maximum Benefit - Per Person (Benefits paid under Preventive, Basic and Major Services apply towards the calendar year benefit maximum)			\$5,000
Calendar Year Deductible (Deductible applies only to Basic and Major Services)			
Per Person			\$50
Family Maximum			\$150
Preventive Services			
Routine Oral Exams	Full Mouth X-rays	Based on allowable charges	Based on allowable charges
Prophylaxis (cleaning)	Other X-rays	Plan will pay 100%	Plan will pay 100%
Bitewing X-rays	Sealants	You will pay 0%	You will pay 0%
Fluoride Treatment	Space Maintainers		
Basic Services			
Restorative Fillings	Emergency Palliative Treatment	Based on allowable charges	Based on allowable charges
Endodontic (root canal)		Plan will pay 80%	Plan will pay 80%
Simple Extractions		You will pay 20%	You will pay 20%
Periodontics			
Major Services			
Inlays, Onlays, Crowns	Implants	Based on allowable charges	Based on allowable charges
Dentures	Bridges	Plan will pay 50%	Plan will pay 50%
Repairs	General Anesthesia	You will pay 50%	You will pay 50%
Complex Extractions	Other Oral Surgery		
Orthodontic Services (Adult & Child)			
Diagnostic, Treatment		Based on allowable charges	Based on allowable charges
		Plan will pay 50%	Plan will pay 50%
		You will pay 50%	You will pay 50%
Orthodontic Lifetime Maximum Benefits - Per Person			\$2,000
MetLife's Allowable Charges (Applies to Preventive, Basic, Major and Ortho Services)		Based on PPO Negotiated Fees	Based on Reasonable & Customary for your area at the 90 th percentile
Benefit Period - Your benefits are based on a Calendar Year. Calendar Year runs from January 1 through December 31			
Understanding Your Dental Plans The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Usual Charge" (the dentist's usual charge for the same or similar services); or "Customary Charge" (the 90th Percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).			
*Frequency and age limits may apply. Continued on page 22 of this Guide.			

METLIFE

DENTAL BASE (LOW) AND BUY UP (HIGH) OPTION PLANS - Continued CONTRIBUTORY PLAN



You have the option to receive services from any Provider. Your maximum benefit will go further and you will pay less out-of-pocket if you use a Preferred Dental Program (PDP) In-Network Dentist. **PDP In-Network Dentist** - this is a Provider who has a contract with MetLife to provide services to Insureds at a negotiated fee. **Out-of-Network Dentist** - this is a Provider who is not a PDP In-Network Dentist. If you receive in-network services, you will be responsible for any applicable cost sharing, PDP Dentist's charges in excess of the calendar year maximum benefit, and for non-covered services. If you receive out-of-network services, you will be responsible for any applicable cost sharing, charges in excess of the calendar year maximum benefit, charges for non-covered services and the dentist may balance bill you for their fees that exceed what MetLife deems to be Reasonable & Customary.

*Frequency and/or age limits may apply. The following is a list of common procedures, how often they are covered and any age limits. This is not a complete list of those services subject to frequency and/or age limits.

Preventive Services:

- Routine exams - once every six (6) months
- Prophylaxis (routine cleaning) - once every six (6) months
- Fluoride - once every twelve (12) months (covered for those members under age 14)
- Bitewings X-rays - once every twelve (12) months
- Full Mouth X-rays - once every sixty (60) months
- Space Maintainers - once per lifetime (covered for those members under age 14)
- Sealants - once per molar, every sixty (60) months (covered for those members under age 16)

Basic Services:

- Amalgam and resin-based composite restorations on anterior - one replacement per surface every twenty-four (24) months
- Amalgam only restoration on posterior teeth
- Periodontal Maintenance - four (4) treatments in one (1) calendar year (includes frequency and benefits for routine Prophylaxis).
- Non-surgical Periodontics, scaling and root planning - once per quadrant, every twenty-four (24) months
- Surgical Periodontal - once per quadrant, every thirty-six (36) months
- Endodontic, root canal - once per tooth, per lifetime

Major Services:

- Crowns Buildups/Post Core- once per tooth every ten (10) years
- Inlays, Onlays, Crowns - replacement per tooth, once every ten (10) years
- Bridges - once every ten (10) years
- Dentures - once every ten (10) years
- Repairs - once every twenty-four (24) months
- Implant Supported Prosthetic - once per tooth every sixty (60) months
- Implant Services - once per tooth position every ten (10) years
- Implant Repairs - once per tooth every sixty (60) months
- Dentures, Rebases/Relines - once every thirty-six (36) months

Late Enrollee Penalty -

If a member (employee, spouse or child) enrolls in either of these dental plans at any time **other than** within 31 days of their initial eligibility date, during a Special Enrollment Period or **during an annual enrollment period**, they may be subject to a Late Entrant benefit waiting period of 12 months to Basic Services and 24 months for Major and Ortho Services.

These Dental Plans Use the PDP Dental Network

These are summaries of the benefits provided under the Dental Plans. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Certificate of Coverage for this Plan.

SECOND OPTION



AMERITAS VISION PLAN - EYEMED PLAN VOLUNTARY PLAN - 100% EMPLOYEE PAID

You have the option to select enrollment in one of three different vision plans. The Plan described below is called the EyeMed Plan. The benefits under this Plan and those under the VSP Plan are similar in structure but your costs and provider network will be different. The third vision plan option is simply a direct reimbursement plan. The premiums for this EyeMed Plan and the VSP Plan are the same. If you wish to enroll for a Vision Plan, you may select only one of three available Plans for the full Plan Year.

