EMPLOYEE BENEFIT GUIDE

COVINGTON
georgia

2025-2026

July 1, 2025- June 30, 2026

TABLE OF CONTENTS

This is a summary of benefits drafted in plain language to assist an employee's understanding of what benefits are offered and does not constitute a policy. Detailed provisions are contained in each provider's plan document. If there is a discrepancy between what is presented here and the official plan documents, the plan documents will govern.

Important Update: Employee Benefits Package for the Upcoming Year

Dear COV Team,

I hope this message finds you well. As we prepare for the coming year, I want to take a moment to share important updates regarding our employee benefits package. These updates reflect our ongoing commitment to supporting your health and well-being while navigating the challenges of rising healthcare costs and regulatory changes.

Health Insurance and IRS Updates

For the upcoming year, our health insurance plans will continue to provide comprehensive coverage. Our group's "medical experience" over the past 12 months has been well over the expected norm which has caused our shared cost of medical coverage to increase. There are also new 2025 IRS requirements that impact deductibles for High-Deductible Health Plans (HDHPs) tied to Health Savings Accounts (HSAs):

- The minimum family deductible for HSA-qualified HDHPs is now set at $3,300.
- The out-of-pocket maximum for family coverage under these plans cannot exceed $16,000 – however, our out-of-pocket maximum limits are well below this IRS requirements.

These changes are designed to align with federal guidelines and ensure compliance with the latest regulations.

Understanding Rising Healthcare Costs

We recognize that the cost of healthcare continues to be a concern for many. Several factors contribute to these increases:

1. **Inflationary Pressures**: The healthcare industry has faced persistent inflation, driving up operational costs for providers.

2. **Prescription Drug Spending**: The growing demand for innovative medications, particularly for chronic conditions, has significantly impacted overall costs.

3. **Behavioral Health Utilization**: Increased use of mental health services, while essential, has added to the financial strain on the system.

4. **Deferred Care Post-Pandemic**: Many individuals delayed medical care during the pandemic, leading to higher demand and costs as they seek treatment now.

5. **Group usage/Experience**: Our usage of medical insurance outside of preventative care has been more than expected. Our goal is to reduce this usage and experience by educating our employees on the importance of wellness and early detection.

Our Commitment to You

Despite these challenges, we remain dedicated to offering a benefits package that supports your needs. We are actively exploring ways to manage costs while maintaining the quality of care you deserve.

If you have any questions or need assistance understanding these changes, please don't hesitate to reach out to the Human Resources department.

Your commitment to excellence in serving our city has been indispensable. Together, we can continue to make our city a "shining jewel" for others to follow.

With regards,

Tres Thomas

City Manager - City of Covington

WELCOME TO YOUR BENEFITS

The City of Covington is pleased to offer our employees a variety of benefit programs to meet the needs of you and your family members. The City of Covington offers Medical, Dental, Vision, Basic Life and AD&D, and Long-Term Disability for employees. Employees have the option of electing our high-deductible medical plan, contribute to a HSA, Voluntary Life and AD&D insurance and supplemental plans such as Aflac Hospital Indemnity, Accident, and Critical Illness. As well as Short Term Disability.

We are here to help you enroll and make benefit selections that are right for you.

Trinekka Miller
770-385-6830
tmiller@cityofcovington.org

Benefit Eligibility

BENEFIT ELIGIBILITY

The City of Covington provides a comprehensive benefits program to all full-time employees working 30 hours or more per week.

Employees are eligible for medical, dental, vision, and life insurance coverage on the first day of the month following date of hire. Long Term Disability coverage starts one year after your date of hire. Employees hired after 4/2/19 are only eligible for the HDHP with HSA medical plan.

You may enroll the following dependents in our benefit plans:

- Your legal spouse.
- Dependent children under age 26 (coverage ends at the end of the month in which they turn 26). Dependent children include natural children, legally adopted children, step-children, and children for whom the employee has been appointed legal guardian.
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (subject to plan rules; documentation of handicapped status must be provided).

Employees may have other dependents in their household who are not eligible for our benefit plans:

- Grandchildren, nieces, nephews or other children that do not meet the specifications listed above.
- Ex-spouses, unless required via court order (documentation must be provided).
- Parents, step-parents, grandparents, aunts, uncles, or other relatives that are not qualified legal dependents.

