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2015 Annual Enrollment * www.annistonal.gov

INTRODUCTION

The City Of Anniston is proud to offer a comprehensive and competitive benefits program designed to meet the diverse needs of our employees. We review the benefits program each year to ensure that it complies with federal requirements and offers a benefits package which meets our overall benefit objectives of providing quality benefits to you and your family members. When considering your options for 2015, look at all your options, paying the tax penalty for no coverage, selecting coverage through your spouse/domestic partner, parent, Medicaid, Medicare, TRICARE, selecting a plan through the federal or state marketplace, or choosing a company plan. Compare each for coverage and cost. This guide includes an overview of the benefits and programs that are available to you.

Our Benefits Package:

The City of Anniston cares about the financial well-being and health of all its employees and their families. For that reason, we have designed an Employee Benefit Plan to protect each of you against the financial disaster and hardship that could be brought about by premature death, disability, sickness, or accidental injury.

Offerings for 2015 Include:

- Medical
- Dental
- Vision
- Flexible Spending – Health Care
- Life & AD&D
- Voluntary Short Term
- Voluntary Long Term Disability
- Worksite Benefits

Please see inside for more plan specifics concerning each of these benefit programs.

Enrollment:

The City of Anniston wants our employees to take advantage of the benefits we offer. You can enroll as a new associate or on a yearly basis during annual enrollment. Any elections are considered final and cannot be changed unless there is a change in status as discussed in the "Change in Status" section of this guide.

1) Selecting a Plan: The goal of the City's medical program is to consistently deliver quality medical care that is flexible, affordable and responsive to the varying needs of our employees.

2) Considerations: Choosing to participate in a medical plan is really a matter of balance between coverage and cost. In order to make the best decision for you and your family it is important to consider:

   - Frequency of Use: How frequently you currently use healthcare services and what care you and your dependents may require in the coming year.
   - History: Your health history and that of your dependents.
   - Payroll Deduction: How much will be deducted from your pay.
   - Copays/Coinsurances: The amount you are expected to pay for out-of-pocket medical expenses at the time of service.
   - Deductibles: The amount you pay out-of-pocket each year before the plan begins to pay benefits.

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Enrolling in Benefits

All regular, full-time employees working a minimum of 30 hours per week are eligible to participate in the Benefit Plans. You may cover your eligible dependent children to age 26 regardless of full-time student status on the medical, dental and vision plans.

Company paid benefits:

- Vision - Employee Only
- Basic Life & Accidental Death & Dismemberment

Benefits that can be selected as a new hire or during the annual open enrollment period:

- Medical /Dental
- Flexible Spending Accounts (Health Care)
- Vision (Family coverage option available)
- Voluntary Short Term Disability (Subject to Evidence of Insurability)
- Voluntary Long Term Disability (Subject to Evidence of Insurability)
- Voluntary Worksite Benefits

Dependent coverage is available. See inside for more details.

New Hire Benefits Waiting Period:

- All full-time employees will become eligible to participate in benefits upon the first day of the month following date of hire.

Dependent Coverage:

Eligible dependents are defined as a lawful spouse (married or common law) and/or child(ren). "Child(ren)" include but are not limited to, natural child(ren), legally adopted child(ren), child(ren) for whom the employee is a court-appointed legal guardian, foster child(ren, and/or stepchild(ren) who permanently resides with the employee. Benefits for a dependent child(ren) will continue until the last day of the calendar month in which the limiting age is reached.

NOTE: When adding a lawful spouse, you must provide either a marriage certificate or any two of the additional documents listed below. Acceptable documents include:

- Income tax records showing married filing a joint return
- Utility bill indicating both names at the same address
- Joint bank statement indicating both names at the same address

Open Enrollment Period:

- Each year, employees of The City Of Anniston are given the opportunity to make benefit election changes. There are no restrictions for making election changes during open enrollment. Any eligible employee may add or drop dependents, add or drop coverage, or change current levels of coverage.

CHANGE IN STATUS (Qualifying Event)

General Rule

Unless one of the qualifying events summarized below applies, pre-tax benefit elections cannot be changed until next year's open enrollment.

If any of the qualifying events specified below occur, you may make a change to your current elections. Each of the following events constitutes a Change in Status (Qualifying Event):

- A change in your legal marital status (such as marriage, divorce, or death of spouse);
- A change in the number of dependents (such as birth, adoption of a child, or death of a dependent);
- A change in your or your spouse's employment status, (including commencement or termination of employment, a leave of absence, or a change from full-time to part-time status, and vice-versa);
- Your dependent satisfying or ceasing to satisfy an eligibility requirement for coverage as a dependent;
- Change of address that limits or restricts network access;
- Loss of other coverage;
- As a benefits eligible employee, you or your dependent has lost coverage under Medicaid or a state child health plan and requests coverage under the group health plan within 60 days of the loss of coverage *; or
- As a benefits eligible employee, you or your dependent has become eligible for a premium assistance subsidy under the group health plan through Medicaid or a state child health plan and requests coverage under the group health plan within 60 days of becoming eligible for assistance. *

* NOTE: The last two qualifying events were added with the April 2009 enactment of the Children's Health Insurance Program Reauthorization Act (CHIPRA).

A change in election is permitted only if it corresponds with the Change in Status that affects eligibility for coverage under a benefit Plan. For example, a change in residence will only entitle an individual to a change in election if, as a result of the change in residency, an affected individual is no longer eligible for a benefit that they were previously enrolled in.

