2024 EMPLOYEE BENEFITS SUMMARY

City of Dunwoody Georgia

Inside you will find information about our:

Benefits Rates | Benefits Enrollment | Health Benefits | Flexible Spending Accounts | Disability Benefits | Life Benefits

For the plan year: January 1, 2024 through December 31, 2024

This booklet provides a summary of plan highlights. Please consult the carrier's contract for complete information on covered charges, limitations, and exclusions. This is not a binding contract. The carrier's contract will prevail. If you have further questions please contact the carrier or USI Insurance Services.

2024

City of Dunwoody Georgia

November 2, 2023

Dear City of Dunwoody Employees,

As 2023 draws to a close, we are offered an opportunity to reflect on all we have accomplished together this year. I would like to express my gratitude to all of you for your hard work and determination to reach our goals. Each individual's contributions are a vital part of our success as a whole. I am proud of our team's achievements, and I appreciate your continued commitment to the City.

In an ongoing effort to provide high-quality and cost-effective benefit programs, we annually review all of our benefit plans. After a thorough evaluation, we are pleased to announce that we will keep all of our insurance plans with our current providers, and we will continue to offer the same plan options.

As always, the City is commited to offering a rich level of benefits to you and your family. In addition to the generous pay increases that Council has approved for employees over the past three years, these benefits are a significant element of your total compensation. As healthcare costs continue to increase, our costs to provide employee benefits also increase. We are very fortunate that the City will be able to continue to fund the majority of the benefits costs for employees in 2024. The full cost of employee medical and dental coverage will continue to be funded by the City. Although you will see an increase in the medical premiums for dependent coverage next year, the premiums for vision and dental will remain unchanged.

We have partnered with a new broker, USI, for our benefit plan design and benefits-related employee assistance. Feel free to utilize USI's Benefit Resource Center for help with claim issues, clarification on insurance questions, or for assistance with benefits-related problems. You will find the contact information for the Benefit Resource Center on the back cover of this booklet.

Please review this benefits booklet for detailed information on the City of Dunwoody's benefits offerings. If you or your family have any questions, please reach out to Nicole Stojka (678.382.6755) or Heather Vseer (678.382.6754), and they will be happy to assist you.

Thank you for being a valuable member of the Dunwoody team. I look forward to an exceptional year and to all we will accomplish together in 2024.

Sincerely,

Eric Linton, ICMA-CM
City Manager

Contents

Our Benefit Goals

We evaluate our benefit program each year to make sure that we accomplish several goals. We strive to:

- Promote health and wellness among City of Dunwoody employees and their dependents.
- Provide employees with affordable access to health benefits.
- Provide a competitive benefits program.
- Provide resources to support employees and their dependents as they make important decisions about their health and health care.

Reminders for This Year

- Cigna will continue to be the health insurance carrier this year.
- A Cigna pre-enrollment, customer service line will be open during open enrollment and during the year to answer any benefit or network questions.
- There will be one health insurance plan offered for employees.
- Register for www.myCigna.com to manage your health and healthcare expenses with ease. Register online and download the myCigna App.

Your Benefits are Paid for with Pre-Tax Dollars

Every penny in your paycheck counts.

To help you stretch your income, we established a Cafeteria Plan or Flexible Benefit Plan that allows you to pay for your benefits using pre- tax money.

What Does a Cafeteria Plan Mean to Me?

- You save at least 15% in Federal Tax
- You save 1.45% in FICA Tax
- You save 6% in Georgia State Tax
- More flexibility— you have a menu of benefit alternatives and levels and can choose the right options for you.

2024 Benefit Rate Sheet

2024 Benefit Rate Sheet		
Cigna POS Plan	**Monthly Employee Cost**	**Bi-Weekly Employee Cost**
Employee Only	$0.00	$0.00
Employee and Spouse	$128.76	$59.43
Employee and Child(ren)	$111.21	$51.33
Family	$239.98	$110.76
Dental Value or NAP Plan		
Employee Only	$0.00	$0.00
Employee and Spouse	$21.89	$10.10
Employee and Child(ren)	$34.74	$16.03
Family	$56.62	$26.13
Vision Discount Plan		
Employee Only	$0.00	$0.00
Employee and Spouse	$0.00	$0.00
Employee and Child(ren)	$0.00	$0.00
Family	$0.00	$0.00
Vision Buy-Up Plan		
Employee Only	$6.37	$2.94
Employee and Spouse	$12.08	$5.58
Employee and Child(ren)	$12.68	$5.85
Family	$18.68	$8.62

Note: Other benefits and applicable costs will be discussed in new hire orientation

Open Enrollment

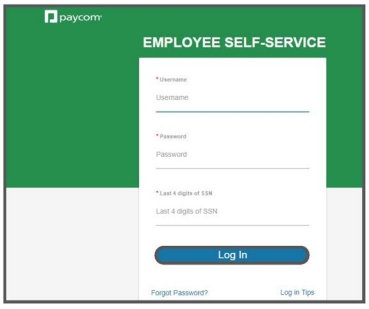
To make benefits enrollment faster and more convenient, we conduct Open Enrollment through the City of Dunwoody Paycom Portal.

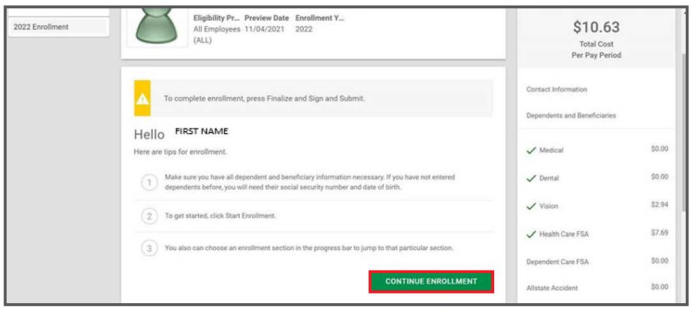
TIP ***Open Enrollment begins on Thursday, November 2nd and ends at 11:59pm on Monday, November 13th. All changes to your benefits must be completed by 11:59pm on Monday, November 13th.***

How to Enroll for Benefits

To enroll:

1. Log on to the City of Dunwoody Paycom website at www.paycom.com
2. Complete the following fields on the Login page:
   - Select Employee Login
   - Enter Username
   - Enter Password
   - Enter Last 4 Digits of SSN



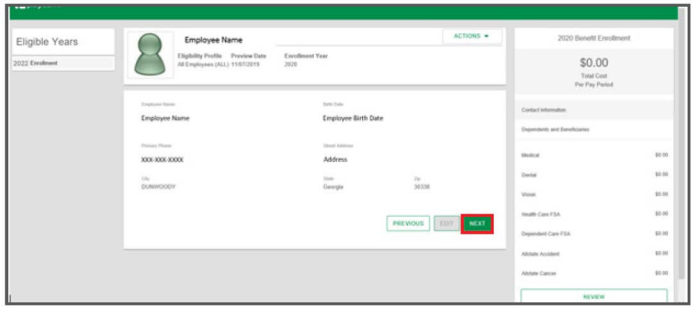


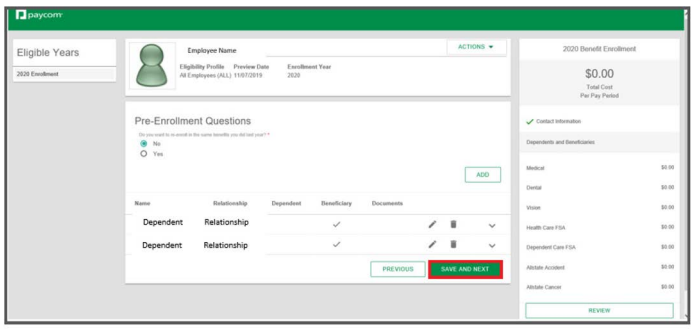
3. Logging into Paycom, you will see a notification letting you know that it is time for Open Enrollment. Once you click on that notification, it will bring you into Open Enrollment.

   After reading the tips, click "Continue Enrollment," which will bring you to a page to review your information.

4. After confirming all of your personal information, and editing if necessary, click "Next." You will then be asked if you would like to re-enroll in the same benefits you did last year. On this screen, you also will review/add/edit/delete dependents and beneficiaries as needed. Click on the down arrow on the row for each dependent to expand and view the current information in the system.

   <u>Please note that this year, we are doing a PASSIVE ENROLLMENT, meaning that even if you select "No" on the question for if you would like to re-enroll in the same benefits as last year, the system will default to your current elections and you will be re-enrolled in the same benefits UNLESS you make changes. If you need to make changes, you will have the opportunity to do so in the following steps.</u>

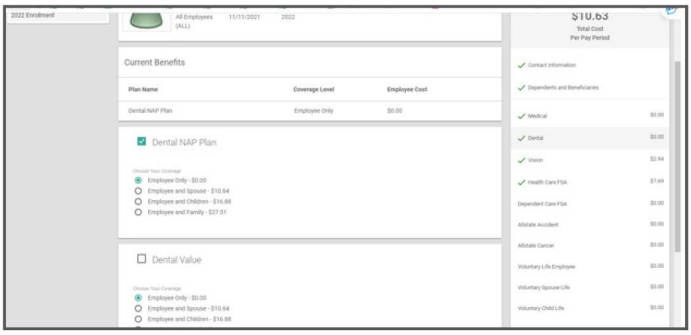




5. If you select "Yes" on the question for if you would like to re-enroll in the same benefits as last year, you will be brought straight to the review and finalize page after you click "Save and Next." Review carefully before finalizing. If you wish to make a change, click on the plan you would like to change in the sidebar menu on the right. Then use the following steps to make a change to that plan.

