2024

COLUMBUS GEORGIA

We do amazing.

Benefits Enrollment Guide

Welcome to your 2024 Benefits Enrollment Guide. This guide is your summary of the benefit options that are available to eligible employees of the Columbus Consolidated Government. Each benefit is designed to protect your health and well-being as well as provide valuable financial protection.

Each section of the Benefits Enrollment Guide is structured to provide you with plan highlights as well as detailed, descriptive instructions to assist you in navigating through the web-based enrollment portal.

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

Please review the plans contained in the Benefits Enrollment Guide and see how these plans can work for you and your eligible dependents. Your participation in the plans is voluntary. The benefit plans have been chosen to provide a continuation of protection that complements the Columbus Consolidated Government's leave policies and retirement plans. The plan year is in effect from January 1, 2024 to December 31, 2024.

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

NOTICE: If you (and/or your dependents) have 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 28 for more details.

Table of Contents

This guide describes the benefit plans available to you as an eligible Employee of Columbus Consolidated Government. The details of these plans are contained in the official Plan Documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all the details that are included in your Summary Plan Descriptions (SPD) (as described by the Employee Retirement Income Security Act).

If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the Plan Documents, the formal wording in the Plan Documents will govern. Please note the benefits described in this guide may be changed at any time and do not represent a contractual obligation on the part of Columbus Consolidated Government and NFP.

Open Enrollment Memo

Columbus Consolidated Government will be holding our annual Open Enrollment beginning October 2nd through October 20th.

We make every effort to provide employees with choices of quality health care plans that provide competitive benefits and coverage for employees and their families, while at the same time, managing the cost of these plans so they are affordable for both our employees and CCG.

Like most employers, managing healthcare costs and analyzing the future impact of health care reform continue to be great challenges for CCG. While some factors that contribute to our rising health care costs are related to government mandates such as provisions of health care reform, other factors are a direct result of the healthcare choices or decisions that plan members make.

Wellness remains the primary focus, as it relates to benefits, for 2024. Employees who choose to participate in the wellness program by completing a Personal Health Assessment and attending health coaching sessions, if required, will not see an increase to their current payroll deduction for medical coverage for the 2024 plan year. The deadline to complete the Personal Health Assessment is October 20th. By focusing on wellness and managing our health conditions, we are better able to control our medical expenses in the future and stabilize the cost for coverage.

Please remember Open Enrollment is your annual opportunity to:

- Compare plan designs and plan costs and determine which benefit plans will best suit your needs for the upcoming plan year.
- Make changes which includes enrolling in a plan for the first time, adding or dropping dependents, switching health plans, and modifying the nature of your coverage (i.e., adding dental coverage).

The elections you make during Open Enrollment will become effective with the new plan year beginning January 1, 2024.

All employees will have the opportunity to earn a $25 gift card and 1 Wellness Day by completing a Personal Health Assessment which consists of a Health Risk Assessment and Biometric Screening.

Employees will have access to two free tobacco cessation programs and can avoid the surcharge by completing the program and providing the certificate of completion to Human Resources.

The Flexible Spending Accounts will continue to be administered by Medcom. The annual maximum in the Flexible Spending Accounts. Contribution limit for the Healthcare FSA has increased for 2024 to $3,050 and the rollover amount is increasing to $610. You must make an election for 2024 to continue participating ants will receive a debit card and all current participants will be awarded any roll over amounts at the end of the run-out period.

Telemedicine will continue to be offered in a benefit discount program through NewBenefits. If you are currently enrolled and do not make changes to your selection, your enrollment will continue for 2024.

Open Enrollment Schedule

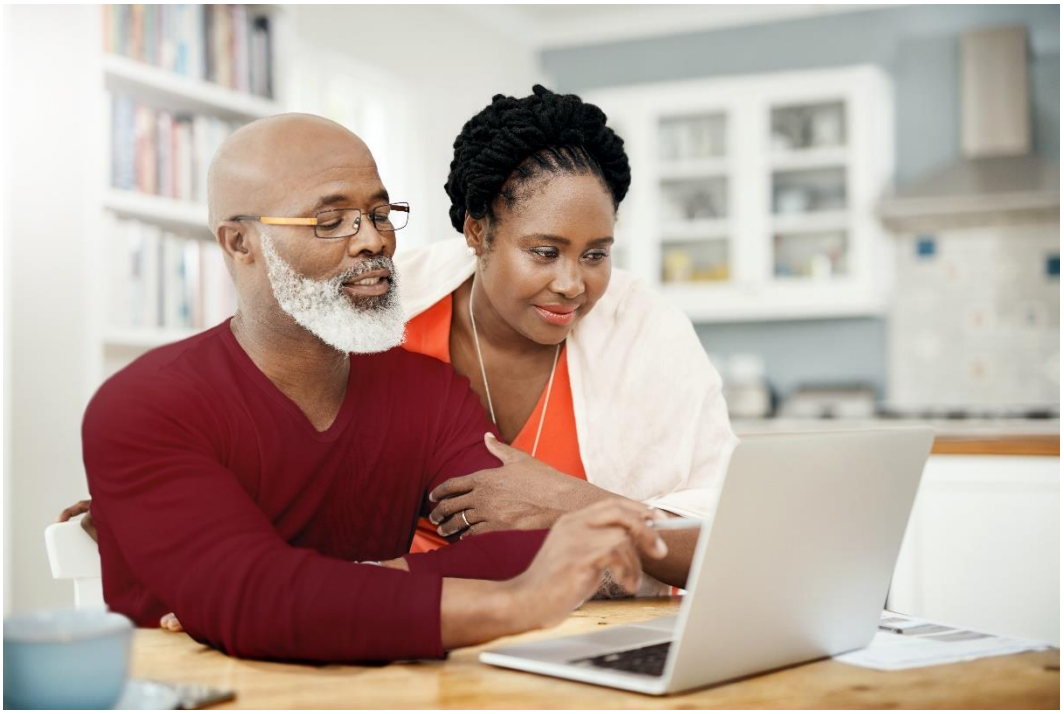
An educational webinar will be conducted on Monday, September 25th at 10:00am. The educational webinar will be recorded and can be accessed at any time by visiting the Benefit Resource Center located on the Human Resources homepage.

If you would like assistance with making a change to your benefits, help with reviewing your current benefits or you simply have questions, you may sign-up for a virtual or telephonic appointment with a NFP benefit counselor. Enrollment Assistance will be available from October 2, 2023 through October 20, 2023. Use the following link to schedule an appointment: https://kcyklf7xeb.timetap.com. In addition, you may contact the NFP Service Center for assistance throughout open enrollment at **1-844-505-9158.**

After scheduling an appointment, using the online appointment scheduler, you will receive a confirmation email. Please place a reminder for your appointment in your phone or on your calendar. You will be sent an email reminder 24 hours in advance of your appointment time and a text reminder 1 hour before your appointment time. You will simply call the phone number provided at the time of your appointment. If you are not on the phone within 5 minutes past your appointment time, the benefit counselor will attempt to reach you at the phone number provided during the scheduling of your appointment.

You can also make your election changes online on your own or with the support of the NFP Service Center.

Employees are highly encouraged to log into bswift to confirm beneficiary information for your Basic Life, Last Pay, and Pension. Also, please remember your FSA elections do not roll-over each year, so you must re-enroll in that benefit.