If you experience a Change in Status/Qualifying Event and wish to make changes to your current elections, you must notify The City's benefit representative in writing within 31 days of the Change in Status.

SECTION 125: PRE-TAX SAVINGS

The City provides you the opportunity to pay your contributions for medical coverage with pre-tax dollars through the Section 125 Premium Only Plan.

A section 125 plan allows The City the ability to offer the option to purchase insurance with pretax dollars. The rules contained in section 125 of the Internal Revenue Code make this possible. (A section 125 plan is also commonly referred to as a premium plan only or a cafeteria plan.)

Participation: The City automatically enrolls everyone in this benefit. Should you decide not to participate in this benefit, the employee is responsible for notifying The City's benefit representative in writing.

The next page is a summary of the Medical benefits. Please review this information carefully so that you can make the choice that best suits the needs for you and your family.

Dependent Eligibility

All benefit eligible employees may elect medical plan coverage for themselves and their eligible dependents. Your eligible dependents are defined as your lawful spouse (marriage or common law) and child(ren). Your child(ren) are considered to be a dependent if they are less than 26 years old regardless of students status, tax dependent status, or marital status. *Please reference page 1 for details concerning lawful spouse enrollment.*

Blue Cross Blue Shield of Alabama

Please review the medical carrier website (www.BCBSAL.com) for information on doctors in your network. In-network hospitals, physicians and other health care providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing health care services at a reduced fee.

Medical Plan Highlights

Our medical plan gives you access to an extensive network of providers. For the most current provider listing, access the website at: www.BCBSAL.com

Our medical plan provides preventive care services to the employee and all covered dependents. Below are a few examples of these covered benefits:

- Physicals
- Child immunizations
- Mammograms
- Preferred Dentist Care

For more details and to manage your plan go to www.BCBSAL.com to register yourself and your dependents. It is here that you will be able to:

- Manage health care expenses. With just one search, individuals can:
  - Sort and compare capabilities to explore possible causes of a specific symptom or condition and get treatment options.
  - Learn how doctors compare in terms of quality of and efficiency.
  - Find estimated cost information on over 400 procedures and services, including inpatient, doctor, diagnostic, imaging and pharmacy costs.
  - Learn how to prepare for a doctors visit, with suggestions for questions to ask.

NOTES:

- **Retirees are eligible to retain health insurance if they meet the requirements specified.**
- **When adding a lawful spouse, you must provide either a marriage certificate or any two of the additional documents listed below. Acceptable documents are:**

- **Income tax records showing married filing a joint return**
- **Utility bill indicating both names at the same address**
- **Joint bank statement indicating both names at the same address.**

This is a summary of benefits only. Please refer to the plan summary and SPD for benefit details.

Summary of Medical Benefits

Benefit		Blue Cross Blue Shield of Alabama PPO In-network	Blue Cross Blue Shield of Alabama PPO Out-of-network
Deductibles and Maximums			
Annual Deductible	*Individual*	$200	$200
	Family	$600	$600
Admission Deductible	*Individual*	$300	$600
Coinsurance			
	You Pay	0%	20%
	Plan Pays	100%	80%
Annual Out-of-Pocket Maximum *(Deductible Included)*	*Individual*	$1,000	
Physician Office Visits			
	Primary Care Physician	$30 copay	Deductible + 20%
	Specialty Care	$40 copay	Deductible + 20%
Inpatient Care		$75 per day hospital copay days 3-6 + $300 Admission Deductible	20% + Admission Deductible
Outpatient Surgery *(In AL out-of-network Facility not covered)		$150 copay	*Facility – 20% + Annual Deductible Provider – 50% + Annual Deductible
Emergency Room (In AL out-of-network Facility not covered)		$150 copay	20% + Annual Deductible
Prescription Drugs			
Retail Pharmacy			
	Tier 1 – (Generic)	15% copay per script $10 minimum and $100 maximum	Not Covered
	Tier 2 – (Brand Preferred)	25% copay per script $30 minimum or $100 maximum	
	Tier 3 – (Brand Non-Preferred)	35% copay per script $50 minimum or $100 maximum	
	Tier 4 – (Specialty)	35% copay per script $50 minimum or $100 maximum	
Mail Order Pharmacy – Up to 90 days supply			
	Tier 1 – (Generic)	15% copay per script $20 minimum or $100 maximum	Not Covered
	Tier 2 & Tier 3 – (Brand Preferred)	25% copay per script $60 minimum or $100 maximum	
	Tier 4 – (Specialty)	$100 copay per prescription	

Medical Deductions	Bi-Weekly Employee Cost No deductions will be taken for 3rd payroll in a month
Employee Only	$64.50
Family	$122.00

Pharmacy Benefit Program

The following is a summary of your Pharmacy / Prescription benefits. Blue Cross Blue Shield of Alabama has a very comprehensive nationwide retail network with approximately 60,000 pharmacies. This represents approximately 90% of all pharmacies in the United States. Most national pharmacy, grocery and pharmacy chains participate in our Plan as well as many regional and dependent pharmacies.

Pharmacy Benefit Program

All prescription drugs for the plan are divided into three groups. Generic, Brand Preferred, and Brand Non-Preferred. The group your prescription falls into will determine your copayment. Generic substitutions are mandatory when available.

You can obtain information on Plan benefits, locate a participating pharmacy, and access drug information by visiting the Prescription Drug Guide at www.bcbsal.com/pharmacy website or by calling 1-800-292-8868 for more assistance.