   If you choose "NO," once you click "Save and Next," you will be brought into the enrollment for each benefit, where you can make changes, leave your enrollments the same, or decline coverage.

How to Enroll for Benefits - continued

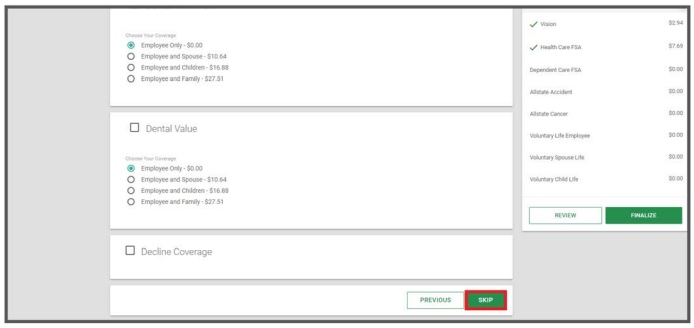


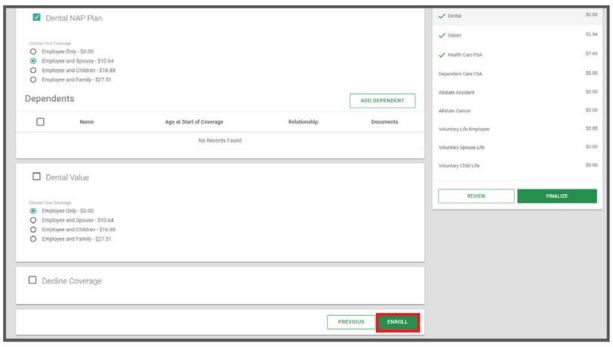
6. Your current 2023 enrollment elections will appear above the new 2024 options. If you do not see this section on a particular benefit plan page, it means you are not enrolled in that benefit in 2023.

   <u>The Paycom system may skip sections of the enrollment if you are already enrolled or if there is only one plan option available. If you want to review or make a change to a plan that is skipped, click on that plan in the menu on the right hand side.</u>

   For example, Paycom will skip medical coverage since there is only one plan and it may go to dental next. If you want to review or make a change to medical, click on medical, which is above dental in the menu on the right hand side.

7. If you chose to keep your coverage the same as the previous year, you will select "Skip," which will leave your elections as they were.

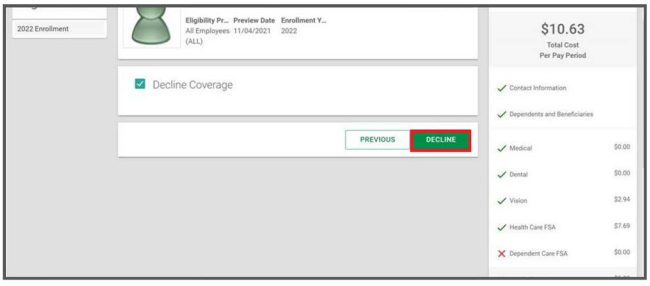




8. If you need to make a change to the enrollment coverage level, you will mark what you want to elect and then an "Enroll" button will appear.

   For example, if you get to the Dental coverage section and see that you are currently enrolled in Employee Only coverage but need to change it to Employee and Spouse, you will select the Employee and Spouse option, which will make the "Enroll" button appear. Once that happens, you will click the "Enroll" button.

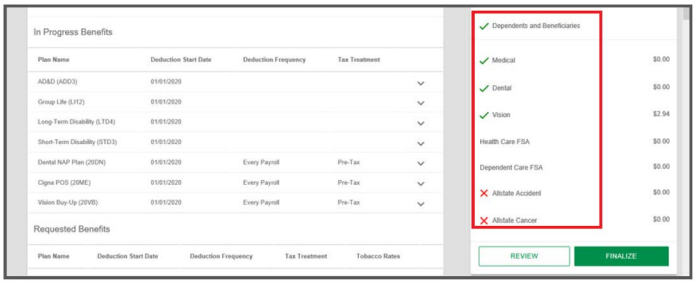
9. If you chose to decline the coverage, you will check the "Decline Coverage" checkbox and then a "Decline" button will appear for you to select.

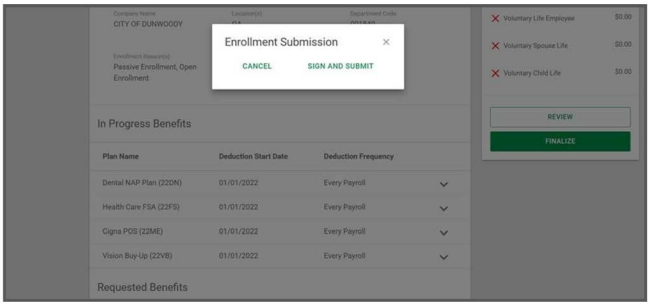


How to Enroll for Benefits - continued

10. Once you click on either the “Enroll,” “Skip,” or “Decline” button, you will be guided to the next benefit selection available to you, and you will continue this process until you are done with your enrollments.

11. Once you are done making all of your elections, you will see a review page where you can review all of the elections you have made. Please verify that there is either a ✓ (green check-mark) or X (red X) next to each benefit on the right side panel. After reviewing, click “Finalize” on the right side of the page. Please note that if any of the plans do not have a ✓ (green check-mark) or X (red X) next to them before you finalize, sign and submit, those plans will be automatically declined.





12. After clicking Finalize, an Enrollment Submission pop-up box appears. Click “Sign and Submit” for your enrollments to be submitted.

Congratulations! You have completed Open Enrollment.

If you have any questions about using the City of Dunwoody Paycom Portal, or if you’ve made an enrollment error, please contact Nicole Stojka at 678-382-6755 or nicole.stojka@dunwoodyga.gov or Heather Vseer at 678-382-6754 or heather.vseer@dunwoodyga.gov.

Benefit Eligibility

Full-time employees are eligible for benefits on the date of hire for medical, dental, vision, and FSA benefits. Life and disability benefits will begin on the first day of the month following 90 days of service.

Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian.

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children under age 26 (coverage extends through the end of the month in which the child turns 26 for medical, dental and vision)
- Children under age 26 for optional life insurance
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

Many employees have other dependents living with them who are not eligible for our benefit plan.

Dependents NOT eligible to be added to your benefit plans:

- Grandchildren, nieces, nephews or other children who do not meet specifications listed to the left
- Common-law spouses or domestic partners (same or opposite sex)
- Ex-spouses, unless required via court order (documentation required)
- Parents, step-parents, grandparents, aunts, uncles, or other relatives who are not qualified legal dependents (even if they live in your house)

Making Changes to Your Benefits

Most benefit deductions are withheld from your paycheck on a pre-tax basis (medical, dental, vision, and flexible spending accounts), and therefore your ability to make changes to these benefits is restricted by the IRS.

Open Enrollment elections are effective January 1, 2024 and stay in effect until December 31, 2024 unless you experience a Life Status Change. To be eligible to make benefit changes because of a Life Status Change, you must notify Human Resources within 30 days of the date of the qualifying event. Proof of your life event may also be required. Changes outside of the 30-day period are not allowed until the next annual Open Enrollment period, unless you experience another qualified Life Status Change.

To make benefit changes as a result of your Life Status Change as allowed under Section 125 of the IRS Code, you must:

- Notify Human Resources within 30 days of the date of the qualifying event
- Provide proof of your life status event
- Complete and submit your enrollment form

The Most Common Life Status Changes

- Marriage, divorce, legal separation
- Birth or adoption
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order or other court order

myCigna.com

Register today. It's this easy:

1. Go to www.myCigna.com and select "Register."
2. Enter your personal details like name, address and date of birth.
3. Confirm your identity with secure information like your Cigna ID, social security number or a security question. This will make sure only you can access your information.
4. Create a user ID and password.
5. Review and submit.

Now you're ready to log in to your personal, secure www.myCigna.com site. See how the site has been redesigned with you in mind, making it easy to navigate and find what you need:

- Manage and track claims
- Find doctors and medical services
- Manage and track your health information
- See cost estimates for medical procedures
- Compare quality of care ratings for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Print ID cards

Medical Benefits

For 2024, the City of Dunwoody will offer one Cigna POS medical plan.

The POS option works like a traditional health plan. Employees pay a $25 copay to see a primary care physician. If the physician is a Cigna Care Designated (CCD) or Tier 1 provider then the copay for an office visit will be $15. The copay for a specialist office visit is $50. If the specialist is a Cigna Care Designated (CCD) or Tier 1 provider then the copay for the visit will be $30. Cigna Care Designation can be found on the www.myCigna.com website (look for "C" symbol) or by calling 1-866-494-2111.