Before You Enroll – Things to Know

You are REQUIRED to **provide the following information/documentation** for all new **dependents/beneficiaries by October 20, 2023:**

- Name
- Date of Birth
- Social Security number
- Address

HOW TO ENROLL ONLINE

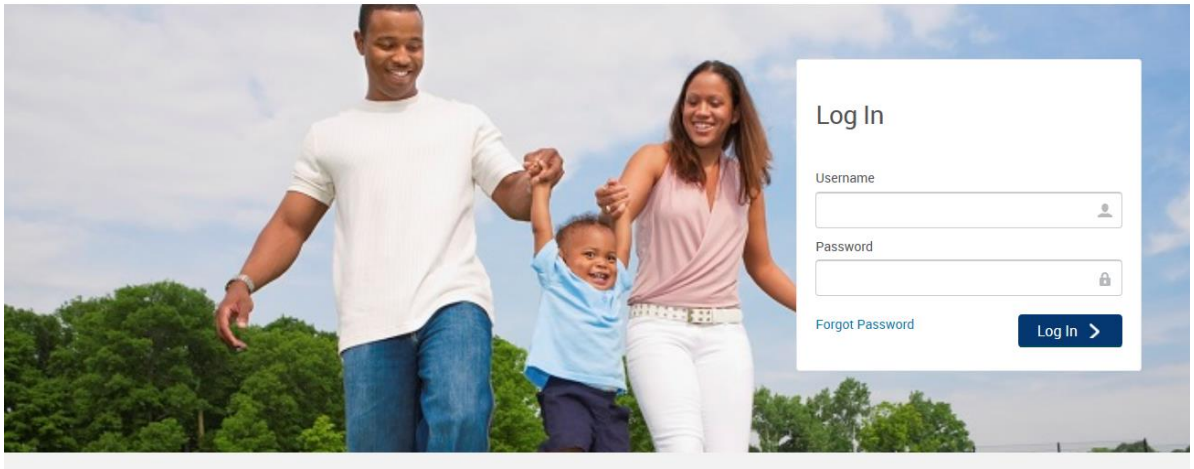
Go to www.columbusga.bswift.com.

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

At the enrollment website enter your Username and Password.

- **Username is the first letter of your first name, your last name, and last 4 digits of your Social Security number (ex. jdoe4567).**
- **Password is the last 4 digits of your Social Security number (ex. 4567).**

You will then be prompted to create a permanent password.



- Please go online or meet with a NFP benefit counselor to make changes and/or elect or decline coverage by **October 20th**. Please see enrollment schedule.
- Please contact the NFP Service Center at **1-844-505-9158** to speak with a benefit counselor if you need assistance with your enrollment.

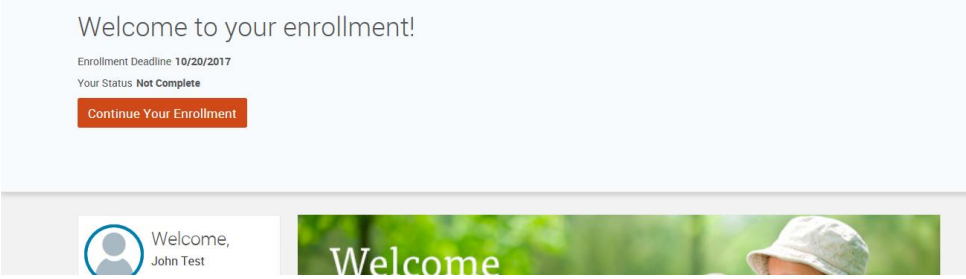
If you make no changes to your 2024 health care coverage, you will continue your current plan and at your current coverage level. ***Exception: Enrollment in a Flexible Spending Account is completely voluntary. You must reenroll each year. Your participation will not automatically carry over from year to year. Your elections during Open Enrollment is effective for the next plan year.***

Failure to enroll within the enrollment time period will result in the forfeiture of your eligibility enrollment/changes until the next annual enrollment period unless you experience an eligible qualifying event.

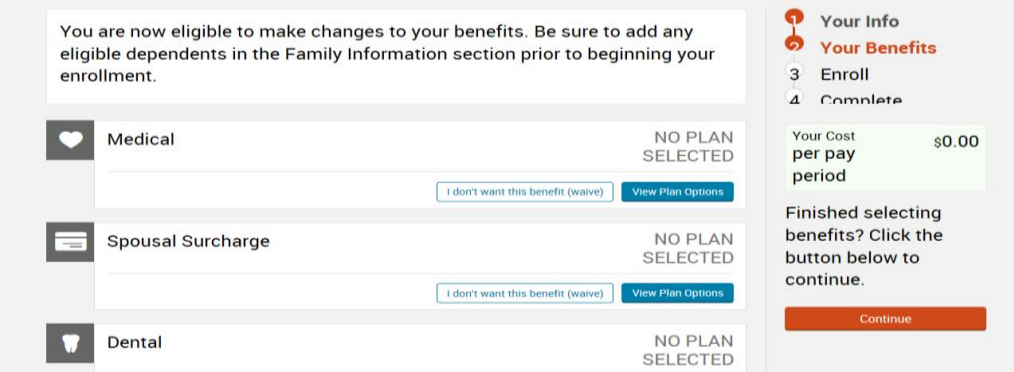
How To Enroll Online

To Begin:

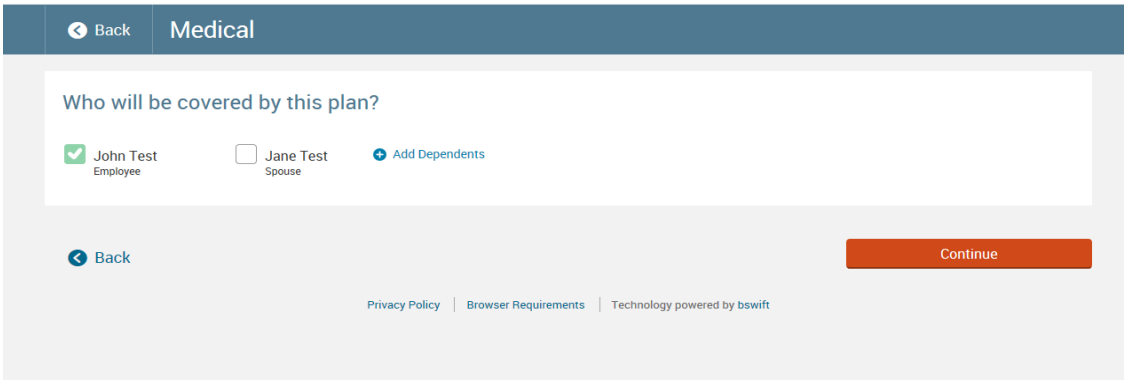
1) From the "Home Page" click on the "Start Your Enrollment" link, to begin the election process. Make sure you go to "My Profile" before you begin the enrollment process to confirm your demographic and dependent information , as well as add any new dependents.



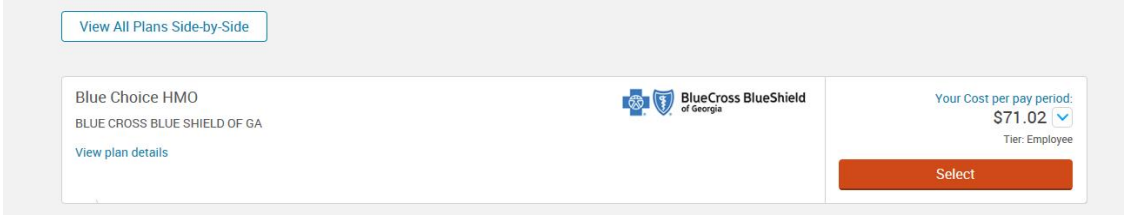
2) To select or change your current election, select the View Plans button for the corresponding benefit.