	IN-NETWORK COPAY	OUT-OF-NETWORK COPAY
Eye Exam Copay	\$10	\$0
Eye Glass Lenses	\$25	\$0
Frames	\$0	\$0
Contact Lens Copay	\$0	\$0
	IN-NETWORK MEMBER COSTS AFTER APPLICABLE COPAY	OUT-OF-NETWORK ALLOWANCE BEFORE APPLICABLE COPAY
Eye Exam	Covered in full	Up to \$30
Frames	You pay balance over a \$130 allowance, less a discount of 20%*	Up to \$65
Standard Lenses (per pair)	Plastic Lens Only	
Single Vision Lens	Covered in full	Up to \$25
Bifocal Vision Lens	Covered in full	Up to \$40
Trifocal Vision Lens	Covered in full	Up to \$55
Lenticular Vision Lens	You pay the cost less a 20% discount. No copay	No benefit
Standard Progressive Lens	\$65	No benefit
Premium Progressive Lens	\$65, then 80% of charge less \$120 allowance	No benefit
Lens Options** (paid by the member and added to the base price of the lens)		
UV Treatment	\$15	No benefit
Tint (Solid and Gradient)	\$15	No benefit
Standard Scratch Resistant Coating	\$15	No benefit
Standard Polycarbonate (Adults & Kids)	\$40	No benefit
Standard Anti-Reflective Coating	\$45	No benefit
Photochromatic	20% discount off retail cost	No benefit
Other Available Add-On Lens Options	20% discount off retail cost	No benefit
Contact Lens (in lieu of any other Lens benefit during the same Benefit Period)		
Standard Contact Lens Fit & Follow Up	Up to \$40	No benefit
Premium Contact Lens Fit & Follow Up	10% off retail	No benefit
Elective Conventional/Disposable Lens	You pay balance over a \$130 allowance, less a discount of 15% for Conventional Lenses	Up to \$104
Medically Necessary Lens	Covered in full	Up to \$200
Frequency	The following Frequency Periods are based on date of service	
Exam	Once every 12 months	
Eye Glass Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

Vision Plan Network

EyeMed Access Network

Not applicable

* Discounts do not apply at any wholesale clubs such as Costco or Sam's

**These costs are subject to change without notice.

This is just a summary of the benefits provided under the EyeMed Vision Plan. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Certificate of Coverage for this Plan.

AMERITAS
VISION PLAN - VISION PERFECT PLAN
VOLUNTARY PLAN - 100% EMPLOYEE PAID

THIRD OPTION



You have the option to select enrollment in one of three different vision plans. The Plan described below is called the Vision Perfect Plan. The benefits under this Plan are provided on a direct reimbursement basis only, and the premiums for this Plan are different from the premiums for the VSP Plan and EyeMed Plan. If you wish to enroll for a Vision Plan, you may select only one of the three available Plans for the full Plan Year.

	IN-NETWORK	OUT-OF-NETWORK
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There is no vision provider network under this Plan. You are free to select any licensed provider (ophthalmologist, optometrist, optician) , pay the provider for all services, and then submit a claim for reimbursement. Reimbursement is subject to the calendar year maximum benefit for all vision services provided during the year.

Eye Exam, Eye Glass Lenses, Frames and Contact Lens Copays There are no copays for any services under this Plan

	MEMBER REIMBURSEMENT
--	----------------------

Calendar Year Reimbursement Maximum	\$100 per person
Eye Exam	Subject to reimbursement maximum
Frames	Subject to reimbursement maximum
Standard Lenses (per pair)	Plastic and Glass Lens
Single Vision Lens	Subject to reimbursement maximum
Bifocal Vision Lens	Subject to reimbursement maximum
Trifocal Vision Lens	Subject to reimbursement maximum
Lenticular Vision Lens	Subject to reimbursement maximum
Standard Progressive Lens	Subject to reimbursement maximum
Premium Progressive Lens	Subject to reimbursement maximum
Lens Options** (paid by the member and added to the base price of the lens)	
UV Treatment	Subject to reimbursement maximum
Tint (Solid and Gradient)	Subject to reimbursement maximum
Standard Scratch Resistant Coating	Subject to reimbursement maximum
Standard Polycarbonate (Adults & Kids)	Subject to reimbursement maximum
Standard Anti-Reflective Coating	Subject to reimbursement maximum
Photochromatic	Subject to reimbursement maximum
Other Available Add-On Lens Options	Subject to reimbursement maximum
Contact Lens (in lieu of or in addition to any other Lens benefit during the same Benefit Period)	
Standard Contact Lens Fit & Follow Up	Subject to reimbursement maximum
Premium Contact Lens Fit & Follow Up	Subject to reimbursement maximum
Elective Conventional/Disposable Lens	Subject to reimbursement maximum
Medically Necessary Lens	Subject to reimbursement maximum
Frequency	Calendar Year Benefit Period
Exam	Unlimited, subject to reimbursement maximum
Eye Glass Lenses or Contact Lenses	Unlimited, subject to reimbursement maximum
Frames	Unlimited, subject to reimbursement maximum
Vision Plan Network	Not applicable

This is just a summary of the benefits provided under the Vision Perfect Vision Plan. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Certificate of Coverage for this Plan.

LINCOLN FINANCIAL
BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT PLAN
NON-CONTRIBUTORY PLAN



EMPLOYEE BASIC LIFE INSURANCE:

Flat benefit of \$25,000 (Principal Sum)

At age 65 your Life Insurance benefit will be reduced to 65%; and then at age 70, your benefit will be reduced to 50% of the original amount.

Guaranteed Issue Amount: \$25,000

Additional Life Benefits Provided Include:

- Waiver of Premium – applies only to the Life Insurance premium
- Accelerated Death Benefit – must have been insured under this policy and be deemed terminally ill with a life expectancy of 12 months or less. Accelerated Death Benefit will be limited to a minimum of \$5,000 and a maximum of 75% of your life insurance benefit. This benefit is payable only once.
- Conversion Privilege

EMPLOYEE BASIC ACCIDENTAL DEATH OR DISMEMBERMENT (ADD):

Flat benefit of \$25,000 (Principal Sum)

At age 65 your Life Insurance benefit will be reduced to 65%; and then at age 70, your benefit will be reduced to 50% of the original amount.

Guaranteed Issue Amount: \$25,000

If you suffer any of the following losses as a direct result of a covered accident and otherwise qualify, this policy will pay a benefit equal to the following percentage of the above AD&D Benefit:

- 100% Loss of Life
- 100% Loss of both feet, both hands, or the sight in both eyes resulting from the same accident
- 50% Loss of one hand, one foot or the sight in one eye

Loss must occur within 365 days of the date of the accident.

Additional ADD Benefits Provided Include:

- Common Carrier Accident Benefit - 2X Principal Sum
- Seat Belt Benefit - 10% additional benefit
- Air Bag Benefit - 10% additional benefit

Value-Added Services:

- EstateGuidance® Will Preparation
- GuidanceResources® Online
- Identity Theft Resources
- Beneficiary Services
- Travel Assistance

For more information on these services, see pages 32-33 of this Guide

Benefits will not be payable if your death results from suicide while sane or insane, and occurs within two years after your Basic Life insurance takes effect.

This is just a summary of the benefits provided under this Basic Life and ADD Plan. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Certificate of Coverage for this Plan.