The plan also has a $500 individual and $1,500 family deductible for certain other services such as hospitalization. Once the deductible is met, the plan begins to pay at 100%. The maximum out of pocket is $850 for an individual and $2,550 for a family.

Prescription drugs are covered with a copay both at retail pharmacies and Cigna home delivery.

There is in and out of network coverage on the Cigna plan. However, out of network services are subject to a higher deductible, cost more and you may have to file your benefits claims yourself. Always stay in network if possible and remember to check the Cigna App or www.myCigna.com to verify participating providers and facilities.

For specifics on the Cigna POS plan, please refer to the following pages.

myCigna App with Cigna One Guide Service

myCigna Mobile App gives you a simple way to personalize, organize and access your important health information – on the go. It puts you in control of your health, so you can get more out of life.

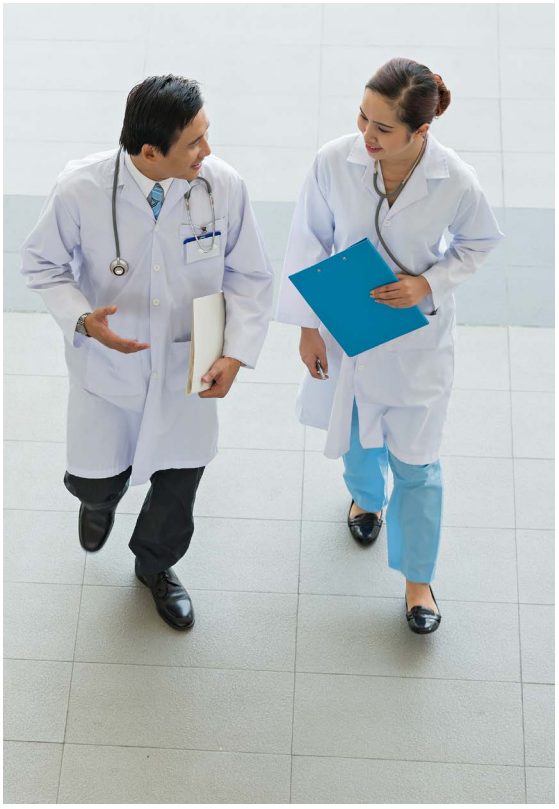
myCigna App with Cigna One Guide Service has big features:

- Access the health care professional directory
- View and easily print, email, and scan your ID cards
- View and search recent and past claims
- Look up and compare drug costs and find the closest pharmacy
- Access and view account balances
- Store and organize important contact information
- Custom health team feature to keep track of your in network doctors, dentists and facilities
- Receive proactive messages from Cigna to guide you
- Click to chat feature when you need assistance

MEDICAL: CIGNA POS PLAN

Cigna POS Plan	In-Network Benefits	Out-of-Network Benefits
Lifetime Maximum	Unlimited	Unlimited
Deductible	$500 individual/$1,500 family	$1,500 individual/$4,500 family
Out-of-Pocket Maximum (includes deductible, coinsurance, medical copays and Rx copays)	$850 individual/$2,550 family	$2,550 individual/$7,650 family
Office Visits: Preventive Care		
Well Child and Immunizations	Plan pays 100% (not subject to deductible)	Plan pays 70% after deductible (deductible waived thru age 5)
Periodic Health Examinations	Plan pays 100% (not subject to deductible)	Plan pays 70% after deductible
Annual Gynecology Examination or Prostate Screening	Plan pays 100% (not subject to deductible)	Plan pays 70% after deductible
Office Visits: Illness or Injury		
Primary Care Physician (includes lab, x-rays, and diagnostic procedures)	$25 copay/$15 copay with CCD or Tier 1 provider	Plan pays 70% after deductible
Laboratory Services as Part of Physician Visit	$25 copay/$15 copay with CCD or Tier 1 provider	Plan pays 70% after deductible
Specialty Care Visit	$50 copay/$30 copay with CCD or Tier 1 provider	Plan pays 70% after deductible
Urgent Care Visit	$60 copay	
Virtual Care Visit	$15 copay	N/A
Maternity Physician Services (prenatal, delivery, postpartum)	PCP or specialist copay (first visit only); plan pays 100% after deductible for delivery	Plan pays 70% after deductible
Allergy Care (testing, serum, shots)	$25 primary care copay/$50 specialist copay	Plan pays 70% after deductible
Inpatient Services		
Daily Room, Board, Nurse Care (at semi-private room rate), ICU, and Diagnostic	Plan pays 100% after deductible	Plan pays 70% after deductible
Physician Services	Plan pays 100% after deductible	Plan pays 70% after deductible
Outpatient Services		
Surgery Facility & Hospital Charges	Plan pays 100% after deductible	Plan pays 70% after deductible
Independent Lab or Outpatient Facility	Plan pays 100% (not subject to deductible)	Plan pays 70% after deductible
Physician Services	Plan pays 100% after deductible	Plan pays 70% after deductible
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 70% after deductible
Emergency Room (Non-emergency use of Emergency Room is not covered)	$150 copay (waived if admitted)	
Therapy Services		
Speech/Occupational Therapy (30-visit calendar year max)	$50 copay at Specialist Office	Plan pays 70% after deductible
Physical Therapy (30-visit calendar year max)	$50 copay at Specialist Office	Plan pays 70% after deductible
Chiropractic Care (30-visit calendar year max)	$50 copay at Specialist Office	Plan pays 70% after deductible
Respiratory Therapy	Plan pays 100% after deductible	Plan pays 70% after deductible
Radiation Therapy, Chemotherapy, Cardiac Rehabilitation (no limit on visits per benefit period)	Plan pays 100% after deductible	Plan pays 70% after deductible
Other Services		
Skilled Nursing Facility (60-day calendar year max)	Plan pays 100% after deductible	Plan pays 70% after deductible
Home Health Care (120-visit calendar year max)	Plan pays 100% after deductible	Plan pays 70% after deductible
Hospice Care	Plan pays 100% (not subject to deductible)	Plan pays 70% after deductible
Ambulance (when medically necessary)	Plan pays 100% after deductible	
Mental Health / Substance Abuse - Services must be precertified.		
Inpatient	Plan pays 100% after deductible	Plan pays 70% after deductible
Outpatient	$25 copay	Plan pays 70% after deductible
Prescription Drug (Mail order maintenance prescriptions have a 90-day limit, except Specialty drugs stay 30-day limit.)		
Generic Preferred	$15 copay	
Brand Preferred	$35 copay	
Non-Preferred	$60 copay	
Specialty Drugs	Member pays 20% coinsurance (up to $300 maximum per prescription)	
Home Delivery (90 day)- Generic/Brand/Non-Preferred	$15 / $70 / $180	
Retail (90 day)- Generic/Brand/Non-Preferred	$45 / $105 / $180	

Note: Cigna Care Designation symbol as shown on www.myCigna.com network directory.



Cigna Member Benefits

Look for the Tier 1 or the Cigna Care Designation!

Tier 1 and Cigna Care Designation (CCD) providers will save the member more money with out of pocket expenses. The Tier 1 provider network is slightly broader than the CCD network and allows a full range of providers for our members.

What does the Cigna Care Designation mean?

Before Cigna awards a doctor the Cigna Care Designation, they do a lot of fact-finding. Doctors in 21 different medical specialties are assessed for quality and cost efficiency, since quality care doesn't have to mean higher costs. Whenever you use the myCigna online directory to find a doctor, you'll see top-performing doctors are shown with the Cigna Care Designation symbol. This gives you an unbiased evaluation of quality and cost that you can trust.

Get help choosing a hospital, too.
Just look for the Centers of Excellence Designation.

Choose an in-network hospital that's right for you. Cigna reviews how successful a hospital is in treating 27 common conditions. Their ratings are based on actual patient outcomes, average lengths of stay, and average costs gathered from outside sources. Hospitals that demonstrate better health outcomes at lower costs for one of the reviewed conditions earn the top rating – the Cigna Centers of Excellence designation. See the hospital ratings on www.myCigna.com.

Cigna Home Delivery Pharmacy

Cigna home delivery is designed especially for individuals who take prescription medications on a regular basis, such as those used for diabetes, asthma, heart conditions, high blood pressure, birth control and more

You will enjoy:

- Easy refills – up to a 90-day supply means fewer refills
- Cigna's free QuickFill service will call or email you when its time to refill your prescriptions
- Fast answers from Cigna pharmacists 24/7 1-800-285-4812

Quickswitch makes filling a prescription simple:

Have this information handy when you call and Cigna will do the rest.

- Name and Cigna ID number
- Prescription medication names and dosage (for you or covered family member)
- Doctor information (name, phone number)
- Payment information (American Express, Discover, MasterCard or Visa)

With this information, we will request a prescription from your doctor. Once we receive it, we will fill your medication and mail it to your home or other location of your choice.