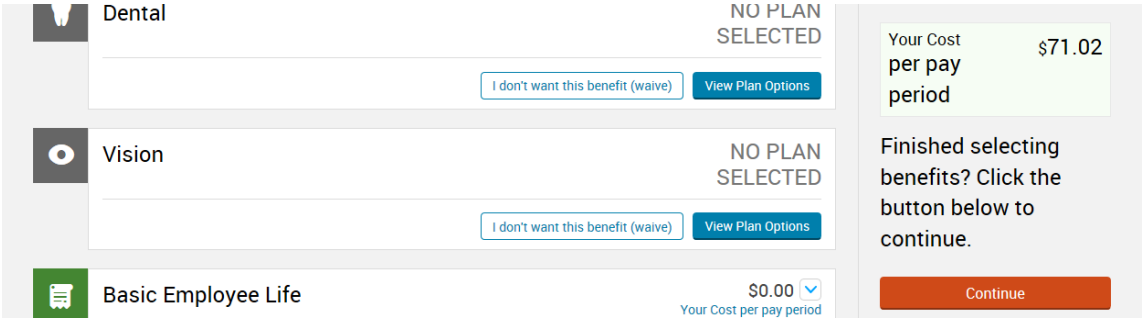
3) Select the dependents you wish to cover under that particular benefit plan. Then click on the Continue button.



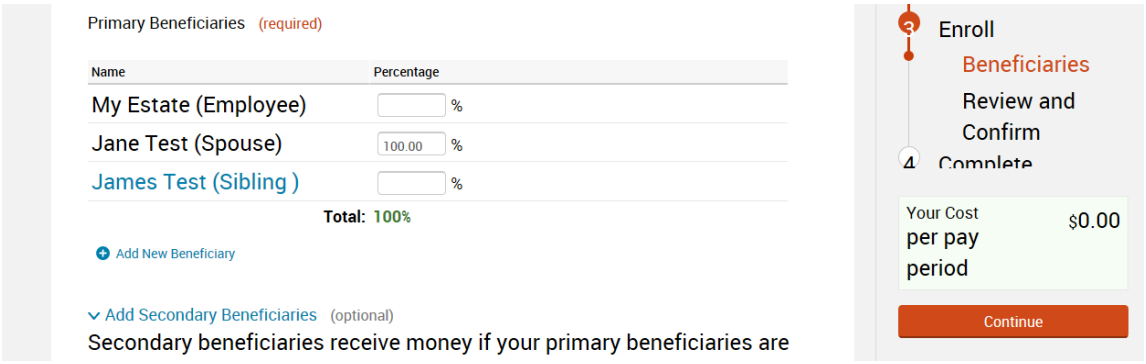
4) Click on View Plan Details to see details for the corresponding plan. After making a decision, choose the appropriate tier using the drop-down menu, then click the Select button under the chosen plan.



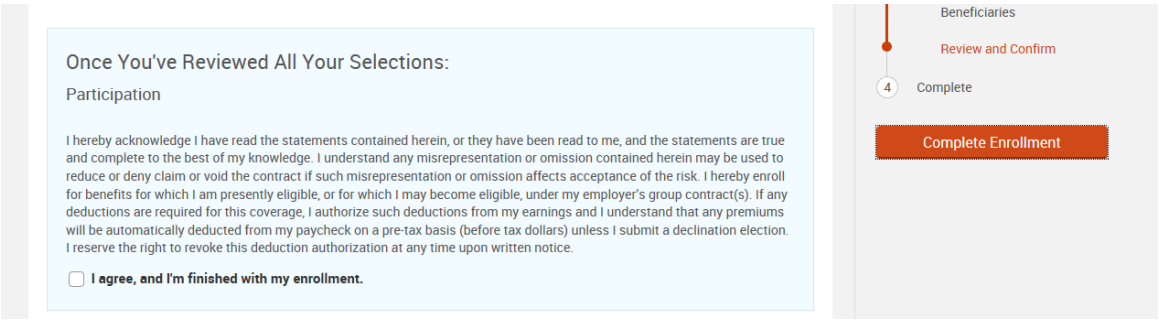
5) Repeat this process for all remaining benefits. Please take note that your per pay period deductions will total on the right hand side as you continue through the enrollment process. Once you have finished selecting benefits, click the Continue button on the right hand side.



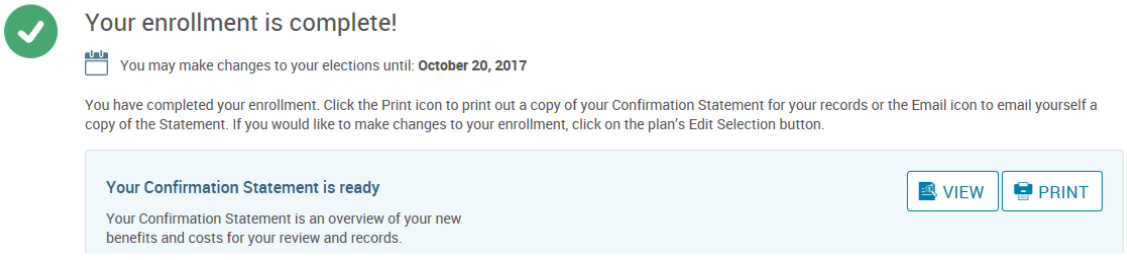
6) Make your beneficiary designations or confirm your current designations, and once finished click on the Continue button.



7) Review all your selections for accuracy. Once you have completed your review, click inside the box next to I agree, and I'm finished with my enrollment. Next click on the Complete Enrollment button.



8) Once you have successfully completed your enrollment, you will see the confirmation above. You will now have the option to view, print, or email your benefit confirmation statement.



Benefit Resource Center

NFP provides the Columbus Consolidated Government Employees a Benefit Resource Center website that gives you access to all of the plan details needed to make decisions on your benefit elections. The Benefit Resource Center contains information on the following topics:

- New Hire Enrollment
- Employee Benefits
  - Medical/Prescriptions
  - Tobacco Surcharge
  - Wellness Program
  - Health and Wellness Center
  - Dental
  - Vision
  - Life
  - Voluntary Benefits
  - New Benefits Telemedicine
  - Flexible Spending Accounts
- Qualifying Life Events
- Enrollment
  - NFP Enrollment Portal
  - Enrollment Guide
  - Benefits At A Glance
  - Enrollment Presentation
- Resources
  - Contacts

For easy access we have included important documents and links to your benefit information along with access to the bswift enrollment system on the enrollment page of the website. The Benefit Resource Center also includes videos that will discuss a high-level overview of the benefit plans and ancillary coverages that you have available. Please visit the Benefit Resource Center site by visiting www.columbusga.gov/HR to view documents on each of your benefits. Remember, if you still have questions, please contact the NFP service center at 1-844-505-9158.

Eligibility & Qualifying Events

Eligibility:
Active Full Time Employees and Pre-65 Retirees of the Columbus Consolidated Government are eligible for benefits. If you are a new employee, you are eligible to join the medical plan the 1st day following 30 days of active employment. You are eligible to join the dental and vision plans the 1st day following 60 days of employment. Otherwise, your annual enrollment elections are effective January 1st of each year.

Your spouse and dependent children are also eligible to participate in our benefit plans. Spouse is defined as your legal spouse who resides in the United States. Your dependent children include natural children, legally adopted children, stepchildren and children for whom the employee has been legally appointed as guardian.

» Your child can be covered on the medical, dental, and vision plans to age 26. If your dependent child is approaching 26 and is disabled, an application for continuation of dependent status must be made within 30 days of the child's 26th birthday.

» Your child can be covered on the life plans to age 26. If your dependent child is approaching 26 and is disabled, an application for continuation of dependent status must be made within 30 days of the child's 26th birthday.

Qualifying Events: (refer to your Summary Plan Description - Special Enrollment Rights)
Most benefit deductions are withheld from your paycheck on a pre-tax basis and therefore your ability to change your benefits elections is restricted by Section 125 of the Internal Revenue Code.

- Once your elections become effective, you will not be able to change your elections until the next annual enrollment period unless you experience an eligible qualifying event.

- Examples of qualifying events include: a change in marital status; a change in the number of dependents due to birth, adoption, placement for adoption or death of a dependent; a change in employment status for yourself or spouse; loss or gain of coverage through your spouse; a change in dependents eligibility.