Mail Order Program

If you take maintenance drugs that are required on an ongoing basis, we recommend that you have them refilled through the mail order program. Using the mail order program can save both you and the Plan. Those savings are passed to you through lower copays for a greater quantity of medication. You also have the added convenience of timely delivery to your home. All mail order prescriptions are filled by registered pharmacists and are processed and shipped via UPS or US Mail.

Ordering and refill procedures are easy to follow through your choice of internet access or toll-free telephone assistance. To access online mail order service, visit www.bcbsal.com/pharmacy or call 1-877-579-7627 to get started with ordering your home delivery prescription.

Helpful Hints:

- When starting a new mail order prescription, remember that processing and delivery time may take up to ten days. You may want to ask your doctor to write two prescriptions – one for a one-month supply to fill retail and one for a three-month supply with refills for mail order.
- Remember, you will need your BCBSAL ID number (listed on your ID card), medication, doctor's name and your credit card information when submitting your request.

Mail Order Notes:

- PrimeMail services this BCBSAL PPO prescription program.
- Prior authorization will be required for specific drugs.

This is a summary of benefits only. Please refer to the plan summary and SPD for benefit details.

Dental Plan

Our dental plan includes benefits for preventive and basic care. If you choose to receive treatment from a non-network provider, it could result in increased expense and balance billing. Your out of pocket expenses will be reduced when using an in-network provider. For your convenience, In-network benefits are listed below.

Summary of Dental Benefits

Benefit	Blue Cross Blue Shield of Alabama *Dental Plan* In-network
Deductibles and Maximums Deductibles and Out-of-Pocket Maximums run on a Calendar Year	
Annual Deductible – Maximum 3 deductibles per family each calendar year *(Restorative Services Only)*	
Individual	$25
Annual Benefit Maximum – Applies only to members age 19 & over	
Per Person	$1,000
Diagnostic & Preventive Services *(Exams, X-rays, Cleanings, along with Sealants, Fluoride and Space Maintainers for Children)*	
You Pay	0%
Plan Pays	100%
Restorative & Supplemental Services – These services are subject to the deductible *(Fillings, Extractions, Root Canal Treatment, Most Oral Surgeries, Pain Management, General Anesthesia)*	
You Pay	0%
Plan Pays	100% After Deductible

This benefit is included as part of the BCBSAL Medical plan. Participation in the Medical benefit is required to allow utilization of these dental services.

Dental Plan Highlights:

- **Network: BCBSAL**

To locate a network dentist, visit www.bcbsal.com and click on "Find A Doctor". Then select "Dentist" for healthcare provider type and enter a search location.

Smile, You have dental insurance

Vision Plan

The City offers a voluntary vision plan through Humana Vision. Humana provides in-network access to more than 58,000 optometrists, ophthalmologists and licensed opticians at more than 25,000 locations throughout the country.

Summary of Vision Benefits

Benefit	Humana Vision Care	
	In-network	Out-of-network
Routine Eye Exam (per person) *Once every twelve (12) months*		
With Dilation as Necessary	$20 Co-Pay	Up to $35
Contacts Lenses: *Elective (Conventional & Disposal)* *Medically Necessary*	$150 Allowance 100%	$150 Allowance $210 Allowance
Eyeglass Frames *Every two years you may select any eyeglass frame*		
Per Person	$100 -$150 Wholesale Allowance Approximate Retail Value	$40 Retail Allowance
Eyeglass Lenses *Every two years you may select any lenses*		
Standard Plastic Single (1 pair)	$20 Co-Pay	
Standard Plastic Bifocal or Trifocal (1 pair)	$20 Co-Pay	

Vision Deductions	Bi-Weekly Employee Cost No deductions will be taken for 3rd payroll in a month
Employee	This Benefit Is Employer Paid
Family	$3.50

*Contact Lens Details

- If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames) (Vision Care Plan only).
- The contact lens allowance applies to professional services (evaluation & fitting fee) and materials. Members receive 15% discount on in-network professional services.
- Contact lens allowance must be used at one time.

Vision Plan Highlights:

Additional Plan Discounts

- Members receive additional fixed copayments on lens options including: anti-reflective & scratch-resistent coatings.
- Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam and available through the VCP network provider who sold the initial pair of eyeglasses.
- After copay, standard polycarbonate available at no charge for dependents less than 19 years old.

To locate a provider or for questions please visit HumanaVisionCare.com; or call 1-866-537-0229

Flexible Spending Account

Using after-tax money to pay for healthcare and daycare? You don't have to!

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars to pay for certain health care expenses. Each dollar you put into the Health Care Flexible Spending Account (HCFSA) is a dollar not taxed. The Flexible Spending Account is offered through TASC.

Health Care Flexible Spending Account:

You and your dependents can use it to pay for eligible health care expenses not covered under your plans, such as medical, dental, vision deductibles, coinsurance, prescription drug copays, over-the-counter (OTC) drugs that are prescribed, LASIK eye surgery and more. For more information on eligible expenses, please review IRS Publication 502 on www.irs.gov.

Maximum contributions to the Account for the 2015 Calendar Year are:

- $2,500

Run-out Period:

A run-out period is a pre-determined period after the plan year ends. During this time period, you may file claims for expenses incurred during the plan year. When the run-out period is over, you forfeit any unused funds. It's an IRS rule.

Flexible Spending Account Regulations:

IRS Health FSA "Use-or-Lose" Rule

The IRS requires that any unused money left in your account at the end of the plan year be forfeited. This means that any money remaining in the account will not be returned to you so careful planning is required.