**LINCOLN FINANCIAL
VOLUNTARY LIFE PLAN
VOLUNTARY PLAN - 100% EMPLOYEE PAID**



**VOLUNTARY EMPLOYEE LIFE
INSURANCE BENEFIT:**

You may elect an amount of insurance between \$10,000 - \$300,000, in increments of \$10,000.

- Minimum benefit of \$10,000
- Maximum benefit equal to the lesser of \$300,000 or five (5) times your basic annual earnings (rounded up to the next \$5,000)
- **If you are age 70 and older, your benefit is subject to a maximum of \$50,000**
- At age 65 your Life Insurance benefit will be reduced to 65%; and then at age 70, your benefit will be reduced to 50% of the original amount

Employee's Guaranteed Issue Amount:

\$150,000 during the initial eligibility enrollment period

Evidence of Insurability Requirements:



You will be required to provide evidence of insurability and be approved by the Insurer whenever any of the following apply:

- You did not elect this coverage within 31 days of your initial eligibility date and you wish to elect the coverage at a later date and outside of an annual enrollment period. All amounts will be subject to evidence of insurability;
- An election or increased amount in Voluntary Life coverage is requested and any amount of coverage has been previously terminated, withdrawn, declined or is pending underwriting review. All amount will be subject to evidence of insurability; and
- During an annual enrollment period, any increase to your current benefit amount of more than two (2) increment levels will be subject to evidence of insurability.

**ANNUAL ENROLLMENT
OPPORTUNITY FOR YOU**

- During this annual enrollment period, you may elect to increase your current benefit amount by two (2) increment levels without having to provide evidence of insurability, subject to the Plan's maximum benefit.
- If you are currently enrolled in this Plan and wish to keep your existing benefit amount, you may do so without having to provide evidence of insurability to the new insurance carrier, Lincoln Financial.
- During this annual enrollment period, if you previously declined to enroll in this Plan, you may elect to enroll at this time for up to two (2) increment levels without having to provide evidence of insurability.

This is just a summary of the benefits provided under this Voluntary Life Plan. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Insurer's Certificate of Coverage for this Plan.

LINCOLN FINANCIAL
VOLUNTARY LIFE PLAN - Continued
VOLUNTARY PLAN - 100% EMPLOYEE PAID



**VOLUNTARY SPOUSE
 LIFE INSURANCE
 BENEFIT:**

For your spouse you may elect an amount between \$5,000 - \$150,000, in increments of \$5,000

- Minimum benefit of \$5,000
- Maximum benefit of \$150,000, not to exceed 50% of your Voluntary Life Insurance benefit amount
- Spouse's benefit reduces to 65% upon your (the employee's) attainment of age 65, and then at your age 70, the benefits will be further reduced to 50% of the original amount

Spouse's Guaranteed Issue Amount: \$50,000 during the initial eligibility enrollment period

**VOLUNTARY CHILD
 LIFE INSURANCE
 BENEFIT:**

For your child(ren) you may elect a flat benefit amount of \$10,000 per child

- However, if the child is age 14 days but less than 6 months, the benefit will only be \$250.
- A child less than 14 days old is not eligible for coverage

Child's Guaranteed Issue Limit: \$10,000

**Additional Benefits Provided Under
 the Voluntary Life Coverage
 Includes:**

- Waiver of Premium (for Voluntary Employee Life coverage only)
- Accidental Death & Dismemberment Benefit (employee option only). See page 29 for more information.
- Accelerated Death Benefit (for employee and spouse coverage only)
- Conversion Privilege
- Portability Option

**Evidence of Insurability
 Requirements for your Spouse and
 Child(ren):**



Your spouse and child(ren) will be required to provide evidence of insurability and be approved by the carrier whenever any of the following apply:

- You did not elect this coverage within 31 days of your initial eligibility date or, if later, the date you acquired the dependent(s), and you wish to elect coverage at a later date and outside of an annual enrollment period. All amounts will be subject to evidence of insurability;
- An election or increased amount in Voluntary Life coverage is requested and any amount of coverage has been previously terminated, withdrawn, declined or is pending underwriting review. All amounts will be subject to evidence of insurability; and
- During an annual enrollment period, any increase to your spouse's current benefit amount of more than two (2) increment levels will be subject to evidence of insurability.

**ANNUAL ENROLLMENT
 OPPORTUNITY FOR YOUR SPOUSE
 AND CHILD(REN)**

- During this annual enrollment period, you may elect to increase your spouse's current benefit amount by up to two (2) increment levels without having to provide evidence of insurability, subject to the Plan's maximum benefit.
- If your spouse and/or child(re) are currently enrolled in this Plan and you wish to keep their existing benefit amounts, you may do so without having to provide evidence of insurability.
- During this annual enrollment period, if you previously declined to enroll your spouse and/or child(ren) in this Plan, you may elect to enroll them at this time for up to two (2) increment levels on your spouse and/or \$10,000 on your child(ren) without having to provide evidence of insurability.

Continued on next page.

LINCOLN FINANCIAL
VOLUNTARY LIFE PLAN - Continued
VOLUNTARY PLAN - 100% EMPLOYEE PAID



Note: the employee must participate in the Voluntary Life Insurance Plan in order for the spouse and/or child(ren) to participate.

Benefits will not be payable if your death or the death of your Dependent results from suicide while sane or insane, and occurs within two years after your Voluntary Life Insurance or Voluntary Life Insurance for the Dependent takes effect. If there is an increase to your or your Dependent's amount of Voluntary Life Insurance following the initial effective date of coverage, the one-year period will apply; but only for the increased amount of coverage.

This is just a summary of the benefits provided under this Voluntary Life Plan. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Insurer's Certificate of Coverage for this Plan.

***AN EMPLOYEE ONLY BENEFIT**

LINCOLN FINANCIAL
VOLUNTARY EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT PLAN*
VOLUNTARY PLAN - 100% EMPLOYEE PAID

VOLUNTARY EMPLOYEE AD&D INSURANCE BENEFIT:

If you elected to enroll in the Voluntary Life Plan, then you have the option to also elect a matching AD&D benefit.