- **You must notify Human Resources, provide proof of your qualifying event, and enroll within 30 days from the effective date of the qualifying event.**

- Please contact NFP at 844-505-9158 to speak with a benefit consultant regarding enrollment due to a Qualifying Event.

Medical Benefits – Administered by Anthem BCBS

Although we don't plan on getting sick or injured, most of us generally will need some type of medical care or attention. Medical insurance is important to assist in paying for medical expenses, whether they are expected or unexpected.

Columbus Consolidated Government offers the following medical plans as summarized below. This summary is to provide key features for In-Network benefits only.

Plan Provisions	Silver	Gold
Lifetime Maximum	Unlimited	Unlimited
Deductible (Individual / Family)	$2,000 / $4,000	$1,000 / $2,000
Annual Out of Pocket Maximum	$6,350 / $12,700	$6,350 / $12,700
Coinsurance	80%	90%
Preventive Care: Immunizations, Pap Smear, Mammography/Cancer Screenings, Annual Physicals, Well Child Check Ups	100% (no copay)	100% (no copay)
Office Visits:		
Primary Care	$40 copay (free at HWC)	$30 copay (free at HWC)
Specialist	$50 copay	$40 copay
Hospital-Outpatient/Inpatient Services	20% after deductible	10% after deductible
Emergency Room (waived if admitted)	$200 + 20%	$150 + 10%
Urgent Care	$60 copay	$60 copay
Prescription Drugs		
Generic (30 day supply) Mail Order (90 day supply)	$15 copay $30 copay	$15 copay $30 copay
Brand (30 day supply) Mail Order (90 day supply)	$40 copay $80 copay	$40 copay $80 copay
Non-Formulary (30 day supply) Mail Order (90 day supply)	$60 copay $120 copay	$60 copay $120 copay
Specialty (30 day supply) Mail Order (90 day supply)	$150 copay N/A	$150 copay N/A
Lifestyle Drugs (30 day supply) Mail Order (90 day supply)	50% N/A	50% N/A

*All medication is free when available at the HWC (Health & Wellness Center).

Medical Benefits - Continued

RX Notes through OptumRx:

- All members are encouraged to fill any prescriptions prior to December 31, 2023.
- All members are encouraged to view the 2024 OptumRx formulary, located on the Benefit Resource Center Site by visiting www.columbusga.gov/HR, before filling prescriptions in 2024.
- All members are encouraged to sign up for Mail Order by following the directions below.

Locate a Provider:
With Anthem Blue Cross Blue Shield of Georgia, you can choose from a diverse network of Primary Care Physicians (PCP) and other medical providers through their national directory.

Visit www.anthem.com to find a provider near you. Click on "Find a Doctor" to begin your search. Be sure to choose **National Open Access POS** as the "Plan /Network".

Member/Patient Services:
(855) 397-9269

Explanation of Benefits (EOB), claims access and much more such as claim cost estimate tools and health calculators:
Register as a member at **www.anthem.com** to gain access.

Mail Order/Home Delivery Instructions:
Ask your doctor to send an electronic prescription to OptumRx at www.optumrx.com.

Go to www.optumrx.com or the OptumRx app to easily find your medications and set up home delivery in just a few steps or call the toll-free number on your ID card.

Medical Per Pay Period Cost (26 per year)
Rates do not include the tobacco surcharge.

Rates per Pay Period Coverage Tier	Silver Plan Wellness Incentive Included	Silver Plan w/Spousal Surcharge & Wellness Incentive	Silver Plan No Wellness Incentive Included	Silver Plan Wellness vs Non Wellness Difference	Gold Plan Wellness Incentive Included	Silver Plan w/Spousal Surcharge & Wellness Incentive	Gold Plan No Wellness Incentive Included	Gold Plan Wellness vs Non Wellness Difference
Employee	$73.03	N/A	$89.40	$16.37	$104.65	N/A	$128.11	$23.46
Employee + Spouse	$137.29	$302.05	$168.07	$30.78	$196.74	$361.50	$240.84	$44.10
Employee + Children	$127.82	N/A	$156.46	$28.64	$183.16	N/A	$224.20	$41.04
Family	$202.31	$367.07	$247.66	$45.35	$289.90	$454.66	$354.86	$64.96

Tobacco Surcharge

To promote and support the health and wellness of employees, the Columbus Consolidated Government will impose a **$75.00 per month or $34.62 biweekly surcharge** above the premium rate for all active employees/Pre-65 retirees' premium plans including the Silver and Gold Plan. This surcharge is subject to change annually. The surcharge applies to employees/Pre-65 retirees, who are tobacco users. For purposes of the premium surcharge, "tobacco use" is defined as:

- Using any tobacco product (other than for religious or ceremonial use) including cigarettes, cigars, pipes, electronic cigarettes; tobacco products applied to the gums (e.g., dipping, chewing tobacco, vaping, or snuff);
- Uses tobacco products on average four or more times a week;
- Within no longer than the past six months.

The Columbus Consolidated Government supports its employees' desire to quit; therefore, employees have access to two free tobacco cessation programs:

Program Option 1 - Georgia and Alabama Department of Health's Tobacco Quit Line Program – Telephonic Format. To register for this program, you must complete and return the Quit Line Referral form to the HWC, or you can scan and email your completed form to Amy Spradlin, Health Coach, at amyspradlin@careatc.com beginning July 5th through October 20th, 2023. Once registered, you will be connected to a Georgia or Alabama Department of Health quit coach that will help you develop a personalized quit plan over a 6-MONTH period. The time may be adjusted depending on your quit date.

Program Option 2 - CareATC Tobacco Cessation Program – 4 Session webinar. You must register on Health Passport through the CareATC Patient Portal. Be sure to review the Tobacco Cessation Manual for more information.

The Health & Wellness Center also offers tobacco cessation medications.

Consequences of False Certification: The penalty for false certification of tobacco product abstinence is the imposition of the tobacco surcharge immediately following the discovery of false certification or positive random nicotine test. ***The $75.00 per month/$34.62 biweekly tobacco surcharge WILL apply.***

Removal of Tobacco Surcharge: The tobacco surcharge may be removed by completing the Tobacco Cessation Program Option offered by CCG. Once you have completed the tobacco cessation program and provided certification (proof) of program completion, the tobacco surcharge will be removed and a retroactive refund of the tobacco surcharge for that year will be issued. Your certificate of completion must be submitted to the HR Department within 10 days of receipt.

Random Nicotine Testing: Employees must agree to random nicotine testing at the Columbus Consolidated Government's expense for evidence of tobacco product consumption.

Failure to Complete a Tobacco/Smoke Free Affidavit on NeoGov.com (E-Forms): EMPLOYEES WHO FAIL TO COMPLETE A SIGNED TOBACCO AFFIDAVIT ON E-FORMS BY October 21,2022 WILL BE ENROLLED BY DEFAULT INTO THE TOBACCO SURCHARGE RATE EFFECTIVE JANUARY 2024.

Wellness Program

Employees who are enrolled in one of the healthcare plans can avoid any increase to payroll deductions for medical coverage by participating in the Wellness Incentive option. Employees who complete a Personal Health Assessment (PHA) consisting of a Health Risk Assessment and a biometric screening, and attend health coaching sessions (if required), will avoid any increase to payroll deductions for medical coverage for 2024. (Your required participation in health coaching sessions will be determined by the results of your PHA.)

Employees who are found to have moderate to high-risk health factors after completing the PHA will have the opportunity to attend health coaching sessions to complete their participation in the wellness program to avoid the increase to medical payroll deductions. Employees/Pre-65 Retirees who are found to have no moderate to high-risk health factors after completing the PHA will automatically complete their participation in the Wellness Program. If you are required to attend health coaching sessions, your participation in the Wellness Program will be considered complete if you graduate from the health coaching program or attend your health coaching sessions and remain compliant as determined by your health coach.