FlexCard

- ✓ A FSA debit card that only allows access to the funds you elected to pay for qualified expenses.
- ✓ If you received a card during the 2014 plan year, you will not receive a new card for 2015 unless that card has expired. In that case a new one will automatically be issued. Otherwise, your current card will be funded with your new plan election amount.
- ✓ For new participants, TASC will send an FSA card within 30 days of enrollment.
- ✓ Remember to keep all receipts as back-up documentation should it be required as proof of purchase.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

Annual Expense Estimate Worksheet	Actual Expenses Last Year	Estimated Expenses New Year
Medical		
Co-pays / expenses		
Prescriptions	$_____	$_____
Physician visits	$_____	$_____
Hospital visit co-pays /expenses *(including Emergency)*	$_____	$_____
Laboratory/testing expenses	$_____	$_____
Deductible expenses	$_____	$_____
Over-the-counter prescription (Prescribed by a doctor)	$_____	$_____
Over-the-counter items (Ex: Blood pressure cuff, splints, etc.)	$_____	$_____
Vision		
Eye examination	$_____	$_____
Eyeglasses	$_____	$_____
Contact lenses and solution	$_____	$_____
Lasik surgery	$_____	$_____
Other expenses	$_____	$_____
Hearing		
Hearing examination	$_____	$_____
Hearing aid	$_____	$_____
Dental		
Co-pays / expenses		
Dental visits	$_____	$_____
Fillings	$_____	$_____
Major work *(root canals, crowns, dentures, etc.)*	$_____	$_____
Orthodontia (braces)	$_____	$_____
Deductible expenses	$_____	$_____
Other expenses	$_____	$_____
Total annual amounts	$_____	$_____

Tips to help you maximize your savings:

1. Review annually the amount you put in your FSA account to make sure you realize all your eligible savings.
2. If you have questions about eligible expenses, the FSA website provides access to a list of available resources. www.tasconline.com; or you may call toll free 1-800-422-4661.
3. Plan ahead for major expenses; FSA is a great way to pay for major expenses such as Lasik surgery or dental work.
4. Your FSA account can be used only for expenses that are incurred during The City's plan year.

Basic Life and AD&D Insurance

Basic Term Life/Accidental Death and Dismemberment (AD&D) Plan is a company paid benefit available to all eligible employees.

Basic Life Insurance helps provide financial protection to your loved ones at no cost to you. In the event of your death, an individual (or individuals) of your choosing will receive a cash payment from the insurance provider.

My family depends on me

BASIC LIFE AND AD&D PLAN	
Carrier Name	Boston Mutual
Life Benefit Amount	(1x) annual salary rounded up to the nearest $1,000 not to exceed $25,000.
AD&D Benefit Amount	Same as Life Benefit Amount
Portability Option	Included
Living Benefit Rider / Accelerated Death Benefit (Terminal Illness)	Included
Age Reduction Schedule (% of benefit offered)	Age 65 – 35% Age 70 – 15% Terminates at Retirement

Portability Option:. A feature that allows the employee to continue the policy at group rates that are generally lower than an individual policy. For example, after termination of employment, the employee may take the contract with him/her and be billed directly for any premiums due. This allows the employee to retain the term life insurance coverage, even though he/she is no longer a part of the group. Please refer to the policy specifications and/or the contract for specific information on requirements, eligibility, and continuation rates.

Living Benefit Rider / Accelerated Death Benefit: In the event that you become chronically or terminally ill, a percentage of your life insurance benefit will be paid to you to offset expenses.

To initiate any one of these provisions, you must contact The City benefit representative.

VOLUNTARY SHORT TERM DISABILITY INSURANCE (VSTD)

Our company offers you the opportunity to purchase Voluntary Short Term Disability coverage at group rates through payroll deductions. Voluntary Short Term Disability insurance helps replace lost income due to of a disabling injury or illness. The Plan is provided by Hartford Life Insurance Company.

If you enroll in the plan after your initial eligibility, coverage is subject to review of evidence of insurability by the insurance carrier.

Since you pay 100% of the Voluntary Short Term Disability premium, your Short Term Disability benefit payment will not have taxes deducted.

VOLUNTARY SHORT TERM DISABILITY PLAN	
Eligibility	Full-time employees working 30+ hours a week
Benefit	60% of your weekly income
Maximum Weekly Benefit	$1,800
Maximum Benefit Period	11 Weeks
Benefits Begin • Accident • Illness	 After 15 Days After 15 Days
Pre-Existing Condition Limitation	3/12 Months

Maximum Benefit Period: If you become disabled, STD benefits may continue during disability up to 11 weeks. This is the maximum period for which STD benefits are payable for any one period of continuous disability.

Pre-Existing Condition Limitations: The plan doesn't pay a short term disability benefit for an illness, injury or pregnancy for which you received medical care or treatment, including prescription drugs, during the 90 days leading up to your coverage effective date. Eligibility for coverage for a disability related to this illness, injury or pregnancy begins once you've been covered under the plan for 12 consecutive months and have been actively at work.