BENEFIT CHANGES

Most benefit deductions are withheld from your paycheck on a pre-tax basis (medical, dental, and vision); therefore, your ability to make changes to these benefits is restricted by the IRS. Voluntary Life benefits can be changed at any time.

Once enrolled, most pre-tax benefit elections cannot be changed until the next annual Open Enrollment period unless you have a Qualifying Life Event. Open Enrollment occurs in the Spring, with plan changes effective July 1 through June 30 of the following year; during this period, employees can add or change their available benefits.

The Most Common Qualifying Events

- Marriage, divorce, legal separation; birth or adoption
- Receipt of a Qualified Medical Child Support Order/other court order
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Change in household work status that affects benefits
- Change in coverage due to spouse's annual open enrollment

To make benefit changes as a result of a Qualifying Event, as allowed under Section 125 of the IRS Code:

- 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.

BENEFIT ENROLLMENT

After open enrollment you will be able to view your benefit information online through bswift. It is available 24 hours a day, 7 days a week, throughout the year. Bswift also includes information regarding your payroll deductions and beneficiaries.

bswift Online Login Instructions

1. Visit https://cityofcovington.bswift.com
2. Enter your username (first initial of your first name + last name +last four of your social security number)
3. Enter your password (the last four digits of your social security number)

Enrollment Assistance

For questions about your benefits or assistance with enrollment, please contact The City of Covington Benefits Specialist Trinekka Miller or the NFP Service Center at 1.844.626.8435.

bswift®

MEDICAL - CIGNA

The City of Covington provides eligible employees with medical benefits through Cigna. Employees hired after 4/2/19 must elect the Cigna HDHP Plan with HSA. Retirees as of July 2019 must elect the Cigna HDHP Plan with HRA.

Choosing a Primary Care Physician (PCP)

It is recommended but not required to choose a PCP as your personal doctor to help coordinate care and act as a health advocate.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC), which summarizes important information about your health coverage in a standard format, is available by logging into the carrier's member portal.

In Network vs. Out-of-Network

When you seek medical care, you can choose your health care professional — one who participates in the network or one who does not. When you visit a participating provider, you receive in network coverage and pay lower Out-of-Pocket costs. In network providers have agreed to charge lower fees and your plan covers a larger share of the charges.

If a non-network provider is used, the amount you pay will be higher. These providers do not have an agreement with the insurance carrier for services at lower costs and may bill you for any amount over the maximum allowable fee, plus any copayment, deductible and coinsurance. Amounts paid over the maximum allowable fee will not apply to your deductible or Out-of-Pocket limit.

Some non-network providers work with network hospitals. Your medical insurance carrier will apply the network provider copayment, deductible and coinsurance to covered expenses received by non-network providers working with network hospitals. However, a member may have to pay these non-network providers any amount over the maximum allowable fee. If admitted to the hospital from an Out-of-Network emergency room, you or your provider should call the medical carrier to review or seek approval for further care. Otherwise, the member may be unaware of additional charges that is the member's responsibility.

Cigna Pharmacy Benefits

The Cigna Prescription Drug List (PDL) divides covered medications into tiers. Members have access to an up-to-date PDL online to view which medications are covered under your plan. Go to Cigna.com/druglist and select. Standard 3 Tier' from the drop down menu. Retail Pharmacy: There are thousands of retail pharmacies in your plan's network. Every in-network pharmacy can fill 30-day prescriptions, and a select number can fill 90-day prescriptions. For a list of retail pharmacies that fill 90-day prescriptions, log in to the myCigna App or myCigna.com.

Home Delivery Pharmacy: Express Scripts Pharmacy, our home delivery pharmacy, is a great option if you take a medication on a regular basis. With just a few simple clicks, your prescriptions will be on their way to you. Visit Cigna.com/homedelivery.

CIGNA WEBSITE AND MOBILE APP

Your myCigna.com account and myCigna mobile app can help you manage your benefits, making it easy to personalize, organize and access your information on the go.

- View, print or fax your Cigna ID card
- Find network doctors & medical services
- Access health & wellness tools/resources
- Review coverage and manage claims
- See cost estimates for medical procedures
- Compare quality-of-care information
- Find in-network retail pharmacies
- Compare medication costs

MEMBER REGISTRATION

1.Visit myCigna.com or launch the myCigna mobile app and select 'Register Now.'
2.Enter the requested personal information.
3.Confirm your identity. Create a user ID and password for secure access.
4.Review and submit.