- At age 65 your Life Insurance benefit will be reduced to 65%; and then at age 70, your benefit will be reduced to 50% of the original amount

If you suffer any of the following losses as a direct result of a covered accident and otherwise qualify, this policy will pay a benefit equal to the following percentage of the above AD&D Benefit:

- 100% Loss of Life
- 100% Loss of both feet, both hands, or the sight in both eyes resulting from the same accident
- 50% Loss of one hand, one foot or the sight in one eye

Additional ADD Benefits Provided Include:

- Common Carrier Accident Benefit - 2X Principal Sum
- Seat Belt Benefit - 10% additional benefit
- Air Bag Benefit - 10% additional benefit

NOTE: If you wish to include this Voluntary AD&D coverage with your Voluntary Life coverage, you will elect them together as one benefit election .

This is just a summary of the benefits provided under this Voluntary AD&D Plan. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Insurer's Certificate of Coverage for this Plan.

**LINCOLN FINANCIAL GROUP
LONG TERM DISABILITY PLAN
NON-CONTRIBUTORY PLAN**



Monthly Benefit: **60% of your pre-disability earnings**

- Maximum Monthly Benefit of \$6,000
- Minimum Monthly Benefit of \$50

Elimination Period: 90 days

Total Disability means: During the elimination period and the following twenty-four months (24), due to an injury or sickness, you are unable to perform each of the main duties of your own occupation; after 24 months, due to an injury or sickness, you are unable to perform each of the main duties of any occupation for which your training, education or experience will reasonably allow.

Maximum Benefit Duration Period: Later of a) the Maximum Benefit Duration Period shown below, or b) your Social Security Normal Retirement Age (SSNRA)

<i>Duration may be limited if disability is due to Specific Conditions*</i>	Age on Date of Disability	Maximum Benefit Duration Period
	Before age 60	SSNRA
	Age 60	60 Months
	Age 61	48 Months
	Age 62	42 Months
	Age 63	36 Months
	Age 64	30 Months
	Age 65	24 Months
	Age 66	21 Months
	Age 67	18 Months
	Age 68	15 Months
	Ages 69 & older	12 Months

***Specific Condition Limitations:** Disabilities due to mental sickness or substance abuse related conditions will limited to a benefit duration period of 24 months for any one period of disability; unless you are confined to a hospital.

Pre-existing Condition Exclusion Period: The Policy will not cover any Total or Partial Disability which is caused or contributed to by, or results from a Pre-Existing Condition; and which begins in the first 12 months after your Effective Date. "Pre-Existing Condition" means a Sickness or Injury for which you received treatment within 3 months prior to your Effective Date. "Treatment" means consultation, care or services provided by a Physician. It includes diagnostic measures and the prescription, refill of prescription, or taking of any prescribed drugs or medicines.



Waiver of Premium : No premiums are required when benefits are payable

Benefit Offset Provision: Benefits may be reduced by other sources of income and disability earnings, including but not limited to Social Security Disability Primary and Family Benefits.

- Additional Benefits Provided Include:**
- Return to Work Incentive Benefit
 - Benefits for Total or Partial Disability
 - Family Income Benefit equal to 3X the last gross Monthly Benefit before your death
 - Progressive Income Benefit increases your core benefit by 10% (up to a maximum of \$5000) if you suffer a serious cognitive impairment or the loss of two or more Activities of Daily Living (bathing, dressing, transferring, continence or eating)
 - Family Care Expense Benefit, reimbursement of eligible dependent care expenses up to a maximum of \$250 per dependent, per month, maximum of 12 months
 - **Employee Assistance Program – See page 32 of this Guide for more information**

Value-Added Service: This is just a summary of the benefits provided under the LTD Plan. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Certificate of Coverage for this Plan.

LINCOLN FINANCIAL GROUP
VOLUNTARY SHORT TERM DISABILITY PLAN
VOLUNTARY PLAN - 100% EMPLOYEE PAID

NEW BENEFIT PLAN!

Weekly Benefit: You may elect a weekly benefit amount between \$100 - \$1,000, in increments of \$50

- Not to exceed 60% of your basic weekly earnings

Maximum Weekly Benefit: \$1,000 per week

Minimum Weekly Benefit: \$50 per week

Benefits Begin:

- 15th day for disability due to an accidental injury
- 15th day of disability due to sickness/illness

Maximum Benefit Duration Period: 13 weeks



NOTE: No benefits will be paid for a period of disability which results from a Pre-existing Condition unless, on the date you become disabled, you have been actively at work for one full day after you have completed 6 months during which you were continuously insured under the STD Plan. A Pre-existing Condition means a sickness or injury for which you received treatment within 3 months prior to your coverage effective date. Treatment means consultation, care or services by a Physician. It includes diagnostic measures and the prescription, refill of prescription, or taking any prescribed drugs or medicines.

Benefit Offset Provision: Benefits may be reduced by other sources of income and disability earnings, including but not limited to

- Social Security Disability Primary and Family Benefits
- Sick Leave Pay*
- Salary Continuance*

*Offsets only when such pay plus the weekly disability benefit exceeds 100% of your pre-disability weekly earnings.

Coverage Type: This Plan provides benefits only for non-occupational related conditions

Conditions Related to Maternity: Disability due to maternity is treated the same as any other illness. Maternity in and of itself is not a disability, and this Plan does not provide a benefit during or after pregnancy unless you meet the definition of disability.

Additional Benefits Provided Include:

- Waiver of Premiums when disabled
- Benefits for Total or Partial Disability
- Rehabilitation Assistance Benefit - 5% of your basic weekly earnings
- Family Income Benefit - equal to 3 times your last weekly gross benefit
- Portability Option

Evidence of Insurability Requirements: Evidence of Insurability will not be required when you are electing coverage during this annual enrollment period.

ENROLLMENT OPPORTUNITY FOR YOU



During this open enrollment period you may elect this coverage up to the maximum under the Plan on a guaranteed issue basis. However, a pre-existing condition exclusion period will apply.

This is just a summary of the benefits provided under the Short Term Disability Plan. For a complete list of all contract/policy exclusions, limitations, benefits and benefit restrictions or waiting periods, please refer to the Certificate of Coverage for this Plan.

LINCOLN FINANCIAL GROUP VALUE-ADDED SERVICES

The following services are made available, at no additional cost, to all employees to whom we provide Basic Life/ADD and LTD benefits. These services are not part of the insurance policies issued on City of Tybee Island and can be changed or cancelled at any time.

ONLINE WILL PREP, GUIDANCE RESOURCES, IDENTITY THEFT RESOURCES & BENEFICIARY ASSISTANCE LIFEKEYSSM

When you choose life insurance, you're planning for your family's future – assuring their comfort and securing their plans. With Lincoln Financial Group, you can also access services that make a real difference now as well as in the future. LifeKeys services, included at no additional cost with all Lincoln Term Life and Accidental Death and Dismemberment Insurance policies, provide assistance to you, your family and your beneficiaries.