Age	Monthly Rate per $10 of Weekly Benefit
<25	$0.399
25-29	$0.371
30-34	$0.456
35-39	$0.450
40-44	$0.495
45-49	$0.561
50-54	$0.720
55-59	$0.885
60-64	$1.05
65-70+	$1.15

How to calculate your *Short Term Disability Premium*:

1. Enter your weekly salary: $_____
2. Multiple by .60 – enter that amount: $_____
3. Divide by 10 – enter that amount: $_____
4. Enter the rate for your age: $_____
5. Multiply the number in (3.) by the rate in (4.) $_____Monthly Premium
6. Multiply the monthly premium by 12 $_____Annual Premium
7. Divide the annual premium by 24 $_____Per Pay Period (24 pay periods)

For example purposes only

A 40-year old earning $450 weekly salary:

- *Weekly salary $450 x .60 = $270*
- *$270 / 10 = 27*
- *$0.495*
- *27 x $0.495 = $13.36 Monthly Premium*
- *$13.36 x 12 = $160.38 Annually*
- *$160.38/ 24= $6.68 Per Pay Period Deduction*

A benefit you'll appreciate!

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This is a summary of benefits only. Please refer to the plan summary and SPD for benefit details.

VOLUNTARY LONG TERM DISABILITY INSURANCE (VLTD)

Our company offers you the opportunity to purchase Voluntary Long Term Disability coverage at group rates through payroll deductions. Voluntary Long Term Disability insurance helps replace income when you are prevented from working for an extensive period of time due to disabling illness or injury. The Plan is provided by Hartford Life Insurance Company.

Since you pay 100% of the voluntary long term disability premium, your long term disability benefit payment will not have taxes deducted.

VOLUNTARY LONG TERM DISABILITY PLAN	
Eligibility	Full-time employees 30+ hours a week
Benefit	60% of your monthly income
Minimum Monthly Benefit	$100
Maximum Monthly Benefit	$7,500
Maximum Benefit Period	Social Security Normal Retirement Age
Elimination Period	90 Days
BENEFIT LIMITATIONS	
Own Occupation	2 years
Pre-Existing Condition	3/12 Months

3 out of every 10 workers between the ages of 25 and 65 will experience an accident or illness that keeps them out of work for 3 months or longer, with nearly 60% of these injuries occurring off the job.

Age	Monthly Rate per $100 of Covered Salary
>25	$0.162
25-29	$0.180
30-34	$0.279
35-39	$0.522
40-44	$0.738
45-49	$1.152
50-54	$1.602
55-59	$1.782

For example purposes only: (Based upon $48,000 annually at age 30), to determine the amount of the monthly benefit and per pay period premium:

- $48,000 / 12 = $4,000 (Monthly Income)
- $4,000 / 100 = 40
- 40 X $0.279 (Rate Age 30 - 34)= $11.16 (Monthly Premium)
- $11.16 x 12 = $133.92(Annual Premium)
- $133.92/24 = $5.58 Per Pay Period (24 pay periods)
- $2,400 = 60% of actual monthly benefit

Elimination Period: It is the period of time that must elapse from the onset of a disability, before you are eligible to receive monthly benefits.

Own Occupation: The inability to perform the material and substantial duties of your regular occupation, the insurance company will consider your occupation to be the occupation you are engaged in at the time you become disabled, they will pay the claim even if you are working in some other capacity.

Pre-Existing Condition Limitations: The plan doesn't pay a long term disability benefit for an illness, injury or pregnancy for which you received medical care or treatment, including prescription drugs, during the 90 days leading up to your coverage effective date. Eligibility for coverage for a disability related to this illness, injury or pregnancy begins once you've covered under the plan for 12 consecutive months and have been actively at work.

What happens if you get sick or seriously hurt?

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This is a summary of benefits only. Please refer to the plan summary and SPD for benefit details.

Offered Benefits

Term Life

How It Works

It offers life insurance protection that remains level for the period of time you select – 10, 20, 30 years. At the end of the selected period, without evidence of insurability, the policy may be continued on a yearly renewable basis.

Colonial Term Life	
BENEFITS	**DESCRIPTION**
10-year level term **20-year level term** **30-year level term**	• Face amounts range from a minimum of $10,000 to an unlimited maximum, based on underwriting. • Provides coverage for 10, 20 or 30 years with guaranteed level premiums and may be renewed annually thereafter without evidence of insurability.
Accelerated Death Benefit Provision	• Automatically included in the base policy at no additional premium. If the insured is diagnosed with a terminal illness and has less than 12 months to live, he can request up to 75 percent of the death benefit, to a maximum of $150,000 (in most states).
Issuing Ages **10 Year Term** **20 Year Term** **30 Year Term**	 • Ages 15 up to age 75 • Ages 15 up to age 65 • Ages 15 up to age 45
Spousal Coverage	• The spouse term life insurance policy offers guaranteed premiums and level death benefits equivalent to those available to employees – whether or not the employee buys a policy.
Convertible to Cash Value Plan	• The policy can be converted to a Life Cash Value life insurance policy any time through age 75 (unless the Accelerated Death Benefit Provider or Waiver of Premium Benefit Rider has been used) with no EOI.