Cigna Medical Plan - POS

This plan is only available to employees hired before 4/2/2019.	In-Network Single / Family	Out-of-Network Single / Family
Plan Deductible (per calendar year)	$1,500 / $3,000	$5,000 / $10,000
Coinsurance	80%	60%
Out-of-Pocket Maximum (includes coinsurance, deductible and medical copays)	$2,500 / $5,000	$10,000 / $20,000
Preventive Services	Plan pays 100%; deductible waived	70% after deductible
Office Visits		
Primary Care Physician	$15 copay	$50 copay
Specialist	$25 copay	$60 copay
Emergency Services		
Urgent Care Clinic	$75 copay	$75
Hospital Emergency Room	$350 copay	$350
Hospital		
Outpatient Facility	80% after deductible	60% after deductible
Inpatient Facility	80% after deductible	60% after deductible
Prescriptions		
Generic	$10	
Preferred Brand	$30	
Non-preferred Generic	$60	
Preferred Specialty	25% to $250	
Non-preferred Specialty	35%	
Mail Order (90 Day Supply)	2x retail	
Prescription Deductible	$100 / $300	

Wellness Rates

MEDICAL COST PER PAY PERIOD	
Employee	$157.95
Employee + Spouse	$335.55
Employee + Child(ren)	$289.56
Family	$466.91

Cigna Medical Plan - HDHP

HIGH-DEDUCTIBLE HEALTH PLAN

REMINDER: To help offset the higher deductible, The City of Covington will contribute to your Health Savings Account based on your election.

CITY OF COVINGTON HSA CONTRIBUTION

Employee	$1,200
Employee + Spouse	$1,500
Employee + Child(ren)	$1,500
Family	$1,800

These amounts are prorated based upon your date of hire after Open Enrollment.

This is the only medical option for employees hired after 4/2/2019.	In-Network Single / Family	Out-of-Network Single / Family
Plan Deductible (per calendar year)	$3,300 / $6,600	$5,200 / $10,400
Coinsurance	100%	80%
Out-of-Pocket Maximum (includes coinsurance, deductible and medical copays)	$3,300 / $6,600	$6,000 / $12,000
Preventive Services	Plan pays 100%; deductible waived	70% after deductible
Office Visits		
Primary Care Physician	100% after deductible	70% after deductible
Specialist	100% after deductible	70% after deductible
Emergency Services		
Urgent Care Clinic	100% after deductible	100% after deductible
Hospital Emergency Room	100% after deductible	100% after deductible
Hospital		
Outpatient Facility	100% after deductible	70% after deductible
Inpatient Facility	100% after deductible	70% after deductible
Prescriptions		
Generic	$10	
Preferred Brand	$20	
Non-preferred Generic	$35	
Preferred Specialty	25% to $250	
Mail Order (90 Day Supply)	2x retail	
Prescription Deductible	Medical Deductible	

Wellness Rates

MEDICAL COST PER PAY PERIOD

Employee	$81.94
Employee + Spouse	$185.70
Employee + Child(ren)	$150.23
Family	$193.79

Budgeting for Your Healthcare

HEALTH SAVINGS ACCOUNT (HSA) – HSA BANK

The City of Covington will automatically enroll employees that have the HDHP Medical Plan in a Cigna Choice Fund Health Savings Account (HSA) with HSA Bank to help with out-of-pocket health expenses for you and your qualified tax dependents. Participants in this plan receive an employer contribution to an HSA to help meet their plan deductible or other eligible health care costs.

2025-2026 Employer HSA Contributions	
Employee Only	$1,200
Employee + Spouse	$1,500
Employee + Child(ren)	$1,500
Family	$1,800

2025 HSA Maximum Contribution Limits

- Single Coverage Contribution: $4,300
- Family Coverage Contribution: $8,550
- Catch Up Contribution: $1,000 (age 55+)

Using the Health Savings Account

Use the money in your HSA to pay for qualified medical expenses such as deductibles, copayments and coinsurance- or save for later expenses like long-term care insurance and Medicare premiums. Refer to your medical benefits summary to determine how much of the amount you pay from your HSA will be applied to your deductible. Once you use up the funds in your HSA, you are responsible for deductibles and coinsurance until you reach your out-of-pocket maximum. Visit Cigna.com/expenses for more information.