EstateGuidance[®] Will Preparation

Create your will online – easily and economically. Follow a step-by-step guide through the entire process, and then use online instructions to execute your will.

GuidanceResources[®] Online

GuidanceResources[®] Online is the place to go for articles, tutorials, streaming videos and “Ask the Expert” personal responses on topics such as laws & regulations, health & wellness, work & education, leisure & home, money & investments, etc.

Identity Theft Resources

Identity theft is one of the fastest-growing crimes in the U.S. Be sure you have the information you need to recognize and prevent it. Our online resource helps you spot the warning signs, take steps to protect your cell phone, computer and tax records from fraud, lessen the damage and repair your credit if identity theft occurs.

Beneficiary Assistance

If you develop a terminal illness and access your Accelerated Death Benefit under the life insurance plan, your beneficiaries will be able to use the beneficiary services through LifeKeysSM. Services are available for up to one year after a loss, and include a combination totaling six in-person sessions for grief counseling, or legal or financial information and unlimited phone counseling.

To access LifeKeysSM services, call 1-855-891-3684 or visit www.GuidanceResources.com (Web ID = LifeKeys)

EMPLOYEE ASSISTANCE PROGRAM (EAP)

EmployeeConnectSM

WHEN HELP IS NEEDED FOR LIFE'S CHALLENGES

EmployeeConnectSM offers our employees and their immediate family members professional and confidential counseling for personal matters. EmployeeConnectSM is included at no charge with Lincoln's Long Term Disability Plan, but you do not have to be on a disability claim in order to access help through this EAP. EmployeeConnectSM services are provided by ComPsych Corporation.

The EAP offers assistance with day-to-day issues and is available for:

- Toll-free phone and web access 24/7
- Up to four* in-person sessions, per person, per issue, per year
- Unlimited phone access to legal, financial and work-life services
- Financial consultations and referrals
- Consultations with a network attorney
- Work-life services for assistance with child care, finding movers, kennels and pet care, vacation planning, and more

*In California, up to three sessions in six months, starting with initial contact by employee.

To learn more about the EmployeeConnectSM program, visit www.Lincoln4Benefits.com or www.guidanceresources.com
User name: LFGsupport Password: LFGsupport1, or call 1-888-628-4824

LINCOLN FINANCIAL GROUP

VALUE-ADDED SERVICES - continued

TRAVEL ASSISTANCE PROGRAM

TravelConnectSM

As a value-added benefit on Lincoln's group life insurance contracts, the TravelConnectSM program offers a wealth of travel, medical and safety-related services to our employees and their family members. Whether traveling for business or leisure, any time a covered individual is more than 100 miles from home, TravelConnectSM services are available 24 hours a day, seven days a week.

The services can be as simple as getting the weather forecast for a travel destination or as complex as an emergency evacuation from halfway around the world. TravelConnectSM services are just a toll-free phone call away. Employees are provided with a valuable benefit they can enjoy when traveling or planning a trip. With many domestic and international business travelers, travel assistance is a popular employee benefit.

A sampling of their services includes:

Medical evacuation. If a traveler is injured or ill, the program will arrange and pay for a supervised medical evacuation to the nearest healthcare facility if adequate care is not available locally.

Family member transportation. If a traveler is alone and hospitalized for more than seven days, the program will arrange and pay for a family member to be with them.

Child transportation. If a dependent child is left unattended because of a medical emergency, the program will arrange and pay for their return home. This includes employing a qualified escort if necessary.

Transportation after stabilization. Once stabilized after an emergency medical evacuation, the program will arrange and pay for a traveler's return to their point of origin or home country.

Repatriation. If a traveler passes away, the plan will pay to have the body returned home.

They also provide these services:

- Destination information. Provide up-to-date information about weather, currency, local culture and more
- Money transfers. Arrange transfer of funds
- Medical and dental referrals
- Legal referrals. Find an attorney and assist with bail bonds
- Emergency messages. Send emergency messages for traveler
- Security and political evacuation assistance
- Emergency travel arrangements. Coordinate new travel plans if traveler is ill or injured
- Lost or stolen travel documents. Arrange replacement passports, tickets and other travel documentation
- Translation services. Provide translation services or refer to a local translator
- Emergency pet services. Arrange for a pet's boarding or return home during a traveler's medical emergency
- Arrange for the delivery of medications

The travel assistance services are subject to specific terms, conditions and limitations. A full program description is available at www.Lincoln4Benefits.com. To use TravelConnectSM services, call UnitedHealthcare Global at 1-800-527-0218 or 410-453-6330, and provide them with the Group Name: Lincoln Financial Group and the ID number 322541.

For a copy of your Travel Assistance brochure and wallet ID card, contact Lee Ann Sharpton at 770-635-2762 or via email at lasharpton@midsoouthbenefits.net

PREMIUM INFORMATION

Voluntary Employee Life Plan

If enrolled, you pay 100% of the cost to participate in this Plan. Your cost will be based on a premium rate determined by your age and by 24 payroll deductions. Divide your elected benefit amount by 1000, determine whether you will include or exclude the voluntary AD&D option and multiply by the rate applicable based on your age and the appropriate table below:

Voluntary Employee Life without matching Voluntary AD&D		SAMPLE BENEFIT AMOUNTS AND PREMIUMS BASED ON 24 PAYROLL DEDUCTIONS					
Employee's Age	Rates Per \$1,000 of Coverage	\$10,000	\$20,000	\$50,000	\$80,000	\$100,000	\$150,000
< 25 years	\$0.040	\$0.40	\$0.80	\$2.00	\$3.20	\$4.00	\$6.00
25-29 years	\$0.040	\$0.40	\$0.80	\$2.00	\$3.20	\$4.00	\$6.00
30-34 years	\$0.040	\$0.40	\$0.80	\$2.00	\$3.20	\$4.00	\$6.00
35-39 years	\$0.050	\$0.50	\$1.00	\$2.50	\$4.00	\$5.00	\$7.50
40-44 years	\$0.085	\$0.85	\$1.70	\$4.25	\$6.80	\$8.50	\$12.75
45-49 years	\$0.130	\$1.30	\$2.60	\$6.50	\$10.40	\$13.00	\$19.50
50-54 years	\$0.200	\$2.00	\$4.00	\$10.00	\$16.00	\$20.00	\$30.00
55-59 years	\$0.325	\$3.25	\$6.50	\$16.25	\$26.00	\$32.50	\$48.75
60-64 years	\$0.470	\$4.70	\$9.40	\$23.50	\$37.60	\$47.00	\$70.50
65-69 years	\$0.820	\$8.20	\$16.40	\$41.00	\$65.60	\$82.00	\$123.00
70-74 years	\$1.820	\$18.20	\$36.40	\$91.00	\$145.60	\$182.00	\$273.00
75+ years	\$2.955	\$29.55	\$59.10	\$147.75	\$236.40	\$295.50	\$443.25