30-Day Specialty Medication Supply Limit:

Specialty medications are used to treat rare and chronic conditions. These medications are costly and are one of the fastest growing components of health care costs. On average, members fill specialty medications twice a year costing around $6,300 per prescription. As a member continues through therapy, the need often arises to change the prescription due to side effects or a new medication may come to market that can more effectively treat the condition. Many of these medications are then wasted because the member has to discontinue the old medication for the new.

Specialty medications are limited to a 30-day supply at retail and Cigna Home Delivery Pharmacy.

Cigna Virtual Care

How Medical Virtual Care Works:

Register with the Vendor (MDlive) at www.myCigna.com - Advanced registration allows services to be available when you need them.

Virtual Care By Phone:

Step 1: Call Toll-Free
Patients call the MDlive toll-free hotline at 1-888-726-3171, which is available 24/7/365 including holidays.

Step 2: Speak with a Coordinator
A consultation coordinator locates the next available doctor and prepares patients for the consultation.

Step 3: Speak with a Doctor
Once an available doctor is located, the system automatically calls and connects the doctor to the patient.

Virtual Care By Video Conference:

Step 1: Visit the Website
Patients visit the MDlive website or can download the mobile app and then log in with user name and password.

Step 2: Find a Doctor
The system helps the patients search for a doctor by criteria, such as specialty, language, gender, location, or simply finds the next available doctor.

Step 3: See the Doctor Online
Once an available doctor is located, the system automatically calls and connects the doctor to the patient.

Cigna Care Management

What is Care Management Preferred? Care Management Preferred offers a comprehensive care management solution. Our model is:

Inpatient and outpatient precertification
Precertification helps the members know in advance whether a procedure, treatment or service will be covered under their health care plan. It also helps make sure they get the right care in the right setting. This could save them from costly or unnecessary care.

Dedicated care managers connect the dots
Our care managers work with the members, their families and their doctors. Our approach integrates medical, behavioral, pharmacy, disability, and disease management. All while helping customers maximize their benefits.

One team, one goal: Outstanding customer support
Our care management approach is delivered through a multi-disciplinary team including a nurse, social worker, medical director, pharmacist and behavioral professional. We connect the dots, bring together the right people and resources to help improve the health of the members.

Specialty care management for whole health support
Cigna's Specialty Care Management programs are designed to help members with complex health issues. These programs feature care managers who are nurses with expertise and training in condition management.

Healthy Rewards

Cigna's Healthy Rewards® provides discounts of up to 60% on various wellness programs and services, ranging from Weight Management and Nutrition, to Vision and Hearing Care, and Tobacco Cessation. To learn more about these and other Healthy Rewards® programs, visit www.myCigna.com, hover over Wellness, select Wellness Home, or select one of the six categories (Food, Stress, Sleep, Exercise, Weight, Prevention) to view discount programs.

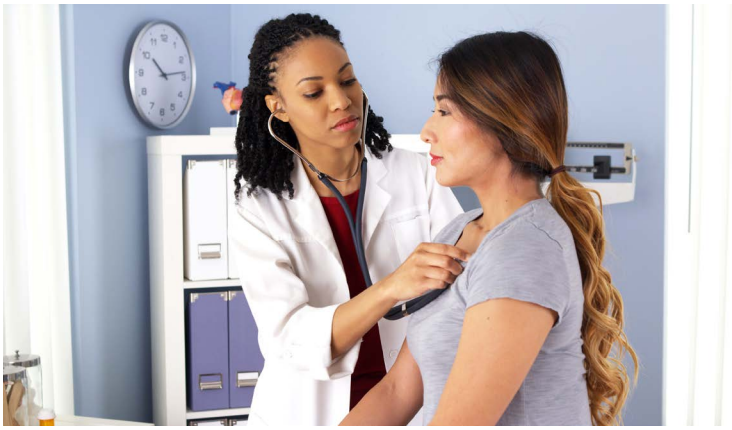
TIP ***For a complete list of Healthy Rewards vendors and programs call 1-800-258-3312.***

How to Save Money with Cigna!

With healthcare costs continuing to rise, it's more important than ever to be conscious of how much you are paying for the care you receive. Becoming an educated healthcare consumer is a great way to help you manage your out-of-pocket healthcare expenses. You don't have to go it alone. Cigna is on your side. Cigna has the tools and support you need to help you find a quality in-network doctor near you, including 24/7 live customer service, plus a host of valuable resources to help you manage and track claims, and compare cost and quality information. Cigna tools are accessible online or on the go, through www.myCigna.com or with the free myCigna mobile App.

Top Seven Tips to Save Money with Cigna

1. Schedule your annual checkup.



Preventive care is key to good health and is covered at 100%. Getting your annual checkup can help keep you in shape. Covered services include:

- Routine physical examinations
- Well baby and child care
- Screening mammography
- Screening colonoscopy or sigmoidoscopy
- Cervical cancer screenings
- Prostate cancer screening
- Diabetes screenings
- Bone and mineral density tests

The best way to treat a serious illness is by catching it early or stopping it from happening. During your checkup, your doctor can often detect the early signs of more serious issues. Remember, in order to receive the 100% preventive care benefit, services must be received in accordance with USPTF guidelines under Health Care Reform and your physician must code the claims as preventive.

Call Cigna 24/7/365 at 1-866-494-2111 to help find a primary care provider within your area!

2. Find the best providers.

The Cigna Care Designation (CCD) is one decision-making tool you can use to choose a doctor. Cigna checks education and board certifications, and they also check to see if the quality of care has earned recognition from within the medical industry. Providers who meet Cigna's specific quality and cost-efficiency criteria will have the Cigna Care Designation symbol next to their name in the online provider directory tools. Quality recognition ratings are assigned to providers and provider groups indicating the quality criteria met, and stars are used to communicate cost-efficiency performance as compared with their peers of the same specialty type and geographic market. Results in the top category for cost-efficiency assessment will be displayed with three stars.

Sample: Online Health Care Professional Directory display (myCigna.com)

Cigna Care Designation Symbol

Cost Efficiency Rating

MEDICAL: CIGNA COST SAVINGS TIPS

3. Find the most cost effective Rx.

There are three ways to spend less on medicine:

- **Buy generic.** When it comes to generic vs. brand name drugs, the main difference is name and appearance. Generic drugs are manufactured to be just as effective as brand name drugs and they are less expensive. Always check with your doctor or pharmacist to understand your options.
- **Ask your doctor about getting a three-month supply of your prescription.** 90-day prescriptions may be filled using Cigna Home Delivery Pharmacy or your preferred retail pharmacy. You may be able to save money when you switch from a retail pharmacy to Cigna's Home Delivery Pharmacy. Call Cigna Home Delivery Pharmacy at 1-800-285-4812.
- **Compare drug costs at different pharmacies.** Login to www.myCigna.com> Select Prescriptions Tab> Select "Price a Medication"> Enter or Select a Drug Name> Enter Form/Dosage, Quantity, Frequency and Duration> Get cost estimates.

4. Stay In-Network.

Costs will be lower if you choose to see doctors, hospitals and facilities in Cigna's network. If you use an out-of-network provider, your costs can add up quickly. You're going to pay full price and not the discounted price an in-network doctor would charge. Out-of- Network doctors / facilities may balance bill you for the amount that Cigna does not cover. When you are scheduled for surgery, ensure that the surgeon, anesthetist, and facility are all In-Network.

How to search for an In-Network Provider:

- **The provider directory on www.myCigna.com shows you results based on your health plan network and your location.** Log in to myCigna.com> Select Find Care & Costs Tab> Find care and cost estimates in your area by "Immediate Care, Doctor by Type, Doctor by Name, Reason for Visit, or Health Facilities"> Select "Doctor by Type" and Enter a specialty or type of doctor> For example, type "Primary Care Provider"> Results for In-Network primary care providers near your area will be displayed.
- **Know before you go.** Before you visit any provider or facility, we recommend you call ahead to be sure they are in your plan's network, as well as confirm their address, office hours, and that they are accepting new patients. Cigna is available 24/7/365! Call anytime day or night for live customer service at 1-866-494-2111.

5. Shop with Cigna for the best outpatient facilities for diagnostic tests.

Costs can vary significantly depending on where you receive care. MRIs, CTs and PET scans can cost much less at some facilities. You can save by making a more informed choice about where you get your services. You could save money without giving up quality care. Local facilities offer the same services at a lower cost.

- **The provider directory on www.myCigna.com shows you cost of service within your location.** Login to www.myCigna.com> Select Find Care & Costs Tab> Find care and cost estimates in your area by "Immediate Care, Doctor by Type, Doctor by Name, Reason for Visit, or Health Facilities"> For example, Select "Reason for Visit" and Enter procedure "Shoulder MRI Scan with Dye"> Select Facilities> Results for facility costs near your area will be displayed.
- **Connect directly with the Cigna Customer Service team.** Cigna's team can find the most cost-effective facility for a service. Cigna will help you compare costs for hundreds of procedures. Call anytime day or night for live customer service at 1-866-494-2111.