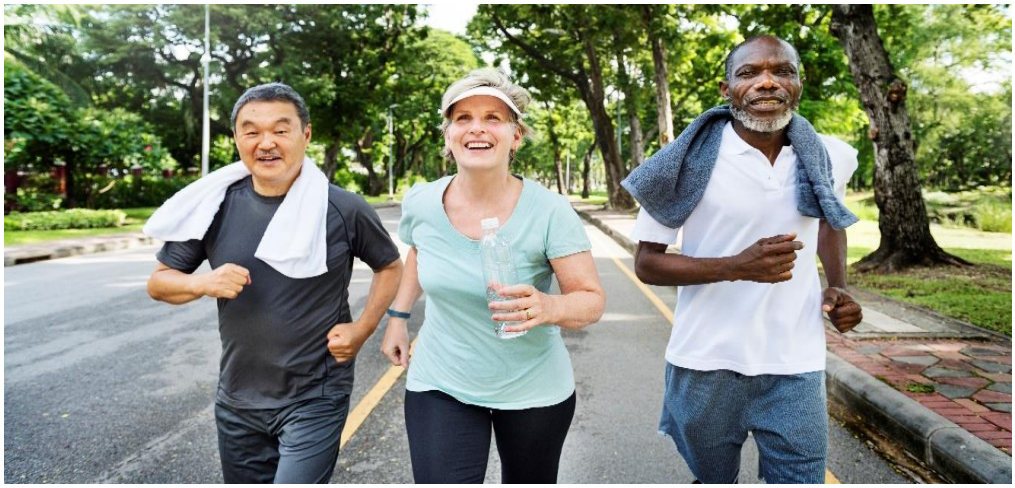
Employees who do not wish to participate in the Wellness Incentive option will see a 22% increase to payroll deductions for medical coverage. Employees who indicate their willingness to participate in the Wellness Incentive option will have no increase to their payroll deductions for medical coverage. Employees who fail to complete the PHA or who do not remain compliant in the health coaching program will be charged the 22% increase.

When you complete the Health Risk Assessment and the biometric screening, you will receive a certificate for 1 Wellness Day. Your Wellness Day certificates must be redeemed by December 31st, 2024. You will not be allowed to redeem your certificates after the 2024 calendar year.

The Health Risk Assessment and biometric screening must be completed by Friday, October 20, 2023. You may also choose to have your biometric screening completed by your Primary Care Physician. However, your results must be provided to the CCG Health and Wellness Center by October 20th, 2023 to receive the Wellness premium rate and to receive one day of Wellness. Please visit the Benefit Resource Center site by visiting www.columbusga.gov/HR to obtain a copy of the Physician Attestation Form and/or the Physician Recommended Alternative/Waiver Form.

All Wellness Day certificates must be provided when you request your time off.

If you have any questions regarding the 2024 Wellness Incentive option, please contact NFP at 844-505-9158.



Health and Wellness Center

Be Healthy: Wellness and Health Care Support

Columbus Consolidated Government cares about your health and the health of your family! That's why we offer comprehensive coverage for wellness benefits and health care support when you need it. Take advantage of these free benefits to keep you and your family healthy throughout the year.

Preventive exams – covered under the health care plans at 100%! Take action and proactively manage your health before a serious medical condition occurs.

Schedule an appointment 24 hours a day- by calling 1-800-993-8244 or online at **www.careatc.com/patients,** using your patient portal credentials.

Employee Medical Center-

- Primary, urgent and preventive care (for ages 3 and up)
- Laboratory testing
- Flu shots
- Treatment for chronic health conditions

Columbus Consolidated Government Health and Wellness Center:

Location
2000 10th Ave. Suite 410 Columbus, GA 31901

Hours of Operation

Mondays:	8:30am-5:30pm
Tuesdays:	7:00am-5:30pm
Wednesdays:	8:30am-5:30pm
Thursdays:	8:30am-5:30pm
Fridays:	7:00am-5:30pm

Clinic is closed from 12:30-1:30 every day.

Schedule an Appointment:
(800) 993-8244

Prescription Refill Hotline:
(800) 993-8244

Types of Services Available:

- Primary, urgent and preventive care (for ages 3 and up)
- Limited onsite pharmacy (dispensary) - requires an appointment and consultation with authorized Wellness Center medical provider.
- Laboratory testing services - requires an appointment and consultation with Wellness Center medical provider.
- Diagnosis and treatment of chronic health conditions (high blood pressure, high cholesterol, diabetes, asthma, etc.)
- Other health and wellness focused programs such as Smoking Cessation and Weight Loss.
- Referral to Columbus Diagnostics Center for diagnostic imaging at no cost for established patients.
- Home delivery of medications, with free shipping, to employees and their dependents. Medications are delivered quickly and conveniently in 5-7 business days.
- Telemedicine services are available to employees 24/7/365.

Dental Benefits – Administered by Anthem BCBS

Maintaining our dental health is a large component in our overall health. While brushing and flossing daily is important, routine dental exams and cleanings are necessary to remove bacteria, plaque, and tartar and detect early signs of gum disease. In addition, regular dental visits may help reveal other health issues.

The Columbus Consolidated Government offers dental coverage as summarized below.

Plan Provisions	Low Plan	High Plan
Calendar Year Deductible Single Family Max	 $50 $150	 $50 $150
Annual Benefit Max	$1,000 calendar year	$1,500 calendar year
Diagnostic/Preventive Services *Periodic oral evaluation; Prophylaxis (cleanings), Bitewing X-rays – four films; Topical fluoride application (to age 19)*	100% coverage No Deductible	100% coverage No Deductible
Basic Treatment Filling, amalgam, e.g., silver-colored, two surfaces; Other visits and Exams; All Other X-rays	70% coverage (subject to deductible)	80% coverage (subject to deductible)
Major Treatment Oral surgery (e.g., tooth extraction, simple); Endodontics (e.g., root canal, molar); Periodontics (e.g., scaling and root planning, per quadrant); Prosthodontics (e.g.: crown, denture); **Implants**	40% coverage (subject to deductible)	50% coverage (subject to deductible)
Orthodontia (Child Only) *Child(ren) only up to age 19*	Not covered	50% coverage up to lifetime maximum benefit of $1,500

Late Entrant Benefit Waiting Periods: Employees and dependents who did not enroll within 31 days of their initial eligibility, will be subject to the following late entrant waiting periods: 6 months- Oral Surgery, 12 months- all other Major Services, 18 months-Ortho.

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. Keep in mind, if your dentist charges more than the Plan's "reasonable and customary" charge, you may be required to pay the extra amount.

Log on to anthem.com and click on **Find Care.**
Click the **Locate Dental Providers** link. Next, choose a specialty from the drop-down menu or select '**no preference**' and then click continue. Enter your search criteria by location or name.

Member/Patient Services:
(855) 397-9269

Coverage Tier	Low Plan	High Plan
Employee Only	$7.95	$12.24
Employee + Spouse	$15.90	$27.11
Employee + Child(ren)	$15.11	$28.14
Employee + Family	$23.87	$43.44

Vision Benefits – Administered by Anthem BCBS

Good visual health can play an important role in our overall health. For those of us with eye care needs, having a Vision plan available from Columbus Consolidated Government can ultimately help offset some of those associated costs in preserving our eye health and ongoing wellness. Becoming a member of the Vision plan available will enable you to take advantage of substantial savings on your eye care and eyewear needs.