Voluntary Employee Life with matching Voluntary AD&D		SAMPLE BENEFIT AMOUNTS AND PREMIUMS BASED ON 24 PAYROLL DEDUCTIONS					
Employee's Age	Rates Per \$1,000 of Coverage	\$10,000	\$20,000	\$50,000	\$80,000	\$100,000	\$150,000
< 25 years	\$0.053	\$0.53	\$1.05	\$2.63	\$4.20	\$5.25	\$7.88
25-29 years	\$0.053	\$0.53	\$1.05	\$2.63	\$4.20	\$5.25	\$7.88
30-34 years	\$0.053	\$0.53	\$1.05	\$2.63	\$4.20	\$5.25	\$7.88
35-39 years	\$0.063	\$0.63	\$1.25	\$3.13	\$5.00	\$6.25	\$9.38
40-44 years	\$0.098	\$0.98	\$1.95	\$4.88	\$7.80	\$9.75	\$14.63
45-49 years	\$0.143	\$1.43	\$2.85	\$7.13	\$11.40	\$14.25	\$21.38
50-54 years	\$0.213	\$2.13	\$4.25	\$10.63	\$17.00	\$21.25	\$31.88
55-59 years	\$0.338	\$3.38	\$6.75	\$16.88	\$27.00	\$33.75	\$50.63
60-64 years	\$0.483	\$4.83	\$9.65	\$24.13	\$38.60	\$48.25	\$72.38
65-69 years	\$0.833	\$8.33	\$16.65	\$41.63	\$66.60	\$83.25	\$124.88
70-74 years	\$1.833	\$18.33	\$36.65	\$91.63	\$146.60	\$183.25	\$274.88
75+ years	\$2.968	\$29.68	\$59.35	\$148.38	\$237.40	\$296.75	\$445.13

Continued on next page

PREMIUM INFORMATION - Continued

- **Voluntary Spouse Life Plan**

If enrolled, you pay 100% of the cost to participate in this Plan. You must also be participating in the Voluntary Employee Life for your spouse to participate. Your spouse's cost will be based on a premium rate determined by your age (not your spouse's age), and by 24 payroll deductions. Divide your spouse's elected benefit amount by 1000, and multiply by the rate applicable based on your age.

**SAMPLE BENEFIT AMOUNTS AND PREMIUMS
BASED ON 24 PAYROLL DEDUCTIONS**

Employee's Age	Rates Per \$1,000 of Coverage	\$10,000	\$20,000	\$50,000	\$80,000	\$100,000	\$150,000
< 25 years	\$0.040	\$0.40	\$0.80	\$2.00	\$3.20	\$4.00	\$6.00
25-29 years	\$0.040	\$0.40	\$0.80	\$2.00	\$3.20	\$4.00	\$6.00
30-34 years	\$0.040	\$0.40	\$0.80	\$2.00	\$3.20	\$4.00	\$6.00
35-39 years	\$0.050	\$0.50	\$1.00	\$2.50	\$4.00	\$5.00	\$7.50
40-44 years	\$0.085	\$0.85	\$1.70	\$4.25	\$6.80	\$8.50	\$12.75
45-49 years	\$0.130	\$1.30	\$2.60	\$6.50	\$10.40	\$13.00	\$19.50
50-54 years	\$0.200	\$2.00	\$4.00	\$10.00	\$16.00	\$20.00	\$30.00
55-59 years	\$0.325	\$3.25	\$6.50	\$16.25	\$26.00	\$32.50	\$48.75
60-64 years	\$0.470	\$4.70	\$9.40	\$23.50	\$37.60	\$47.00	\$70.50
65-69 years	\$0.820	\$8.20	\$16.40	\$41.00	\$65.60	\$82.00	\$123.00
70-74 years	\$1.820	\$18.20	\$36.40	\$91.00	\$145.60	\$182.00	\$273.00
75+ years	\$2.955	\$29.55	\$59.10	\$147.75	\$236.40	\$295.50	\$443.25

- **Voluntary Child Life Plan**

If enrolled, you pay 100% of the cost to participate in this Plan. You must also be participating in the Voluntary Employee Life for your child(ren) to participate.

Dependent Child(ren) Rate based on 24 payroll deductions is \$1.00 per family unit; this covers the cost for \$10,000 of coverage on each eligible child, regardless of the number of children.

- **Long Term Disability Plan**

City of Tybee Island pays 100% of the cost for your enrollment in this plan.

- **Basic Life and AD&D Plan**

City of Tybee Island pays 100% of the cost for your enrollment in this plan.

Continued on next page

PREMIUM INFORMATION - Continued

- **Voluntary Short Term Disability Plan**

If enrolled, you pay 100% of the cost to participate in this Plan. Your cost will be based on a premium rate determined by your age and based on 24 payroll deductions. Divide your elected weekly benefit amount by 10, and multiply by the rate applicable based on your age.

**SAMPLE WEEKLY BENEFIT AMOUNT AND PREMIUMS
BASED ON 24 PAYROLL DEDUCTIONS**

Employee's Age	Rates Per \$10 of Weekly Benefit	\$100	\$200	\$400	\$600	\$800	\$1,000
< 25 years	\$0.240	\$2.40	\$4.80	\$9.60	\$14.40	\$19.20	\$8.40
25-29 years	\$0.240	\$2.40	\$4.80	\$9.60	\$14.40	\$19.20	\$8.40
30-34 years	\$0.235	\$2.35	\$4.70	\$9.40	\$14.10	\$18.80	\$8.23
35-39 years	\$0.230	\$2.30	\$4.60	\$9.20	\$13.80	\$18.40	\$8.05
40-44 years	\$0.235	\$2.35	\$4.70	\$9.40	\$14.10	\$18.80	\$8.23
45-49 years	\$0.265	\$2.65	\$5.30	\$10.60	\$15.90	\$21.20	\$9.28
50-54 years	\$0.310	\$3.10	\$6.20	\$12.40	\$18.60	\$24.80	\$10.85
55-59 years	\$0.400	\$4.00	\$8.00	\$16.00	\$24.00	\$32.00	\$14.00
60-64 years	\$0.490	\$4.90	\$9.80	\$19.60	\$29.40	\$39.20	\$17.15
65-69 years	\$0.555	\$5.55	\$11.10	\$22.20	\$33.30	\$44.40	\$19.43
70+ years	\$0.665	\$6.65	\$13.30	\$26.60	\$39.90	\$53.20	\$23.28