Save and Invest with Cigna Choice Fund HSA

With the Cigna Choice Fund HSA, any earnings on your contributions are tax-advantaged - instead of paying taxes on contributions, interest and investment earnings each year, more of your money stays with you. Your account earns interest, and you'll have access to investment options once you reach the minimum balance of $2,000.

HOW YOUR HEALTH SAVINGS ACCOUNT WORKS

At the doctor's office:

1. Receive services: With an HSA-powered plan, no copay is required at the time of service. Be sure to present your insurance ID card. If your health care provider requires a deposit, it will be applied to your invoice. Your health plan has a network of providers that it recommends, however you can use HSA funds to pay any qualified medical expense even if it is not covered by your insurance. This provides significant tax savings on out-of-network services.

2. Provider bills health plan: The provider submits a claim to your health plan for services rendered.

3. Health plan sends EOB: Your providers send you an invoice or statement, reflecting the allowed changes. Make sure the amount matches the EOB sent to you by your health plan. If not, contact your insurance provider for assistance.

4. Pay invoice with HSA: You can pay the provider invoice with your HSA debit card or set up an online payment that is sent directly to the provider or as a reimbursement to you.

At the pharmacy:

1. Get prescription: Obtain a legal prescription from your doctor for needed medication and present it along with your insurance ID card to a pharmacy.

2. Pharmacy verifies insurance coverage: The pharmacy checks with your health insurance on-the-spot to determine the exact amount that is the member's responsibility for the prescription.

3. Pay for your prescription: The pharmacy fills your prescription, and you can pay the amount owed with your HSA debit card or set up an online payment as a reimbursement to you. The expense is automatically applied to your deductible and/or coinsurance.

FREQUENTLY ASKED QUESTIONS ABOUT HSA

What is a High-Deductible Health Plan (HDHP)? A HDHP is a health plan that has a lower monthly cost and pays no benefit until a higher annual deductible is met. Once the annual deductible is met, health expenses are paid at 100%.

What is the HSA and how does it work? Employees enrolled in a qualified HDHP will automatically have a HSA Bank account opened where you can make pre-tax contributions. You will receive a debit card to pay for eligible health expenses, or you can reimburse yourself if you pay out of pocket.

Who can make deposits to an HSA? Anyone can make a deposit to your account but as the account owner, you are the only one who can claim a deduction on your personal tax return. You do not need to claim contributions to your HSA made by your employer or others on your federal tax return.

How do I make deposits to my HSA? Deposits are made through pre-tax payroll deductions or as an initial lump sum deposit at enrollment. You can change your HSA payroll deductions at anytime. You can also make post-tax contributions and deduct them from your income when you file your taxes.

When are the contribution deadlines? Contribute to your HSA until the tax filing deadline for the year (without extension). Please note that payroll contributions are applied to the calendar year only. Contributions for the prior tax year should be made directly to your account through EFT or by check.

Can I have a HSA and a FSA? No, you cannot have a HSA and FSA

How are medical expenses paid before my annual deductible is met? Expenses incurred are paid by the employee until the annual deductible is met. You may use funds in your HSA or pay them as out-of-pocket expenses.