Benefit	In-Network	Out-of-Network	Frequency
Vision Exam	$10 copay	Up to $30 allowance	Once every calendar year
Contacts Fitting Standard Premium	Member cost up to $55 10% off retail price	Not covered	Once every calendar year
Contact Lenses *	Allowance	Max Amount	Once every calendar year
Elective Medically Necessary	Up to $130 allowance Covered in full	Up to $105 allowance Up to $210 allowance	
Standard Plastic Lenses	Copayment	Max Amount	Once every calendar year
Single Vision Bifocal Trifocal	Covered in full after a $10 copay	Up to $25 Up to $40 Up to $55	
Frames	Up to $130 allowance; 20% off additional cost	Up to $45 allowance	Once every other calendar year

***Your contact lens allowance must be used at the initial time of service.**
****Please note: This plan covers either contact lenses or lenses for your glasses once every calendar year.**

Coverage Tier	Cost per 26 pay periods
Employee Only	$2.73
Employee + Spouse	$4.77
Employee + Child(ren)	$5.18
Employee + Family	$7.91

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including West Georgia Eye Care, LensCrafters®, Target® Optical, and Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at (866) 723-0515 with questions about vision benefits or provider locations.

Basic Life/AD&D & Voluntary Life Insurance – Administered by Aflac

Basic Term Life and AD&D Insurance provides valuable financial protection for your family. Columbus Consolidated Government is pleased to provide Basic Life & AD&D Insurance to all full-time employees in the amount of 1.5 times your base annual income (not to exceed $250,000) **at no cost to you**.

Voluntary Term Life and AD&D Insurance is also available to provide additional financial protection for you and your family.

Benefit	Coverage
Employee Voluntary Life/AD&D	You can purchase coverage in increments of $10,000 up to a maximum of $500,000. **New Hires:** You will have a guaranteed issue (GI) amount of $200,000. Employee elections over GI will require Evidence of Insurability.
Spouse Voluntary Life/AD&D	You can purchase coverage in increments of $2,000 to a maximum of $10,000. **New Hires:** You will have a guaranteed issue amount of $10,000.
Child(ren) Voluntary Life	You can purchase coverage in increments of $2,000 to a maximum of $10,000. **New Hires:** You will have a guaranteed issue amount of $10,000.
Annual Enrollment	During Open Enrollment for employees already enrolled in Voluntary Term Life employees can increase coverage up to the guaranteed issue amount of $200,000 without completing an Evidence of Insurability form.

Evidence of Insurability (EOI) is required if your election for you or your dependents exceeds the guaranteed issue amounts. EOI is required if you did not elect to enroll in the VTL as a new hire.

Voluntary Life Insurance - Continued

Important Terms to Understand

Evidence of Insurability: Evidence of Insurability is a request to verify good health and is often in the form of a questionnaire. This is required when you are requesting insurance that is over the Guaranteed issue amounts or if you are enrolling after your initial enrollment.

Guaranteed Issue: Guaranteed Issue is the amount of life insurance that you can elect without having to provide evidence of insurability. The guaranteed issue period is 31 days from the date you first become eligible for the plan from your date of hire. If you choose not to enroll when you are first eligible and enroll later, the entire amount of insurance will be subject to evidence of insurability.

Employee Life/AD&D Pay Period Rates per $10,000 (26 pay periods)	
Age	**Employee Rate**
<30	0.37
30-34	0.42
35-39	0.51
40-44	0.83
45-49	1.38
50-54	2.31
55-59	3.60
60-64	5.58
65-69	10.02
70-74	16.06
75+	25.38

Steps to Calculate Employee Premium Per Paycheck

Step 1: Desired amount of Voluntary Life Insurance _____ Coverage Amount

Step 2: Divide amount of Voluntary Life In Step 1 by $10,000 _____

Step 3: Insert Rate from table based on age _____

Step 4: Multiply Step 2 by Step 3 _____ Premium per paycheck

Spouse & Child Life/AD&D Per Pay Period Premium is $0.33 per $2,000 of coverage. (Ex: $10,000 in coverage would cost $1.66 per pay period).

www.aflacgroupinsurance.com

Customer Service:
(800) 206-8826

Whole Life – Administered by AFLAC

While Term Life Insurance is an important benefit to maintain through your working years, Whole Life Insurance can also provide you with an additional level of Life Insurance coverage for the rest of your life.

Don't leave your family unprotected, provide for them now with whole life insurance.

Many employees choose our whole life insurance products because they offer the flexibility to meet a variety of personal needs. With whole life insurance plans, employees have a choice of benefit and premium amounts that fit their paychecks and lifestyles.

Employees also have access to the cash value accumulated in their plans and may use these savings for loans or withdrawals. And with our voluntary plans, employees own their coverage and can keep them in force even when they retire or change employers.

FLEXIBILITY TO MEET YOUR NEEDS
Employee – Coverage amount: up to $100,000. Spouse – Coverage amount: up to $50,000 (not to exceed employee's coverage). Children (ages 15 days - 24 years) – $10,000 child term life rider covers all your dependent children for only $1.38 per week. A $10,000 or $25,000 certificate is also available for each child.

BUILDS CASH VALUE
In addition to having valuable life insurance protection, you can accumulate savings at a guaranteed rate of return. You have access to your cash value and have the ability to make loans or withdrawals.

NO MEDICAL EXAMS REQUIRED
Employees and their families may apply for benefit amounts by answering only a few medical questions.

PERMANENT INSURANCE PROTECTION
Once your insurance application has been approved and payroll deductions have started, the coverage is yours to keep by continuing to pay premiums. Your premium will never increase.

PORTABILITY
Take your coverage with you if you leave the company (with certain stipulations).

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. Definitions, waiting period, pre-existing condition limitation, limitations and exclusions, benefits, termination, portability, etc., may vary based on your employer's home office. Please see your agent for the plan details specific to your employer.

Group Critical Illness – Administered by AFLAC

Critical Illness Benefits are payable for specified conditions and can help to cover the costs of your treatments and related expenses, regardless of your major medical insurance coverage.

Benefits		
COVERED CRITICAL ILLNESSES:[1]	CANCER (Internal or Invasive) 100% HEART ATTACK (Myocardial Infarction) 100% STROKE (Apoplexy or Cerebral Vascular Accident) 100% MAJOR ORGAN TRANSPLANT 100%	RENAL FAILURE (End-Stage) 100% CARCINOMA IN SITU[2] 25% CORONARY ARTERY BYPASS SURGERY[2] 25%
FIRST-OCCURRENCE BENEFIT	After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts available from $5,000 to $50,000. Spouse coverage is also available in benefit amounts up to $25,000. If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase Spouse coverage.	
ADDITIONAL OCCURRENCE BENEFIT	If an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered critical illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months.	
RE-OCCURRENCE BENEFIT	If an insured collects full benefits for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months, or for cancer, 12 months treatment free. Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless the Insured has gone treatment free for 12 months.	
CHILD COVERAGE AT NO ADDITIONAL COST	Each Dependent Child is covered at 25 percent of the primary insured amount at no additional charge.	
$50 HEALTH SCREENING BENEFIT (Employee and Spouse only)	After the waiting period (30 days), an insured may receive a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under your certificate. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the certificate remains in force. This benefit is payable for the covered Employee and Spouse. This benefit is not paid for Dependent Children.	
COVERED HEALTH SCREENING TESTS INCLUDE:	• Mammography • Colonoscopy • Pap smear • Breast ultrasound • Chest X-ray • PSA (blood test for prostate cancer) • Stress test on a bicycle or treadmill • Bone marrow testing• CA 15-3 (blood test for breast cancer) • CA 125 (blood test for ovarian cancer) • CEA (blood test for colon cancer)	• Flexible sigmoidoscopy • Hemocult stool analysis • Serum protein electrophoresis (blood test for myeloma) • Thermography • Fasting blood glucose test • Serum cholesterol test to determine level of HDL and LDL

Group Hospital Indemnity – Administered by AFLAC

Having the Aflac group Hospital Indemnity plan means that you could have added financial resources to help with medical costs or ongoing living expenses.