- **Medical Plan - OAP5 2K/0 6.6K A**

If you are enrolled in this plan, the City of Tybee Island contributes 100% of the cost for employee only coverage, approximately 79% of the cost for employee & spouse or employee & child(ren) coverage and 70% of the cost for family coverage. You are responsible for the remaining balances. Shown below are the total monthly premiums and your cost based on 24 payroll deductions and on coverage type:

<u>Coverage Type</u>	<u>Total Monthly Premium</u>	<u>Your Cost Per 24 Deductions</u>
Employee Only	\$494.53	\$0
Employee & Spouse	\$1,038.52	\$109.33
Employee & Child(ren)	\$964.34	\$101.52
Employee, Spouse & Child(ren)	\$1,508.32	\$226.83

- **Dental Base (Low) Option Plan**

If you are enrolled in this plan, the City of Tybee Island contributes 100% of the cost for employee only coverage. If you have elected to cover your spouse and/or child(ren), you are responsible for the additional cost. Shown below are the total monthly premiums and your cost based on 24 payroll deductions and on coverage type:

<u>Coverage Type</u>	<u>Total Monthly Premium</u>	<u>Your Cost Per 24 Deductions</u>
Employee Only	\$26.21	\$0
Employee & Spouse	\$54.66	\$14.23
Employee & Child(ren)	\$58.53	\$16.16
Employee, Spouse & Child(ren)	\$93.16	\$33.48

Continued on next page

PREMIUM INFORMATION - Continued

▪ Dental Buy Up (High) Option Plan

If you are enrolled in this plan, the City of Tybee Island contributions 100% of the cost for employee only coverage applicable under the Dental Base (Low) Option Plan. You are responsible for the balance. In addition, if you have elected to cover your spouse and/or child(ren), you are responsible for their additional cost. Shown below are the total monthly premiums and your cost based on 24 payroll deductions and on coverage type:

<u>Coverage Type</u>	<u>Total Monthly Premium</u>	<u>Your Cost Per 24 Deductions</u>
Employee Only	\$28.43	\$1.11
Employee & Spouse	\$59.24	\$16.52
Employee & Child(ren)	\$71.82	\$22.81
Employee, Spouse & Child(ren)	\$110.69	\$42.24

▪ Vision VSP Plan

If enrolled, you pay 100% of the cost to participate in this Plan. Shown below are the total monthly premiums and your cost based on 24 payroll deductions and on coverage type:

<u>Coverage Type</u>	<u>Total Monthly Premium</u>	<u>Your Cost Per 24 Deductions</u>
Employee Only	\$8.10	\$4.05
Employee & Spouse	\$16.21	\$8.11
Employee & Child(ren)	\$14.15	\$7.08
Employee, Spouse & Child(ren)	\$22.25	\$11.13

▪ Vision EyeMed Plan

If enrolled, you pay 100% of the cost to participate in this Plan. Shown below are the total monthly premiums and your cost based on 24 payroll deductions and on coverage type:

<u>Coverage Type</u>	<u>Total Monthly Premium</u>	<u>Your Cost Per 24 Deductions</u>
Employee Only	\$8.10	\$4.05
Employee & Spouse	\$16.21	\$8.11
Employee & Child(ren)	\$14.15	\$7.08
Employee, Spouse & Child(ren)	\$22.25	\$11.13

▪ Vision Perfect Plan

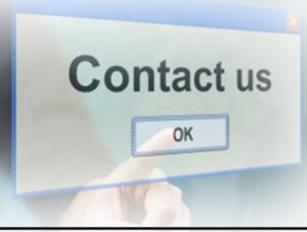
If enrolled, you pay 100% of the cost to participate in this Plan. Shown below are the total monthly premiums and your cost based on 24 payroll deductions and on coverage type:

<u>Coverage Type</u>	<u>Total Monthly Premium</u>	<u>Your Cost Per 24 Deductions</u>
Employee Only	\$5.85	\$2.93
Employee & Spouse	\$11.69	\$5.85
Employee & Child(ren)	\$10.21	\$5.11
Employee, Spouse & Child(ren)	\$16.05	\$8.03



If you do not wish to have your insurance premiums deducted on a pre-tax basis, you must submit a written request to our Plan Administrator prior to the start of each Plan Year. The Plan Administrator will provide you with the appropriate document /form for submitting such a request.

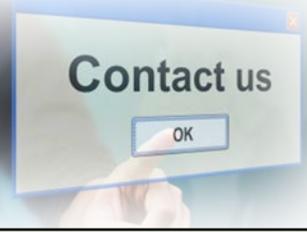
CONTACT INFORMATION - FOR ASSISTANCE



City of Tybee Island	Our Plan Administrator	Janice Elliott, Human Resources Manager Janice can be reached at jelliott@cityoftybee.org or via phone at 912-472-5029 City of Tybee Island 403 Butler Avenue Tybee Island, GA 31328
Medical Plan	Insurer/Provider Customer Service Website To locate a Provider in the medical network	BLUE CROSS BLUE SHIELD OF GEORGIA For questions regarding your eligibility, benefits, claims, or to request a new ID Card, call 1-855-397-9267. To check the status of a claim online, visit www.BCBSGA.com To determine the RX Tier Level for a particular drug, visit www.anthem.com/pharmacyinformation/ Call 1-855-397-9267 or visit www.bcbsga.com Your plans use the <i>Blue Open Access POS Network</i>
Vision Plans	Insurer/Provider Customer Service Vision Network Name Insurer/Provider Customer Service Vision Network Name Insurer/Provider Customer Service To locate a Vision Network Provider under the VSP Plan or EyeMed Plan	AMERITAS - EYEMED PLAN For questions regarding your vision benefits, file or check on a claim, or request an ID card, call EyeMed at 1-888-581-3648, or visit www.eyemed.com <i>Access Network</i> AMERITAS - VSP PLAN For questions regarding your vision benefits, file or check on a claim, or request an ID card, call VSP at 1- 800-877-7195, or visit www.vsp.com <i>VSP Signature Network</i> AMERITAS - VISION PERFECT PLAN For questions regarding your vision benefits, file or check on a claim, or request an ID card, call Ameritas at 1-800-487-5553 or visit www.ameritas.com Call the Customer Service listed for each Plan above or visit the Ameritas website at http://www.ameritas.com/wps/portal/corp?1dmy&current=true&urile=wcm:path:/group/providers/find-a-provider This is the easiest entry point into locating a provider for all of the plan options (VSP Signature, EyeMed Access).
Dental Plans	Insurer/Provider Customer Service To locate a Network Provider	METLIFE For general questions regarding your benefits or a claim, call 1-800-275-4638. If you want to print an ID card or check a claim status online, register online at www.metlife.com/mybenefits Call 1-800-275-4638 or visit www.metlife.com/mybenefits Your plan uses the <i>PDP Dental Network</i>