Freestanding Facility vs Outpatient Hospital	
Radiology Center Cost	**Outpatient Hospital Cost**
MRI: $706	MRI: $1,676
CT Scan: $457	CT Scan: $1,376
Potential Savings: Over $900	

National averages of participating facilities; actual costs will vary. The information provided here is intended to be general information on how you can get the most out of your plan and your health care dollars. It is not intended as medical advice. You should consider all relevant factors and consult with your treating doctor when selecting a provider for care.

6. The value of In-Network labs.

One of the biggest contributors to your health care costs may be laboratory expenses. You can save money if you use an In-Network lab instead of an Out-of-Network lab. Cigna's network includes national labs like LabCorp or Quest as well as regional and local labs. It's easy to find In-Network labs in your area by using the Cigna directory. These In-Network labs can provide general and specialty laboratory and pathology testing in locations that are convenient and cost-effective. You have a choice when it's time for lab tests, like blood work. Labs in Cigna's network give you quality service at a lower cost. When your doctor says you need lab tests, tell your doctor you want to stay In-Network. Even if samples are taken in the doctor's office, you can ask for them to be sent to an In-Network lab.

7. Access care in the right settings.

Deciding whether to see a doctor, go to urgent care, or use another option can be difficult. When you need treatment for common ailments and injuries, you have more choices. Now you can get high-quality, affordable services for a wide variety of routine medical conditions through different types of settings.

Cigna Health Information Line: A telephone service staffed by nurses that helps you understand and make informed decisions about health issues you are experiencing, at no extra cost. It can help you choose the right care in the right setting at the right time, whether it's reviewing home treatment options, following up on a doctor's appointment, or finding the nearest urgent care center. Just call Cigna at 1-866-494-2111.

Your Guide For Where To Go When You Need Medical Care				
Cigna Virtual Care	**Convenience Care Clinic**	**Doctor's Office**	**Urgent Care Center**	**Emergency Room**
Treat minor medical conditions. Connect with board-certified doctor via video or phone.	Treat minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies.	The best place to go for routine or preventive care, to keep track of medications.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to nearest ER.
Colds and flu Rashes Sore throats Headaches Stomachaches Fever Allergies Acne UTIs and more	Colds and flu Rashes or skin conditions Sore throats, earaches, and sinus pain Minor cuts or burns Pregnancy testing Vaccines	General health issues Preventative care Routine checkups Immunizations and screenings	Fever and flu symptoms Minor cuts, sprains, burns, rashes Headaches Lower back pain Joint pain Minor respiratory symptoms Urinary tract infections	Sudden numbness, weakness Uncontrolled bleeding Seizure or loss of consciousness Shortness of breath Chest pain Head injury/ major trauma Blurry or loss of vision
Costs same or less than a visit with primary care provider. Appointments typically in an hour or less.	Costs same or lower than doctor's office. No appointment needed.	May charge copay/ coinsurance and/or deductible. Usually need appointment.	Costs lower than ER. No appointment needed. Wait times will vary.	Costs highest. No appointments needed. Wait times may be long.

The information provided here is intended to be general information on how you can get the most out of your plan and your health care dollars. It is not intended as medical advice. You should consider all relevant factors and consult with your treating doctor when selecting a provider for care.

Ready to End Your Tobacco Addiction?

In order to support our employees in their goals to end tobacco usage, the City is proud to offer a tobacco cessation product reimbursement program. The program reimburses employees and spouses for tobacco cessation products only. The amount of available funds is subject to annual appropriation by Council. The individual reimbursement limit is $1,500 per year. Spouses are eligible for reimbursement only if funding exists after employees who wish to participate do so. Please contact Human Resources for more information about the program.

Tobacco cessation treatment options include hypnosis, prescription alternatives, acupuncture, and over-the-counter remedies such as the patch and gums that include nicotine products or natural formulas. Studies show that treatment programs through a facility or physician that also include therapy and social support are usually more effective for long-term success than other alternatives.

Health Benefits of Quitting

Within 20 minutes:

- Your blood pressure and pulse rate drop to normal.

Within 24 hours:

- Your risk of a sudden heart attack goes down.

Within 2 weeks to 3 months:

- Your circulation improves. Walking becomes easier. Your lungs work better. Wounds heal more quickly.

Within 1 to 9 months:

- You have more energy. Your coughing, nasal congestion, fatigue, and shortness of breath improve.

Within 1 year:

- Your risk of coronary heart disease is half that of someone still using tobacco.

Within 5 years:

- Your chances of developing lung cancer drop by nearly 50% compared to people who smoke one pack a day. Your risk of mouth cancer is half that of a tobacco user.

Within 10 years:

- Your risks of cancer goes down. Your risk of stroke and lung cancer are now similar to that of someone who never smoked.

Finding the Right Tobacco Cessation Program

The program that works best for you may be very different from the program that works best for someone else. Talk to your primary care physician because he/she is one of your best resources for finding cessation programs designed to meet your total health needs. Your physician can discuss over-the-counter and prescription medications and provide a reference to tobacco cessation programs as well.

A tobacco user spends on average $2,500 a year on tobacco alone and incurs higher health care costs over their lifetime. Living a tobacco-free lifestyle can help save you thousands of dollars and improve your energy level and your quality of life.

RESOURCE LIST

Your Physician

Cigna Lifestyle Management Tobacco Cessation Program

Georgia Tobacco Quitline
1-877-270-7867

CDC-Tobacco Information and Prevention Source (TIPS)
www.cdc.gov/tobacco

Smoke Free Support
www.smokefree.gov

E-Cigarettes
https://e-cigarettes.surgeongeneral.gov/

American Lung Association
https://www.lung.org
1-800-LUNG-USA (1-800-586-4872)

American Heart Association.
Healthy for Good™

How much physical activity do you need?

Here are the American Heart Association recommendations for adults:

Fit in 150+

Get at least 150 minutes per week of moderate-intensity aerobic activity or 75 minutes per week of vigorous aerobic activity (or a combination of both), preferably spread throughout the week.

Move More, Sit Less

Get up and move throughout the day Any activity is better than none. Even light-intensity activity can offset the serious health risks of being sedentary.

Add Intensity

Moderate to vigorous aerobic exercise is best. Your heart will beat faster, and you'll breathe harder than normal. As you get used to being more active, increase your time and/or intensity to get more benefits.

Add Muscle

Include moderate to high-intensity muscle strengthening activity (like resistance or weight training) at least twice a week.

Feel Better

Physical activity is linked with better sleep, memory, balance and cognitive ability. And less risk of weight gain, chronic disease, dementia and depression. It's one of the most important things you can do for your health and well-being.

Move more, with more intensity, and sit less.
Find out how at https://www.heart.org/en/healthy-living/fitness.

Employee Assistance Program (EAP)

The Standard and Health Advocate is our confidential EAP provider.

The EAP provides employees and their family telephonic and online access to Master's Level Counselors who can assist with a variety of issues including:

- Child care resources
- Relationship problems
- Depression
- Financial concerns
- Grief issues
- Stress
- Alcohol and drug abuse

TIP ***To access our EAP, call 1-888-293-6948 or visit www.healthadvocate.com/standard3.***

Fitness Center Memberships

The City of Dunwoody offers free fitness center memberships to our employees.

The memberships are currently available through two organizations, both with fitness center locations in Dunwoody. Dunwoody Baptist Fitness Center offers free memberships to all City employees. The Marcus Jewish Community Center offers a free membership to our sworn Police Department employees. Please see Human Resources for more information.

Cigna offers discounted fitness center memberships to eligible members.

Cigna members and any dependents over the age of 18 are eligible to join the Active & Fit gym membership network.

Start by logging in to www.myCigna.com > Wellness > Exercise > Healthy Rewards > Start Saving > Become a Gym Member. Memberships are $25 per month (plus a $25 enrollment fee) which allows you access to multiple local gyms in the Active & Fit network.

Identity Theft Protection-IdentityForce

IdentityForce through Sontiq offered through your Cigna medical plan at no additional cost.

Now is the time to protect what is most important. As our digital activity expands, fraud and scams increase exponentially, along with vulnerabilities that result from having sensitive personal information exposed. It's why IdentityForce offered through Cigna will be included in your Cigna medical coverage at no additional cost for you and any child(ren) living in your household up to age 26. IdentityForce will provide you with award-winning identity theft protection built to proactively monitor, alert, and help fix any identity theft compromises.