Benefits	
HOSPITAL CONFINEMENT BENEFIT (up to 180 days per confinement) - This benefit is paid when a covered person is confined to a hospital as a resident bed patient because of a covered sickness or as the result of injuries received in a covered accident. To receive this benefit for injuries received in a covered accident, the covered person must be confined to a hospital within six months of the date of the covered accident. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accident, more than one covered sickness, or a covered accident and a covered sickness.	**$200** per day
HOSPITAL INTENSIVE CARE BENEFIT (30-day max for any one period of confinement) - This benefit is paid when a covered person is confined in a hospital intensive care unit because of a covered sickness or due to an injury received from a covered accident. To receive this benefit for injuries received in a covered accident, the covered person must be admitted to a hospital intensive care unit within six months of the date of the covered accident. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accident, more than one covered sickness, or a covered accident and a covered sickness. If we pay benefits for confinement in a hospital intensive care unit and a covered person becomes confined to a hospital intensive care unit again within six months because of the same or a related condition, we will treat this confinement as the same period of confinement.	**$200** per day
SURGICAL AND ANESTHESIA BENEFITS - These benefits are paid when a covered person has surgery performed by a physician due to an injury received in a covered accident or because of a covered sickness. If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit, the largest, will be provided. Surgical and Anesthesia Benefits are available subject to plan definitions and the Surgical Schedule. (The Anesthesia Benefit will be 25 percent of the Surgical Benefit paid.)	Surgery up to **$2,000;** Anesthesia up to **$500**
OUT-OF-HOSPITAL PRESCRIPTION DRUG BENEFIT - We will pay an indemnity benefit, based on the plan definitions, for each prescription filled for a covered person. Prescription drugs must meet three criteria: (1) be ordered by a doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and treatment of the patient. This benefit is subject to the Out-of-Hospital Prescription Drug Benefit maximum.	**$10** with a 5-prescription maximum per year per covered person
HOSPITAL EMERGENCY ROOM/PHYSICIAN BENEFIT (MEDICAL FEES BENEFIT)- If a covered person is injured in a covered accident or has treatment as the result of a covered sickness, we will pay the benefit as shown for a maximum benefit of $50 based on the following: $50 – Physician (per visit) / X-ray (per visit) $25 – Laboratory fees (per visit) / Injections/medications (per visit) Not to exceed a maximum of $50 per visit.	Up to a maximum of **$50** per visit Maximum $250 per covered person per calendar year Maximum $1,000 per Family per calendar year
WELL BABY CARE BENEFIT - We will pay the Well Baby Care Benefit amount associated with each benefit plan option when an insured baby receives well baby care (four visits per calendar year, per insured baby). For this plan, a baby is a dependent child 12 months of age or younger. This benefit is payable only if coverage is issued with the Dependent Children Benefit Rider.	**$25** per visit

Flexible Spending Accounts – Administered by Medcom

The FSA consists of two separate accounts: a Health Care Spending Account and Dependent Care Spending Account. The FSA increases your take home pay by reducing your taxable income. Payment with pretax dollars means that you have more money to use on these important expenses.

Who is Eligible to Participate?

All full-time benefit eligible employees are able to participate in the flexible spending accounts.

Elections under the Plan

Elections **may not be changed outside the Open Enrollment period** unless you have a change in family status. Eligible changes in status include:

- marriage or divorce or legal separation;
- death of a spouse;
- birth or adoption of a child or a change in legal custody; and
- your or your spouse's new employment or termination of employment or other change in employment status that affects your or your spouse's eligibility for benefits.

Any change to your election because of a change in family status will be effective on the first day of the month following your election.

Health Care Spending Account

Your Health Care Spending Account allows you to pay for health-related treatments and expenses for you and your dependents not paid for by your insurance programs. The maximum contributions to the Health Care Spending Account cannot exceed $3,050 during the plan year (as of January 1, 2024). You may roll over up to $610 of unused funds at the end of the plan year. Expenses that are eligible for reimbursement from the Health Care Spending Account include, but are not limited to, the following examples:

- Deductibles and co-payments not paid by the health insurance option or dental insurance option in which you or any family members participate
- Cost of eligible procedures not covered by health or dental plans
- Vision examinations, glasses, contact lenses and supplies
- Hearing exams and hearing aids
- Alcoholism treatment, birth control, braces, chiropractor fees, prescription drug and medical supplies (used to alleviate or treat injury or illness), orthopedic shoes, psychiatric care, transportation expenses (related to the rendering of medical services), weight loss programs (if prescribed by a physician), wheelchair

All participants in the Health Care Spending Account will receive a debit card that can be used for eligible expenses at the time of purchase.

Dependent Care Spending Account

A Dependent Care FSA can save you money on dependent care expenses you pay while you're at work. These include day care and summer camps for children under age 13 and care for an elderly parent.

- You can contribute up to $5,000 a year if married and file income taxes or $2,500 if single or you're married and file separate income tax returns.
- Claims for reimbursement must be made after payment for dependent care expenses are paid.
- Reimbursements can only be made using the funds contributed at the time the claim is submitted.

Once enrolled, you can monitor your Flexible Spending Account balance by registering at **www.medcombenefits.com**.

Employee Assistance Program – Pastoral Institute

Columbus Consolidated Government provides confidential counseling sessions at the Pastoral Institute for you and your family at no cost to you.

With licensed and certified counselors located across the United States, our program gives you easy access to professional help with issues that impact your personal, family and work life. Take advantage of your benefit for any number of issues, including but not limited to, the following.

- Relationships
- Child and elder care
- Stress, anxiety and depression
- Alcohol and drug abuse and other addictions
- Domestic violence and anger
- Divorce, remarriage and step-parenting
- Grief
- Work issues

Frequently Asked Questions:

Q: How can the EAP be free to me?
A: There is not cost to you because Columbus Consolidated Government pays for a specified number of counseling sessions for you and your family.

Q: How do I set up an appointment for counseling?
A: In the Columbus area, call **706-649-6500**. When you call mention the name of your employer (Columbus Consolidated Government) and that you are using your EAP benefit.

Q: What if I don't live in the Columbus area?
A: Call 1-800-649-6446. We will provide you with the names of counselors in your area who meet our standard of care through our Affiliate Provider Network. Then, simply call the counselor's office to make an appointment. Be sure to tell them the name of your employer and that you are using your EAP benefit. Then, call us back with the date of your appointment and counselor's name.

Q: How many EAP sessions do I have?
A: Employees have access to six free visits and the spouse/children have six free visits for a total of 12 visits per year.

Q: What happens if I need more counseling sessions than the company will pay for through the EAP?
A: You have mental health coverage through your medical insurance. After your EAP sessions end, you access a provider through that coverage in the Columbus area. If your church participates in the Pastoral Institute's Covenant Congregation Program, you may be able to use that service as well.

Q: Will management at my company know I'm going to counseling?
A: No. Neither your name nor SSN is given to Columbus Consolidated Government.

Q: In addition to the employee, which family members are covered by the EAP?
A: Most companies cover your spouse, plus unmarried dependent children, stepchildren, and foster children under the age of 26 living in a parent-child relationship with the employee, including unmarried full-time students under the age of 26.

Q: What do I do if I have an emergency situation when you aren't open?
A: If you are suicidal, tell someone in your family immediately. You may also dial 911 to help get you to a safe place. If you have an existing relationship with a counselor, you may call our Counseling Center at 706-649-6500. The Pastoral Institute and its affiliates have a 24/7 on-call emergency service.

Telemedicine – Administered by New Benefits

This is a discount benefits program offering significant savings on things that matter. All of the benefits listed are available to the employee and his/her immediate family.

The membership is simple to use. Employees can search for providers on www.MeMD.me.

Packages	Benefits	*Per Pay Period Deduction
NFP Advantage	• MeMD • Online Wellness • Worklife Services • Pharmacy	$3.06

*Deduction shown covers all immediate family members living in your household.

Following your enrollment in the plan, you will receive a packet of information containing an ID card. You will be instructed to go online and register your account and list all eligible family members. Registering before receiving services will greatly reduce the wait time upon initial use.