Term Life
Per Pay Period Rates

Non-Tobacco Employee Rates

10 Year Term Base Plan				20 Year Term Base Plan				30 Year Term Base Plan			
Age	$25,000	$50,000	$100,000	Age	$25,000	$50,000	$100,000	Age	$25,000	$50,000	$100,000
15	3.42	4.84	7.67	15	3.52	5.04	8.09	15	3.94	5.88	9.75
25	3.42	4.84	7.67	25	3.52	5..04	8.09	25	3.94	5.88	9.75
35	3.42	4.84	7.67	35	3.91	5.81	9.63	35	4.87	7.73	13.46
45	5.11	8.21	14.42	45	6.58	11.15	20.29	45	9.31	16.63	31.25
55	9.29	16.59	31.17	55	13.55	25.11	48.21				
65	21.48	40.96	79.92	65	33.18	64.35	126.71				

Tobacco Employee Rates

10 Year Term Base Plan				20 Year Term Base Plan				30 Year Term Base Plan			
Age	$25,000	$50,000	$100,000	Age	$25,000	$50,000	$100,000	Age	$25,000	$50,000	$100,000
15	4.18	6.36	10.71	15	4.38	6.75	11.50	15	5.84	9.67	17.34
25	4.18	6.36	10.71	25	4.38	6.75	11.50	25	5.84	9.67	17.34
35	4.71	7.42	12.84	35	5.84	9.67	17.34	35	8.15	14.29	26.58
45	9.35	16.69	31.38	45	12.41	22.81	43.63	45	15.38	28.75	55.50
55	22.15	42.29	82.58	55	26.78	51.56	101.12				
65	41.58	81.17	160.33	65	53.55	105.10	208.28				

Offered Benefits

Critical Illness

How It Works

Critical Care coverage helps provide a financial cushion with a lump-sum benefit if you are diagnosed with a covered critical illness: Heart Attack, Stroke, Cancer, Major Organ Transplant, End Stage Renal Failure, Permanent Paralysis due to a Covered Accident, Blindness, Coma, Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D, Carcinoma in Situ (25%) or Coronary Artery Bypass Surgery (25%). If you are diagnosed with cancer and continue to receive care, you'll receive an additional Cancer Treatment & Care Benefit that pays $500/month for 12 months. This plan includes an annual $50 Health Screening Benefit and a one-time $500 Skin Cancer Diagnosis Benefit. Payment for subsequent diagnosis of each specified critical illness is also included.

Wellness claims can be filed, no paperwork needed, by calling 800-325-4368 or going online, www.coloniallife.com. Information needed is type of test, date of test, doctor's name and telephone number. The website contains all the necessary claims forms.

Colonial Life

GROUP CRITICAL ILLNESS

COVERED SPECIFIC CRITICAL ILLNESSES	AMOUNT
Heart Attack	100%
Cancer	100%
Stroke	100%
Renal Failure (End Stage)	100%
Major Organ Transplant	100%
Carcinoma In Situ	25%
Coronary Artery Bypass Surgery	25%
Permanent Paralysis (due to covered accident)	100%
Coma	100%
Blindness	100%
Occupational Infectious Hepatitis B,C or D	100%
Occupational Infectious HIV	100%
OTHER BENEFIT	**AMOUNT**
Initial Skin Cancer Diagnosis	$500
Cancer Vaccine	$50
Cancer Care and Treatment (Per month for 12 months)	$500
Pre-Existing Condition	12 month / 12 month
Waiting Period	No waiting period
Spouse & Children Coverage	Yes – 50% of Employee
Portability Option	Yes
ADDITIONAL PROVISIONS	
Additional Occurrence Benefit	Yes
Re-Occurrence Benefit	25%
Health Screening Benefit	$50 per insured

Group Critical Care
Per Pay Period

Non-Tobacco Employee Only				Tobacco Employee Only			
Age	$5,000	$10,000	$15,000	Age	$5,000	$10,000	$15,000
16-29	4.63	5.53	6.43	16-29	5.62	7.07	8.52
30-39	5.51	7.28	9.06	30-39	6.95	9.72	12.50
40-49	7.41	11.08	14.76	40-49	9.97	15.77	21.57
50-59	10.46	17.18	23.91	50-59	14.82	25.47	36.12
60-74	14.56	25.38	36.21	60-74	21.67	39.17	56.67
Non-Tobacco Employee & Spouse				**Tobacco Employee & Spouse**			
Age	$5,000	$10,000	$15,000	Age	$5,000	$10,000	$15,000
16-29	8.16	9.51	10.86	16-29	9.86	12.03	14.21
30-39	9.46	12.11	14.76	30-39	11.81	15.93	20.06newkid
40-49	12.31	17.81	23.31	40-49	16.38	25.08	33.78
50-59	17.06	27.31	37.56	50-59	24.01	40.33	56.66
60-74	23.31	39.81	56.31	60-74	34.43	61.18	87.93
Non-Tobacco 1-Parent Family				**Tobacco 1-Parent Family**			
Age	$5,000	$10,000	$15,000	Age	$5,000	$10,000	$15,000
16-29	4.88	5.90	6.93	16-29	5.89	7.49	9.09
30-39	5.75	7.65	9.55	30-39	7.19	10.09	12.99
40-49	7.68	11.50	15.33	40-49	10.24	16.19	22.14
50-59	10.73	17.60	24.48	50-59	15.09	25.89	36.69
60-74	14.83	25.80	36.78	60-74	21.94	39.59	57.24
Non-Tobacco Family				**Tobacco Family**			
Age	$5,000	$10,000	$15,000	Age	$5,000	$10,000	$15,000
16-29	8.41	9.88	11.36	17-29	10.10	12.40	14.70
30-39	9.71	12.48	15.26	30-39	12.05	16.30	20.55
40-49	12.58	18.23	23.88	40-49	16.65	25.50	34.35
50-59	17.33	27.73	38.13	50-59	24.28	40.75	57.23
60-74	23.58	40.23	56.88	60-74	34.73	61.65	88.58