Plan Features:

Privacy and Security

- Password Manager
- Bank and Credit Card Activity Alerts
- Identity Vault and Secure Storage
- Auto On Monitoring
- Advanced Fraud Monitoring (Instant Inquiry Alerts)
- Change of Address Monitoring
- Identity Threat Alerts
- Smart SSN Tracker (SSN Monitoring)
- Lost Wallet Assistance
- 401(k), HSA & Investment Account Activity Alerts

Credit Monitoring

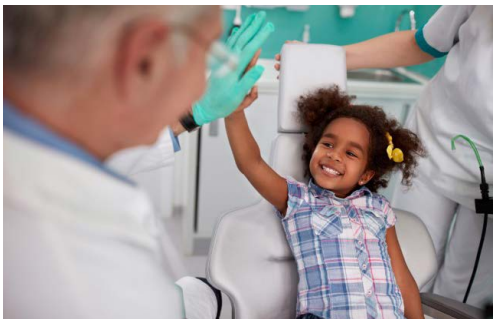
- Credit Report Assistance
- Credit Freeze and Lock Assistance (Adult and Child)
- Credit Report Monitoring (Daily)
- Credit Report and Score (Quarterly)
- Credit Score Simulator

Restoration Services

- White Glove Restoration
- Pre-existing Identity Theft Restoration
- Deceased Family Member Fraud Remediation
- Identity Theft Insurance
- Stolen Funds Replacement

Three ways to enroll in IdentityForce:

1. Employees with Cigna medical who are registered on www.myCigna.com will receive an enrollment link email directly from IdentityForce
2. Call 833-580-2523
3. Visit https://cigna.identityforce.com/starthere



Dental Plan

Good oral hygiene is part of a healthy lifestyle.

We offer two different Guardian dental plans at the same cost. The Value Plan provides the best value if you stay in-network. The Network Access Plan provides a better benefit if you usually use out-of-network providers.

It's About More Than a Pretty Smile

Our oral health affects our ability to speak, smell, taste, chew, and swallow. However, oral diseases, which can range from cavities to oral cancer, cause pain and disability for millions of people each year.

DENTAL

	Value Plan	Network Access Plan
Calendar year Deductible	No deductible	$50 individual $150 family
Out-of Network Reimbursement (In-network reimbursement is always paid at the contracted rate)	Members billed for charges above contracted rates	Members billed for charges above the 90th UCR amount
Preventive Services • Oral exams, dental cleanings and Fluoride (2 per year)	100%	100% no deductible
Basic Services • Denture adjustments, repairs to existing crowns, repairs to dentures and bridges, fillings, ViziLite Plus®, periodontal procedures, extractions and anesthesia (when medically necessary), and white resin fillings (for all teeth).	100%	80% after deductible
Major Services • Inlays, onlays, crowns, root canals, dentures, bridges and endodontic procedures	60%	50% after deductible
Orthodontia (dependents up to age 19)	50% to $1,500 lifetime maximum	50% to $1,500 lifetime maximum
Maximum Annual Benefit (per individual per calendar year)	$1,500	$1,500

** ViziLite Plus assists dentists in the early detection of oral cancer. Guardian's plan covers Vizilite Plus exams for members over the age of 40, once every two years.*

Finding a Provider

Guardian's online DentalGuard Preferred Provider (PPO) Directory makes it easy to find in-network dentists. **To find out if your dentist is in-network, call 1-800-627-4200.**

Visit https://www.guardianlife.com/dental-insurance and from the home screen follow these directions:

1. Locate "Find a Dentist" at the top of the page. Then select "Dental benefits bought through your workplace." The page defaults to PPO: DentalGuard and then you can search by location, dentist name, or office name
2. Enter a Zip or City and State and Miles
3. Narrow the search by Dentist Last Name or Office Name
4. Click "Search"
5. This brings up a provider list that can be printed or emailed

You can also download the Guardian mobile app to find a provider and view your ID card.

Visit Your Dentist Regularly

Regular preventive visits to your dentist can help protect your health, and we are talking about more than just your mouth. Recent studies have linked gum disease to damage elsewhere in the body. According to the Centers for Disease Control and Prevention, there may be associations between oral infections and diabetes, heart disease, stroke, and preterm, low-weight births. Research is underway to further examine these connections.

Our plan covers preventive services at 100% in-network, with no deductible. Plan members can visit a DentalGuard Preferred Provider every six months for an oral exam and the plan pays for 100% of preventive services. You can visit any dentist, however, stay in-network if you want the best value.

Dental Benefit Rollover Feature

Guardian automatically rolls over a portion of each member's unused annual maximum into that member's Maximum Rollover Account (MRA). The MRA can be used in future years, if a member reaches the plan's Annual Maximum. To qualify, a member must submit at least one claim during the calendar year and all member claims for the calendar year cannot exceed $700. Members can rollover $350 per year for a maximum rollover amount of $1,250. That amount can be used in later years in addition to the maximum annual benefit. The employee and each dependent insured maintain separate MRAs based on their own claim activity.

EyeMed Vision Care

Taking care of your vision is important to your overall health

EyeMed Vision Care members can take care of their vision and have routine eye exams, while saving money on all of their eye care needs. Employees and dependents are covered for free under EyeMed's Discount Plan or they can purchase the more robust Buy-Up Plan.

To start using your benefit, visit www.eyemedvisioncare.com or call 1-866-939-3633 to locate a participating provider.

For the Discount Plan, select "Access" network. For the Buy-Up Plan, select "Insight" network.

Did you know?

Taking care of your vision can also mean early detection for symptoms of:

- Diabetes
- Hypertension
- High cholesterol
- Tumors
- Thyroid disorders
- Neurological disorders

A qualified vision care professional can help treat and manage:

- Cataracts
- Corneal diseases
- Diabetic retinopathy
- Eye infections
- Glaucoma
- Macular degeneration

TIP *Go to www.eyemed.com> Find an eye doctor.*

VISION		
	Discount Plan (In-Network)	**Buy-Up Plan (In-Network)**
Exam	$5 off routine exam or $5 off contact lens exam	$10 copay
Standard Plastic Lenses		
• Single Vision	$50	$25
• Bifocal	$70	$25
• Trifocal	$105	$25
Frames (any frame available at provider location)	35% off retail	$120 allowance plus 20% off remaining balance over $120
Lens Options	(paid by member and added to the base price of lens)	
• UV Coating	$15	$15
• Tint (solid and gradient)	$15	$15
• Standard Scratch Resistance	$15	$15
• Standard Polycarbonate	$40	$40
• Standard Progressive (add on to bifocal)	$65	$90
• Standard Anti-Reflective Coating	$45	$45
• Other Add-Ons and Services	20% off retail price	20% off retail price
Contact Lens Fit and Follow-Up		
• Standard Contact Lens Fit & Follow-Up	Not covered	Up to a maximum copay of $40
• Premium Contact Lens Fit & Follow-Up		10% off retail price
Contact Lenses	(covers materials only)	(covers materials only)
• Conventional	15% off retail price	$135 allowance, 15% off balance over $135
• Disposables	Not covered	$135 allowance
• Medically Necessary	N/A	$0 copay, Paid in Full
Laser Vision Correction Lasik or PRD from U.S. Laser Network	5% off promotional price or 15% off retail price	5% off promotional price or 15% off retail price
Frequency		
• Examination	Unlimited	Once every 12 months
• Frame	Unlimited	Once every 24 months
• Lenses and Contact Lenses	Unlimited	Once every 12 months

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows employees to use pre-tax money for qualified expenses.

The rising cost of health and dependent care (or day care) is encouraging more employees to take advantage of FSAs. You can save anywhere from 10% – 30% by using pre-tax money in an FSA to pay for health or dependent care expenses incurred during the plan year. Determine how much you anticipate spending on qualified expenses throughout the year and fund your FSA for that amount through pre-tax payroll deductions. You can then use those funds to pay for eligible expenses using a debit card at the time of service or by submitting a receipt after-the-fact. Please be aware that Health Care FSA and Dependent Care FSA accounts are separate, and you cannot co-mingle funds.

Health Care FSA – used to pay for qualified medical, dental and vision expenses incurred by you and your dependents during the plan year. Over-the-counter drugs are not covered without a prescription. See box for examples of eligible expenses.

Note:

- Annual maximum contribution is $3,200.
- Annual minimum contribution is $100.
- You have access to your full annual contribution at any time during the plan year for qualified expenses incurred during the plan year.
- You cannot change your annual contribution amount during the plan year, so be conservative in determining the amount you decide to contribute.
- You have a 90-day grace period after year end to submit claims.
- A maximum of $640 may be rolled forward into the next plan year for the Health Care FSA only. Any monies in excess of $640 at the end of the plan year will be forfeited.

Dependent Care FSA – used to pay for qualified dependent child care or elder care expenses incurred during the plan year, to allow you (and/or your spouse if married) to work or go to school full-time.

Note:

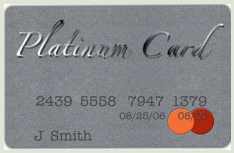
- Annual maximum contribution is $5,000 per household and $2,500 per individual if married and filing separately.
- Annual minimum contribution is $100.
- You ONLY have access to funds that have been withheld from your paycheck. If you submit receipts for a higher amount, you will be automatically reimbursed as future payroll deductions are deposited into your account.
- You have a 90-day grace period after year end to submit claims.

TIP ***Visit the Medcom Wealthcare portal where you can manage your account, submit claims for reimbursement, shop for FSA eligible items, and more!***
https://medcom.wealthcareportal.com

Health Care FSA Eligible Expenses

- Medical plan copays and deductible
- Prescription drugs
- Dental and orthodontia expenses
- Vision care expenses including lasik, glasses and contact lenses
- Tobacco cessation programs
- Infertility treatment
- Psychology and psychoanalysis medical expenses
- Medically necessary massage therapy
- Medically necessary weight-loss programs
- Services not covered under your health plan as long as medically necessary
- Medically necessary cosmetic surgery

Please refer to our plan document for a full list of eligible expenses and exclusions.