MeMD
Illness or injury can strike suddenly! MeMD gives members and their families access to medical help via telephone or web, any time, day or night – $0 per visit. When primary care is not available, during travel or after-hours, MeMD's national network of US-licensed, board-certified medical providers is available to diagnose and prescribe medication when medically necessary for common, acute conditions.

Online Wellness
Poor health can result in poor productivity. Members have access to resources to help them get stronger, lose weight and feel better with tools to make wellness part of their daily life. Enjoy personal workouts, health tips, thousands of articles and more. Access personalized fitness plans for all stages of life, health and wellness calculators, health risk assessments, and links to hundreds of other wellness resources.

Work Life Services
Everyday help for everyday living. Work Life Services can help with the good, the challenging and everything in between. Representatives handle the heavy lifting so you can stay focused on what's important. You can be provided with information on childcare, summer camps, and school-aged programs. Receive public, private and specialty school references from kindergarten through college. Find resources for adoption, pregnancy, and disabled and aging loved ones. You can even obtain referrals for house cleaning, lawn maintenance, pet care, and home and auto repair.

Pharmacy
Members save 10% to 85% on most prescriptions at 60,000 pharmacies nationwide including CVS, Walgreens, Target and more. Just present your card to save an average of 46% on your prescriptions. Members can also compare prescription prices and find participating locations at **MyRxPrice.com**. Even if you have insurance, you can present both cards at the pharmacy to receive the lowest price. Immediate family included.

Medicare Information

I'm turning 65 this year and still actively working.

What do I need to do?

If you're turning 65 this year, you'll be getting a Medicare Enrollment kit from CMS, giving you the option to enroll in Medicare Parts A, B as well as Medicare Part D. **You'll be getting the kit 60 to 90 days before your birthday.**

Please read the Medicare materials carefully. It helps to know all you can when you decide about enrolling in Medicare.

If you're an active employee and you get health insurance through Columbus Consolidated Government, this coverage will be your primary insurance. Medicare will be your secondary coverage.

Your coverage as an active employee is considered Creditable Coverage for Medicare Parts B and D. As long as you're enrolled in health coverage through Columbus Consolidated Government as an active employee, you won't be penalized if you put off enrolling in Medicare Parts B and D until your retirement.

For more information, visit the Medicare website at:
http://www.medicare.gov or contact the Human Resources Department.

PeachCare Information

PeachCare for Kids offers free to low-cost health insurance to uninsured, eligible children living in Georgia.

Eligibility requirements:

- U.S. citizens, certain qualified legal residents, refugees or asylees who reside in Georgia.
- Age 18 and under (eligible until 19th birthday).
- Uninsured for at least 2 months
- Family income less than or equal to 247% of the federal poverty level, $49,800 for a family of three and $60,024 for a family of four.

Your child may be ineligible if:

Your child is eligible for Medicaid. If your child is potentially eligible for Medicaid, PeachCare for Kids® will forward your application to the Medicaid agency and your child will be enrolled.

If you are determined ineligible for PeachCare for Kids, you may qualify for other health benefit programs with the State of Georgia or with the Health Insurance Marketplace under the Affordable Care Act. Your information may be forwarded to those programs for review.

Changing Eligibility Requirements for Medicaid Enrollment for Children:

In 2014, the Affordable Care Act raised mandatory Medicaid eligibility to:

- 205% of the Federal Poverty Level for children from birth to 12 months of age
- 149% of the Federal Poverty Level for children from age 1 through 5
- 133% of the Federal Poverty Level for children from age 6 through 19th birthday

This means that your child may become eligible for Medicaid. When your next annual review is completed, your child may be transferred to Medicaid. Your child's case will remain with PeachCare for Kids until that time. Your Care Management Organization (CMO) will remain the same after the transfer. You will be notified of the details when this occurs.

PeachCare for Kids® health benefits include:

- Care from a doctor when your child is sick
- Preventive services such as immunizations and regular check-ups
- Specialist care
- Dental care
- Vision care, including vision screenings and eyeglasses
- Hospitalization
- Emergency room services
- Prescription medications
- Mental health care

Each child will have a choice of a Georgia Families Care Management Organization (CMO), a private health plan that is responsible for coordinating your child's health care. You will also be able to choose your child's primary care provider.

How much does it cost?

There is no cost for children under age 6. Currently, the cost per month for PeachCare for Kids® coverage is $0 to $36 for one child and a maximum of $72 for two or more children living in the same household. Once you complete the application, information about paying your premium will be displayed.

If you have any questions, please call toll-free at 877-GA-PEACH (427-3224) or visit **www.peachcare.org.**

Disclosure Notice – Prescription Drug and Medicare Notice

Important Notice from the Columbus Consolidated Government About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Columbus Consolidated Government 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:

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

2. The Columbus Consolidated Government has determined that the prescription drug coverage offered by the Anthem BCBS Gold and Silver 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 your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Columbus Consolidated Government coverage will not be affected.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the **Columbus Consolidated Government** benefit plan during an open enrollment period under the Columbus Consolidated Government benefit plan.

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

You should also know that if you drop or lose your current coverage with the Columbus Consolidated Government 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 Columbus Consolidated Government 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).

From: January 1, 2024, to December 31, 2024

Name of Entity/Sender: Columbus Consolidated Government

Contact Person: Keisha Johnson

Disclosure Notice - CHIP

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health & Human Resources
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext 61564

Disclosure Notice – Continued

Unless otherwise noted, a paper copy is available, free of charge, by calling NFP at 800-994-7429.

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

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

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

NEWBORNS' ACT DISCLOSURE:
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96) hours.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION: This Notice describes how the Plan(s) may use and disclose your protected health information ("PHI") and how you can get access to your information. The privacy of your protected health information that is created, received, used or disclosed by the Plan(s) is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice is available on the web at: www.ccg.bswift.com. A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan."

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS*:* On April 7, 1986, a federal law was enacted (Public Law 99272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. If you or your eligible dependents enroll in the group health benefits available through your Employer, you may have access to COBRA continuation coverage under certain circumstances. Therefore, your plan makes available to you and your dependents the General Notice Of COBRA Continuation Coverage Rights. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The full Notice is available on the web at: www.ccg.bswift.com . A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their spouse/dependents covered under the group health plan.

SUMMARY OF BENEFITS AND COVERAGE (SBC): As an employee, the group health (medical) benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC) which summarizes important information about any health coverage option in a standard format to help you compare across options. The SBC is available on the web at www.ccg.bswift.com. A paper copy is also available, free of charge, by calling your Employer or NFP at 800-994-7429. Please note the participant is responsible for providing a copy to their dependents covered under the group health plan.

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

Why Would I Contact the NFP Service Center?

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

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

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

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

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

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

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

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

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

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

1-844-505-9158
NFPsecustomerservice@NFP.com

Contact Information

Plan	Administrator	Website	Phone Number
Benefit/Enrollment Questions	NFP	www.NFP.com	844-505-9158
Retiree Service Center	NFP	www.NFP.com	844-505-9458
Medical Benefits	Anthem BCBS	www.anthem.com	855-397-9267
Pharmacy Benefits	OptumRx	www.optumrx.com	800-367-5690
Dental Benefits	Anthem BCBS	www.anthem.com	800-627-0004
Vision Benefits	Anthem BCBS	www.anthem.com	866-723-0515
Life and AD&D Insurance	AFLAC	www.aflacgroupinsurance.com	800-206-8826
Whole Life, Critical Illness, Hospital Indemnity	AFLAC	www.aflacgroupinsurance.com	800-433-3036
Flexible Spending Accounts	Medcom	www.medcombenefits.com	800-523-7542
Telemedicine	NewBenefits	www.MeMD.me	855-636-3669
Employee Assistance Program (EAP)	Pastoral Institute	www.pastoralinstitute.org	800-649-6446
CCG Health and Wellness Center	CareATC	www.patients.careatc.com	800-993-8244

NFP.com
1-800-994-7429