Colonial Life

GROUP ACCIDENT COVERAGE	
ACCIDENTAL DEATH	
Named Insured	$25,000
Spouse	$25,000
Children	$5,000
INITIAL CARE	
Ambulance	$200
Air Ambulance	$1,500
Emergency Room Treatment	$125
Surgery – Hernia	$200
Surgery – Exploratory and Arthroscopic	$150
Hospital Admission	$1,000
Hospital Confinement (up to 365 days)	$200 per day
Hospital Intensive Care Admission	$1,500
Hospital Intensive Care (up to 15 days)	$400
Coma (duration at least 14 days)	Up to $10,000
Lodging (up to 30 days)	$150
COMMON ACCIDENTAL INJURY	
Open Fractures	Up to $7500
Closed Fractures	Up to $3750
Open Dislocations	Up to $6000
Closed Dislocations	Up to $3000
Other Benefits	
Blood and Plasma	$300
Physical Therapy (up to 15 days per covered accident – OT, PT, Speech)	$25 per visit
Transportation	$500 per round trip
Guaranteed Renewable	Yes
Wellness Benefit	$50

Offered Benefits

Accident Coverage

How It Works

Accident insurance helps offset unexpected medical expenses, which can result from a fracture, dislocation, burn or other covered accidental injury that occurs off the job. Surgical care, hospitalization, transportation and lodging assistance are among the benefits covered. We've also included an annual $50 health screening benefit.

Wellness Benefit

Wellness claims can be filed, no paperwork needed, by calling 800-325-4368 or going online, www.coloniallife.com. Information needed is type of test, date of test, doctor's name and telephone number. The website contains all the necessary claims forms.

Group Accident Per Pay Period	
Employee	$8.60
Employee + Spouse	$14.49
One-Parent Family	$15.35
Two-Parent Family	$21.24

Wellness claims can be filed, no paperwork needed, by calling 800-325-4368 or going online, www.coloniallife.com. Information needed is type of test, date of test, doctor's name and telephone number. The website contains all the necessary claims forms.

Family Medical Leave Act (FMLA)

The City complies with all applicable laws.

The Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to:

Twelve work weeks of leave in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or
- Twenty-six workweeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

Please see The City's benefit representative to verify qualification for FMLA.

Extend Health Advantage – Medicare Exchange:

The McCart Group offers a value-added Medicare service called Extend Health. This service is offered to Medicare eligible employees and their Medicare eligible family members.

With Extend Health, employees will have access to a state-of-art Medicare marketplace that includes over 3500 plans from more than 70 of the nation's leading health insurers. Extend Health evaluates all plans of value, quality and customer service. Licensed, trained benefit advisors are dedicated to finding you the plan that best matches your unique needs.

Helpful online tools at your fingertips:

- Online quotes for all Medicare product types
- Online quotes for dental and vision
- Estimates of your out of pocket expenses based on your individual prescription profile
- Comparisons of your existing plan
- Side-by-side plan benefit comparisons

To speak to a licensed benefit advisor, call (866) 823-0918, or visit the Extend Health website at www.extendhealth.com.

Important information regarding legislative changes to healthcare benefits. If any information in these Legal Notices conflict with the plan documents and insurance policies, those plan documents and policies will govern.

The following pages contain annual notices that may or may not apply to you and/or your family. Your company is required to provide these notices to each employee enrolled in our benefit plans in order to comply with various federal legislation related to Health and Welfare Plan

Women's Health & Cancer Rights Act of 1998:
VERY IMPORTANT NOTICE

To All Eligible Employees & Dependents Covered by your Group Health Plans

On October 21, 1998 the Women's Health and Cancer Rights Act was signed into law. Beginning January 1, 1999 this law requires your company's group health plans and health insurance issuers that provide medical and surgical benefits for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

This notice provides you with information about the law's provisions.

A participant or beneficiary who is receiving benefits in connection with a mastectomy reconstruction in connection with such mastectomy is provided coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

This coverage is provided in consultation with the attending physician and the patient, and is subject to annual deductible and coinsurance provisions that are consistent with those established for other benefits under the plan or coverage.
If you have any questions about the benefits provided under the law, please contact your insurance carrier customer service department.

Newborns' and Mothers' Health Protection Act of 1996:
VERY IMPORTANT NOTICE

To All Eligible Employees & Dependents Covered by your Group Health Plans

On September 26, 1996 the Newborns' and Mothers' Health Protection Act (NMHPA) was signed into law. Beginning January 1, 1998 this law prohibits your company's group health plans and health insurance issuers that provide benefits for hospital lengths of stay in connection with childbirth, from restricting these benefits for mothers and newborns to less than 48 hours following a vaginal delivery, or 96 hours following a delivery by cesarean section.

The NMHPA permits an exception to the 48 hour (or 96 hour) general rule if the attending provider, in consultation with the mother, discharges the mother or her newborn earlier. An attending provider is an individual who is licensed under applicable state law to provide maternity or pediatric care and who is directly responsible for providing such care to a mother or newborn child.

Group health plans and health insurance issuers may not:

- penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider furnished care to a mother or newborn in accordance with the NMHPA, or provide monetary or other incentives to an attending provider to induce the provider to furnish care to a mother or newborn in a manner inconsistent with the NMHPA
- deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan or policy solely to avoid the NMHPA requirements,
- provide monetary rebates to a mother to encourage her to accept less than the minimum protections available under the NMHPA,
- restrict the benefits for any portion of a 48 hour (or 96 hour) hospital length of stay in a manner that is less favorable than the benefits provided for any preceding portion of the stay, or The NMHPA does not prevent health plans or health insurance issuers from imposing deductibles, coinsurance or other cost sharing measures for health benefits related to hospital stays in connection with childbirth, as long as the cost sharing for any portion of a hospital stay subject to the law is not less favorable to mothers and newborns than that imposed on any preceding portion of the stay.