Dependent Care FSA Expenses:

- Care at licensed nursery school or day care facility
- Before and after school care for children 12 and under
- Day Camps
- Nannies and Au Pairs

Dependent Care Ineligible Expenses:

- Services provided by a family member
- Overnight camp expenses
- Babysitting expenses for time when you are not working or your spouse is not at school or working
- Late payment fees
- Tuition expenses for school

Life Insurance and AD&D

The City pays for a life insurance benefit of three times annual earnings up to $600,000 for all full-time employees and an additional benefit of three times salary up to $600,000 in AD&D insurance.

Optional Life Insurance

Our voluntary life insurance program allows you to purchase additional coverage for yourself and coverage for your dependents. The voluntary life program provides optional employee coverage ranging from $10,000 to $300,000, purchased in $10,000 increments. Your spouse may purchase coverage ranging from $5,000 to $150,000, in $5,000 increments. The amount of coverage for a spouse cannot exceed the amount of coverage that the employee has elected for himself or herself. Children are eligible for a flat $10,000 benefit (through age 25).

Why Buy Life Insurance?

Life insurance provides a lump sum cash benefit to surviving dependents to cover immediate expenses such as funeral expenses or ongoing living expenses. Life insurance benefits often help survivors adjust to the loss of income related to the death of a wage earner or provide funds for college or retirement for the survivors.

Waiver of Premium

If an insured employee becomes totally disabled (unable to work at any job) prior to age 60 and has completed a six month waiting period, insurance will remain in force (proof of total disability is required) during that disability without further payment of premiums until age 65, at which time coverage will terminate.

What is Evidence of Insurability?

Our carrier guarantees that all employees will be able to purchase life insurance coverage up to $50,000 for themselves and $15,000 for their spouse during New Hire enrollment. To purchase voluntary life coverage above those amounts, the carrier requires Evidence of Insurability. If you or your dependents have medical conditions that make it difficult to purchase life insurance on your own, understanding Evidence of Insurability and the guaranteed issue amount is important.

Providing Evidence of Insurability means you will need to complete a medical questionnaire, obtain a physical (at the carrier's request), and receive carrier approval before your insurance takes effect. Life insurance enrollment time frames are limited as detailed below:

- **New Hires –** You may apply for coverage up to $50,000 for yourself and $15,000 for your spouse through the normal enrollment process. To purchase coverage above that, you will be required to provide Evidence of Insurability.
- **Marriage, Adoption or Birth –** If you are already enrolled in employee life insurance you can enroll new dependents as long as you follow normal Life Status Change deadlines. If you wish to increase your employee life amount above $50,000 or spouse coverage above $15,000, or if enrolling a child outside of your new hire enrollment period, you must complete the Evidence of Insurability Form and submit it within the normal Life Status Change deadlines.

Disability

One third of all Americans between the ages of 35 and 65 will become disabled for more than 90 days, according to the American Council of Life Insurers. The City pays for employees' short-term and long-term disability insurance, which provides income continuation if you are ever unable to work due to an accident or illness. The disability benefit is based on your annual salary. The salary calculation is based on 42 hours per week for applicable employees.

Short-Term Disability (up to 90 days)

Your short-term disability insurance provides coverage of 60% of gross wages up to a maximum of $2,500 per week for a qualified disability. Benefits are payable on the 8th day of a disability or illness for a maximum of 90 days. Pregnancy is covered under short-term disability the same as any other disability.

Long-Term Disability (beyond 90 days)

Your long-term disability benefit provides a benefit of 60% of your monthly salary up to a maximum of $12,500 per month after 90 consecutive days of total disability. This is a gross-up plan which means employees are taxed on the premium, but if you go out on disability the benefit you would receive would be tax free.

If you were disabled and unable to work, how would you pay your bills?

Disability Insurance provides income protection to insure that you have a consistent flow of income if you are unable to work for an extended period of time due to a disabling illness or injury.

If you suffer from an illness or injury and are unable to work, do you know how you will pay your rent or mortgage, car payments, utilities, and health insurance? The loss of income can be so devastating that the U.S. Department of Housing and Urban Development estimates that 46% of all home foreclosures are caused by a disability.

If you are like most Americans, your monthly expenses eat up most of your paycheck and little is left for saving. If you worry that you haven't set aside a big enough emergency fund, then this benefit should help you sleep better at night.

Retirement Savings Plans

The City provides employees with a comprehensive retirement program consisting of a 457(b) plan, a 401(a) plan, and a Social Security replacement plan administered by OneAmerica.

The 457(b) plan allows employees to defer part of their pay on a tax-deferred basis into the investment of their choice.

- **Salary Deferral Contributions:** You may contribute from 1% to 100% of your pay each pay period. Your taxable income is reduced by the amount you contribute through salary deferral. Your total salary deferral and employer contributions may not exceed $23,000 for 2024.
- **Catch-Up Contributions:** If you are age 50 or older by December 31st, you may contribute a catch-up contribution of up to $7,500 for 2024.
- **Vesting:** You are always 100% vested in the contributions YOU choose to defer.
- **Investments:** Contributions are automatically directed to the plan's investment default if you do not choose any investment options.
- **Match:** If you contribute 8%, the City will fund a 4% match to your 401(a) plan.
- **When You Receive Benefits:** Termination of employment, retirement (at any age), disability, death, or Plan termination.

The City will contribute the equivalent of 11% of your compensation each pay period to your 401(a) plan.

- **Vesting:** You will be 100% vested in the contributions after completing one year of service with the City.
- **Investments:** Contributions will be automatically directed to the plan's investment default if you do not select investment options.
- **When You Receive Benefits:** Termination of employment, age 59 ½ and still working, retirement (age 60), disability, or death.

The City also contributes the Social Security withholding amount (6.2% for 2024) for each eligible employee into a Target Date Fund. All Participants shall at all times be fully vested in their Social Security replacement plan.

TIP

Contact OneAmerica's Participant Service Center at 1-800-249-6269.

Supplemental Insurance Policies

The City currently makes available the opportunity for employees to purchase supplemental insurance policies through Allstate that can be paid for through payroll deduction. The current policies are the Group Accident Insurance Plan and the Group Cancer Insurance Plan. See Human Resources for more information.

Housing Reimbursement Program

The housing reimbursement program provides additional compensation as reimbursement to eligible employees of the City of Dunwoody who reside within the City limits. Eligible employees are defined as employees who are Uniformed Officers of the City of Dunwoody Police Department, including Police Officers, Detectives, Sergeants, Lieutenants, Majors, the Deputy Chief and the Chief of Police. Housing reimbursement is for the rent or payment of mortgage for a single family home, condominium, apartment or any unit suitable for housing one family. The allowance amount is $800 per month ($9,600 per year), subject to annual appropriation each year on a first-come, first-served basis. See Human Resources for more information.

Travel Assistance Program

The travel assistance program is provided free by the City and is administered through Standard Insurance Company and Assist America. The plan provides many benefits related to travel including, but not limited to, pre-trip assistance, medical assistance while traveling, emergency transportation, and legal services. Employees and their family members are eligible for the program. Employees will receive a wallet card that lists the contact information for Assist America. Support is available 24 hours a day, 365 days a year.

Education Assistance Program

To encourage employees to continue their education and improve their job skills, the City offers an education assistance program. The City reimburses regular, full-time employees for tuition, lab fees, and textbooks associated with coursework that meets the requirements of the program. The current annual allotment is $3,000 per employee for associate or bachelor's degree programs and $4,000 per employee for master's degree programs. Please see Human Resources for more information.

NOTICES: CHILDREN'S HEALTH INSURANCE

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 Website:
http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA—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

ARKANSAS —Medicaid Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA—Medicaid Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO—Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)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

FLORIDA—Medicaid Website:
https://www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA—Medicaid GA HIPP Website: https://medicaid.georgia.gov/programs
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA—Medicaid
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)
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

KANSAS—Medicaid Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY—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

LOUISIANA—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)

MAINE—Medicaid 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

MASSACHUSETTS—Medicaid and CHIP Website:
https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA—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

MISSOURI—MedicaidWebsite:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA—Medicaid Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA—Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA—Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE—Medicaid
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

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: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA—Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA—Medicaid Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

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

OREGON—Medicaid Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA—Medicaid Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND—Medicaid Website:
http://www.eohhs.ri.gov/
Phone: 1-855-697-4347,
or 401-462-0311 (Direct RIte Share Line)

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

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

TEXAS—Medicaid Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH—Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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

VIRGINIA—Medicaid and CHIP
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

WASHINGTON—Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA—Medicaid Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN—Medicaid Website:https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING—Medicaid 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 and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice from the City of Dunwoody 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 our company's group health plan prescription drug coverage, and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Our company's group health plan is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage will pay, and is considered "creditable coverage."

Because our plan is considered creditable coverage, you can enroll and/or stay enrolled in our plan, and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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. All Medicare prescription 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.