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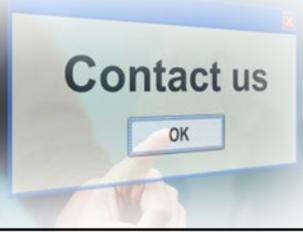
CONTACT INFORMATION - FOR ASSISTANCE - Continued



<p>Life, AD&D and Disability Plans</p>	<p>Insurer/Provider Customer Service</p>	<p>LINCOLN FINANCIAL For general questions regarding your benefits call 1-800-423-2765 or send an email to clientservices@LFG.com. For questions on how to submit a claim or check on the status of a claim, call 1-800-423-2765 or send an email to claims@LFG.com. You may submit a disability claim to disabilityclaims@LFG.com.</p>
<p>LifeKeysSM EstateGuidance[®] GuidanceResources[®] ID Theft Resources & Beneficiary Services</p>	<p>Administrator Customer Service</p>	<p>LINCOLN FINANCIAL GROUP To access LifeKeysSM services, call 1-855-891-3684 or visit www.GuidanceResources.com (Web ID = LifeKeys)</p>
<p>TravelConnectSM Travel Assistance Program</p>	<p>Administrator Account Information Customer Service</p>	<p>LINCOLN FINANCIAL GROUP & UNITEDHEALTHCARE GLOBAL To access services, use the group name: Lincoln Financial Group and ID # 322541 Call 410-453-6330 or, within the U.S., call 1-800-527-0218 or visit www.jpfic.com</p>
<p>EmployeeConnectSM Employee Assistance Program</p>	<p>Administrator Customer Service</p>	<p>LINCOLN FINANCIAL GROUP & COMPSYCH CORPORATION Visit www.Lincoln4Benefits.com or www.guidanceresources.com User name: LFGsupport Password: LFGsupport, or call 1-888-628-4824</p>
<p>COBRA Administrator</p>	<p>Insurer/Provider Customer Service</p>	<p>BLUE CROSS BLUE SHIELD OF GEORGIA For questions call 1-866-800-2272 or send an email to Cobraservices@benefitadminsolutions.com</p>
<p>All the Above Benefit Plans</p>	<p>Benefits Broker Customer Service</p> 	<p>MIDSOUTH BENEFITS Should you need assistance and are unable to get a satisfactory response by going directly to the Insurers or Providers listed above, please feel free to contact our Account Managers with Midsouth Benefits at 770-579-7099 or 1-844-624-9805. They are Lee Ann Sharpton, lasharpton@midsouthbenefits.net and Meg Marland, mmarland@midsouthbenefits.net</p>
<p>Employees may also reach out to us for assistance through the Midsouth Benefits website at www.midsouthbenefits.net, look for the link that says <i>EMPLOYEE ASSISTANCE</i>. Any information sent to us through <i>EMPLOYEE ASSISTANCE</i> will be sent through a secure link.</p>		

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CONTACT INFORMATION - FOR ASSISTANCE - Continued



Employee Assistance Services	Administrator Customer Service	LIFESTYLE MANAGEMENT RESOURCES John Capachione 912-429-2596 912-353-0004 (24 hour support)
SUPPLEMENTAL INSURANCES		
Colonial	Administrator	Carie Chaney 912-352-9683 Ext. 103 912-844-0068 (cell) Carie.chaney@coloniallife.com
AFLAC	Administrator	Whitney Millwood 912-201-1123 478-747-1589 (cell) Whitney_millwood@us.aflac.com
Liberty National	Administrator	Brian Cannington 912-283-2252 912-337-3370 (cell) bm404@libnat.com
SUPPLEMENTAL RETIREMENT (457B PLANS)		
Nationwide	Administrator	Jennifer Disrud 912-312-5918 disrudj@nationwide.com
	Customer Service Website	1-877-677-3678 www.nrsforu.com
MetLife	Administrator	Scott Turner 1-877-300-6246 Ext 3894 404-704-3894 sturner1@metlife.com
	Customer Service Website	1-800-543-2520 www.mlr.metlife.com
OTHER CONTACTS		
Boston Mutual		Kim Belknap Carpenter-belknap@comcast.net 501-225-8602
Georgia Municipal Employee Benefit System		Steve Durden sdurden@gmanet.com 1-888-488-4462
Georgia's Own Credit Union		Stephen Bell sjbell@georgiasown.org 912-352-0357 Ext 7205
LegalShield		Ron Harrell ronharrell@live.com 912-414-7570
SunTrust Bank		Barbara (Barb) Young barbarayoung@suntrust.com 912-898-3123
TASC		Customer Service www.tasconline.com 1-800-422-4661

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1- 866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 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/ Phone: 1-800-869-1150 - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
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.flmedicaidtprecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
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://www.lahipp.dhh.louisiana.gov 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/ofc/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.dpw.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: www.ohhs.ri.gov Phone: 401-462-5300
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: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhr.wv.gov/bms/ 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: 1-866-435-8427	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: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

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

The information in this Enrollment Benefits Guide is intended to only provide you with a brief overview of each benefit plan. Please consult each Insurer's Certificate of Coverage for the complete details on benefits, covered charges, limitations, and exclusions that may apply. The information in this document is not binding. If there are any discrepancies between the information in this Enrollment Benefits Guide and the Insurer's Certificate of Coverage, the Insurer's Certificate of Coverage will prevail and govern how the benefits are provided and administered.

Prepared By:



Midsouth
BENEFITS

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