Under the NMHPA group health plans and health insurance issuers may not require a physician or other health care provider to obtain authorization from the plan or issuer to prescribe a hospital length of stay up to 48 hours (or 96 hours). However, to use certain health care providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information regarding pre-certification requirements, please call your insurance carrier customer service department.

Notice regarding 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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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, 2013. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

IDAHO – Medicaid and CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid

Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

TEXAS – Medicaid

Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs
Then Click on Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

MONTANA – Medicaid

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-800-383-4278

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

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

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

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

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

OREGON – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

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

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

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

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

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

UTAH – Medicaid and CHIP
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

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

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

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

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

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

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

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

Important Notice for Employees and Dependents Age 65 or Older About Your Prescription Drug Coverage and Medicare – Medicare Part D Notices (Creditable Coverage)

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

Cont. of Important Notice for Employees and Dependents Age 65 or Older About Your Prescription Drug Coverage and Medicare – Medicare Part D Notices (Creditable Coverage)

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back until the next Open Enrollment period or until you have a Qualified Change in Status.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

The Patient Protection and Affordable Care Act/Health Care Reform
GRANDFATHERED STATUS

This is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the ACA that apply to other plans; e.g., the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA; e.g., the elimination of lifetime limits on benefits.

NOTICE

Prohibition on Recessions

Under the Patient Protection and Affordable Care Act, a group health plan is prohibited from rescinding coverage except in three circumstances. A rescission is a retroactive termination of coverage. Effective for plan years that began on or after September 23, 2010, coverage can only be terminated in the following circumstances:

- Failure of the individual to pay premiums
- Where the individual has engaged in fraud
- Where the individual has made an intentional misrepresentation of material fact

If coverage is to be rescinded, the affected individual must be given at least 30 days advanced written notice that his or her coverage is being terminated retroactively. Outlined below are the ACA regulations that apply to grandfathered plans. For more information, contact the insurance carrier's Customer Service Department.

NOTICE

Lifetime Limit No Longer Applies -- Enrollment Opportunity

The lifetime limit on the dollar value of benefits under no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact the insurance carrier's Customer Service Department.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Dependent Coverage to Age 26

Individuals are able to cover their dependent child until the age of 26 regardless of student status, tax dependent status, or marital status. (The plan will not cover the child's spouse or children.) For more information contact your Benefits Representative or HR Department.

Patient Protection Disclosure

Access to Out-of-Network Emergency Room Services:

Your plan does not require a higher copayment or co-insurance for out-of-network emergency room services and you are not required to obtain prior approval before seeking emergency room services from a provider or hospital outside your plan's network.

- Please note that you still may be responsible for the difference between the amount billed by the provider for out-of-network emergency room services and the amount paid by your plan.

Additional Health Care Reform Information Applicable to Your Benefit Plan:

Over-the-Counter Drugs

Effective January 1, 2011, if you have a Flexible Spending Account (FSA), a Health Reimbursement Arrangement (HRA), or a Health Savings Account (HSA), over-the-counter medications without a prescription will no longer be reimbursed.

Your Right to Appeal

You have the right to appeal, or to ask the carrier to reconsider its decision to deny payment for a service or treatment. New rules, now in effect, govern how the carrier must handle your initial appeal. If the denial of coverage is upheld after internal review, the law permits you to appeal to an independent reviewer who does not work for the carrier.

Pre-Existing Conditions

The carrier cannot limit or deny benefits or deny coverage simply because a person has a "pre-existing condition" — that is, a health problem that developed before the person applied to join the plan. This rule applies whether or not your health problem or disability was discovered or treated before you applied for coverage.

Preventive Care

You do not have to pay a copayment, co-insurance or any deductible to receive preventive health services from an in-network provider, such as recommended screenings, vaccinations, and counseling.

The City Of Anniston

Bersheba Austin
P.O. Box 2168, Anniston, GA 36202
Email: baustin@annistonal.gov

INSURANCE COMPANIES

Blue Cross Blue Shield of Alabama - Medical

www.bcbsal.com

Customer Service:

- Member Services: 1-800-810-2583

Prescriptions:

- Member Services – 1-800-810-2583
- www.bcbsal.com
- Mail Order – PrimeMail – 1-877-579-7627

Blue Cross Blue Shield of Alambama - Dental

www.bcbsal.com

Customer Service:

- Member Services: 1-800-810-2583

Humana Vision Care

www.HumanaVisionCare.com

Customer Service:

- Member Services: 1-866-537-0229

FSA -TASC– Flexible Spending Account

www.tasconline.com

Customer Service:

- Member Services: 1-800-422-4661

Hartford – STD & LTD

www.hartfordlife.com

Customer Service:

- Member Services: 888-747-8819

Colonial – Worksite Benefits

www.coloniallife.com

Customer Service:

- Member Services: 800-325-4368

THE MCCART GROUP

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THE McCART GROUP
RISK MANAGEMENT & INSURANCE

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www.annistonal.gov

This guide is designed to assist you in making benefit election choices and represents only a brief summary of available Plans. This booklet is not intended as an official interpretation of the Plans. For more detailed information, please refer to the Certificate of Coverage. Should any question arise, the Certificate of Coverage will be the final authority in determining your Plans. The company reserves the right to modify, amend, or terminate the Plan at any time.