Individuals (employees and/or their dependents) may enroll in a Medicare prescription drug plan when they first become eligible for Medicare, and each year from October 15th through December 7th, the annual Medicare Open Enrollment Period, with coverage effective on January 1st. Individuals leaving a group health plan during other times of the year may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you may not be able to get this coverage back. See below for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with your employer's group health plan and do not enroll in Medicare prescription drug coverage within 63 days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may always be at least 19% higher than the regular premium. You will 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 Medicare Open Enrollment Period to enroll.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail from Medicare every year. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at (800) 772-1213; TTY (800) 325-0778.

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare that offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you have maintained creditable coverage, and are not required to pay a higher premium amount (a penalty).

Date:	November 1, 2023
Name of Entity/Sender:	City of Dunwoody
Contact--Position/Office:	Nicole Stojka, Human Resources Director
Address:	4800 Ashford Dunwoody Road, Dunwoody, GA 30338
Phone Number:	678-382-6755

COBRA Continuation Coverage

A federal law known as the Consolidated Omnibus Reconciliation Act (COBRA) requires that most employers that sponsor 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 from the terms of the plan would otherwise end. This notice is intended to inform you of your rights and obligations from the continuation coverage provisions of the law.

If you are an employee and are covered by the group health plan, you have a right to choose this continuation coverage if you lose your group health coverage from the terms of the plan because of reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you are the spouse of an employee and are covered by the group health plan, you have the right to choose this continuation coverage if you lose your group health coverage from the terms of the health plan for any of the following reasons:

- The death of your spouse
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction of your spouse's hours of employment
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare

If an employee's dependent child is covered by the group health plan, he or she has the right to continuation coverage if group health coverage from the terms of the health plan is lost for any of the following reasons:

- The death of a parent
- A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment
- Parents' divorce or legal separation
- A parent becomes entitled to Medicare
- The dependent ceases to be a dependent child within the terms of the health plan

The individuals described above, who are entitled to COBRA continuation coverage, are called qualified beneficiaries. If a child is born to a covered employee or if a child younger than age 18 is adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage, the newborn or adopted child also is a qualified beneficiary. These new dependents can be added to COBRA upon timely notification to the plan administrator in accordance with the terms of the group health plan.

Under the law, the employee or a family member has the responsibility to inform the plan administrator of a divorce, legal separation or a child losing dependent status within the terms of the health plan. This information must be provided within 60 days the event or the date on which coverage would end under the terms of the plan because of the event. If the information is not provided within 60 days, rights to continuation coverage through COBRA ends. The employer has the responsibility to notify the plan administrator of an employee's death, termination of employment or reduction in hours or Medicare entitlement.

When the plan administrator is notified that one of these events has happened, the plan administrator will, in turn, notify you of your right to choose continuation coverage. According to the law, you have 60 days from the date you are notified of your rights, or the date you would lose coverage because of one of the events described above, to inform the plan administrator that you want continuation coverage.

If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end. COBRA continuation coverage is not available to any covered individual if coverage is lost due to termination of employment for gross misconduct.

If you choose continuation coverage, the employer is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided with the plan to similarly situated employees or family members. Any changes made to the health plan for similarly situated employees or family members also will apply to the individual who chooses COBRA continuation coverage. The terms of the coverage are governed by the plan documentation, which is available upon request from the plan administrator in the event you have misplaced your documentation.

The law requires that you are given the opportunity to maintain continuation coverage for up to three years unless you lost group health coverage because of a termination of employment (except for gross misconduct) or reduction in hours. If such termination or reduction of hours is the reason for your loss of coverage, the required continuation coverage period is up to 18 months. These 18 months may be extended to 36 months if other events (such as death, divorce or the employee's Medicare entitlement) occur during the 18-month period. If the covered employee became entitled to Medicare less than 18 months before a qualifying event that is termination of employment or reduction of hours, then qualified beneficiaries, other than the covered employee, may receive continuation coverage for up to 36 months measured from the covered employee's Medicare entitlement.

The 18-month continuation coverage period applicable to termination (except for gross misconduct) or to reduction of hours may be extended to up to 29 months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time within the first 60 days of continuation coverage. In order to extend the 18-month period, a qualified beneficiary must notify the plan administrator within 60 days of the determination by The Social Security Administration and before the end of the 18-month continuation period.

If the above requirements are satisfied, the continuation coverage for all qualified beneficiaries may continue for up to an additional 11 months beyond the end of the initial 18-month period. A higher monthly premium (150 percent of the applicable premium used to determine regular COBRA rates) will be required. The plan administrator also must be notified within 30 days after the date of any final determination of the Social Security Administration that the disability no longer exists, if such a determination is made before the end of the 29-month continuation coverage period. Continuation coverage will be cut for any of the following reasons:

- The employer no longer provides group health cover- age to any of its employees
- The premium for your continuation coverage is not made on time
- You become covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition you have
- You become entitled to Medicare
- In the case of the 29-month continuation of coverage period for the disabled, the disability ends

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the plan administrator reserves the right to terminate your COBRA coverage retroactively if you are ineligible.

Under the law, you may have to pay all or part of the premium, plus a 2 percent administration fee, for your continuation coverage. As explained above, higher rates apply to the 11-month extension due to disability. There is a grace period of 30 days for payment of the regularly scheduled premium. In addition, upon the expiration of the 18-month or 36-month continuation coverage period, you are allowed to enroll in an individual conversion plan if conversion is provided from the terms of the health plan.

HIPAA Special Enrollment Right

Loss of Other Coverage: If you have declined or will be declining enrollment for yourself and/or your dependents because of other in-force health plan coverage, you may be able to enroll yourself and/or your dependents in this plan in the future. If you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards other group health plan coverage, it may trigger a special enrollment right.

You must request enrollment in this plan within 30 days after the other coverage ends. You will be required to submit proof of prior coverage, such as a coverage termination letter from an insurance company or employer.

New Dependent: If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependents. This triggers a special enrollment right. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. You will be required to submit proof of a newly eligible dependent, such as a marriage certificate or birth certificate.

Termination of Medicaid or CHIP Coverage: If you and/or your dependents are covered under a Medicaid plan or a state child health insurance plan (CHIP), and coverage under such a plan is terminated as a result of loss of eligibility, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date Medicaid or state-sponsored CHIP coverage ends.

Eligibility for Premium Assistance Under Medicaid or CHIP: If you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right. This is usually a program where the state provides employed individuals with premium payment assistance for their employer's group health plan, rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP.

Please keep this notice in a secure place with your other health plan materials.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires all group health plans that provide medical and surgical benefits for a mastectomy must also provide certain other related benefits. A participant or beneficiary who is receiving benefits for a mastectomy that is covered by a health plan and elects breast reconstruction is entitled to receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

The coverage will be provided in a manner determined in consultation with the attending doctor and the patient The coverage will be subject to the same annual deductible, co-insurance, copay and other conditions and limitations otherwise applicable under the health plan If you have any questions about coverage for these benefits, contact the health insurance carrier.

Newborns' and Mothers' Health Protection

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 insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your employer Human Resources Department (see back cover) and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTES

IMPORTANT CONTACT INFORMATION

BENEFIT	PROVIDER	WEBSITE/EMAIL	PHONE NUMBER
Flexible Spending Accounts	Medcom	www.medcombenefits.com	1-800-523-7542
Medical Plan	Cigna Group #: 0623771	www.myCigna.com	1-866-494-2111
Pre-Enrollment Help Line	Cigna		1-888-806-5094
Dental Plan	Guardian Group #: 452860	www.guardianlife.com	1-800-627-4200
Vision Plan	EyeMed Group #: 9746157	www.eyemedvisioncare.com	1-866-9EYEMED
Life Insurance	Standard Group #:147285	www.standard.com	1-800-628-8600
Long-Term Disability	Standard Group #:147285	www.standard.com	1-800-368-1135
Short-Term Disability	Standard Group #:147285	www.standard.com	1-800-368-2859
EAP	Standard and Health Advocate	www.healthadvocate.com/standard3	1-888-293-6948
Travel Assistance	Assist America	medservices@assistamerica.com	1-800-872-1414 | United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda 1-609-986-1234 | Everywhere else
Retirement	David T. Griffin SVP, Atlanta Retirement Partners | One Digital	david.griffin@onedigital.com	678-557-7981
Supplemental Products	Allstate Account #: 19795	marco@vbwork.com	Customer Service: 678-888-0848 800-521-3535
City of Dunwoody Human Resources Director	Nicole Stojka	nicole.stojka@dunwoodyga.gov	678-382-6755
City of Dunwoody Human Resources Manager	Heather Vseer	heather.vseer@dunwoodyga.gov	678-382-6754
Benefit Resource Center (BRC)	USI Insurance Services	BRCsouth@usi.com	855-874-0835

USI INSURANCE BENEFITS RESOURCE CENTER (BRC)

The Benefit Resource Center (BRC) is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time via phone at 855-874-0835 or via email at BRCsouth@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or email message by the end of the following business day.

CALL THE BENEFIT RESOURCE CENTER ("BRC") WE'RE HERE TO HELP!

We speak insurance.
Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution

USI