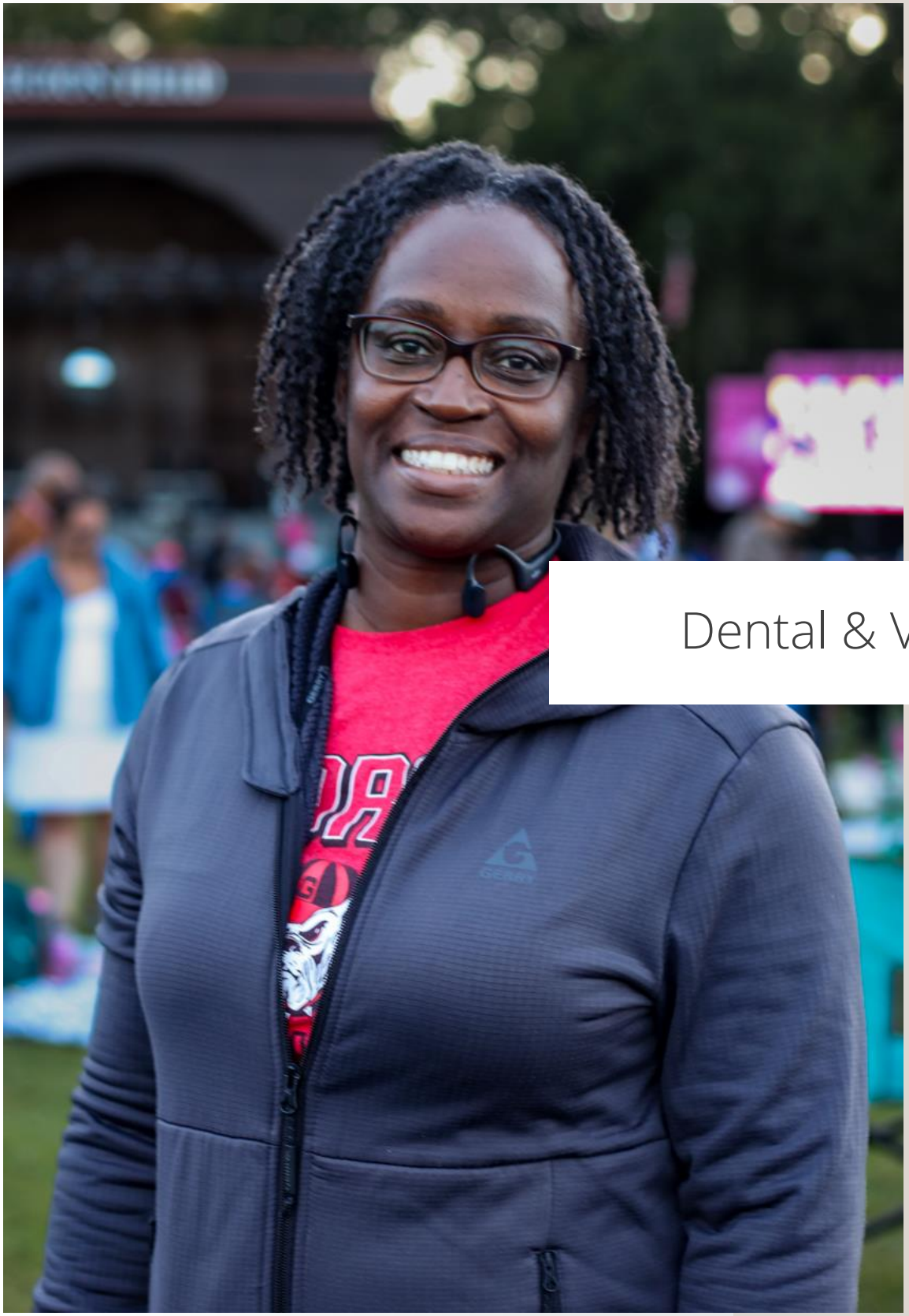
What expenses are counted towards my deductible? Only medical expenses covered by your medical plan apply towards your deductible. HSA funds used for qualified expenses not covered under your medical plan (for example, orthodontia) will not count towards your health plan deductible.

Who verifies that my HSA was used for qualified expenses? Save your receipts — in the event of an IRS audit, you are responsible for providing documentation to the IRS.

What happens to my HSA if I never withdraw funds, change jobs, or retire? Money in your HSA accumulates interest and balances will rollover each year. HSA funds are portable if you change employers or retire. HSA funds are not taxed or penalized if they are used for qualified medical expenses. Funds can be withdrawn without penalty at age 65.

Can I pay for dependent expenses with my HSA? HSA funds can be used to pay for your qualified medical expenses, as well as those of your spouse and other tax dependents, even if the dependent is not covered under your health plan.

What if I enroll in Medicare? You cannot make contributions to a HSA after you enroll in any part of Medicare, even if you are also covered on an HSA qualifying plan. At the time of Medicare enrollment, you are responsible for notifying HR to cancel HSA contributions.



Dental & Vision

The City of Covington offers eligible employees and their dependents with one dental plan option through Cigna.

Cigna Total Dental Preferred Provider Organization (DPPO)

When you enroll in the Cigna Total Dental PPO plan, certain preventive dental care services like cleanings, oral exams and routine x-rays are covered at no additional cost. Routine preventive dental care can lead to better overall health. Poor oral health has been linked to conditions including diabetes, heart disease, and strokes.

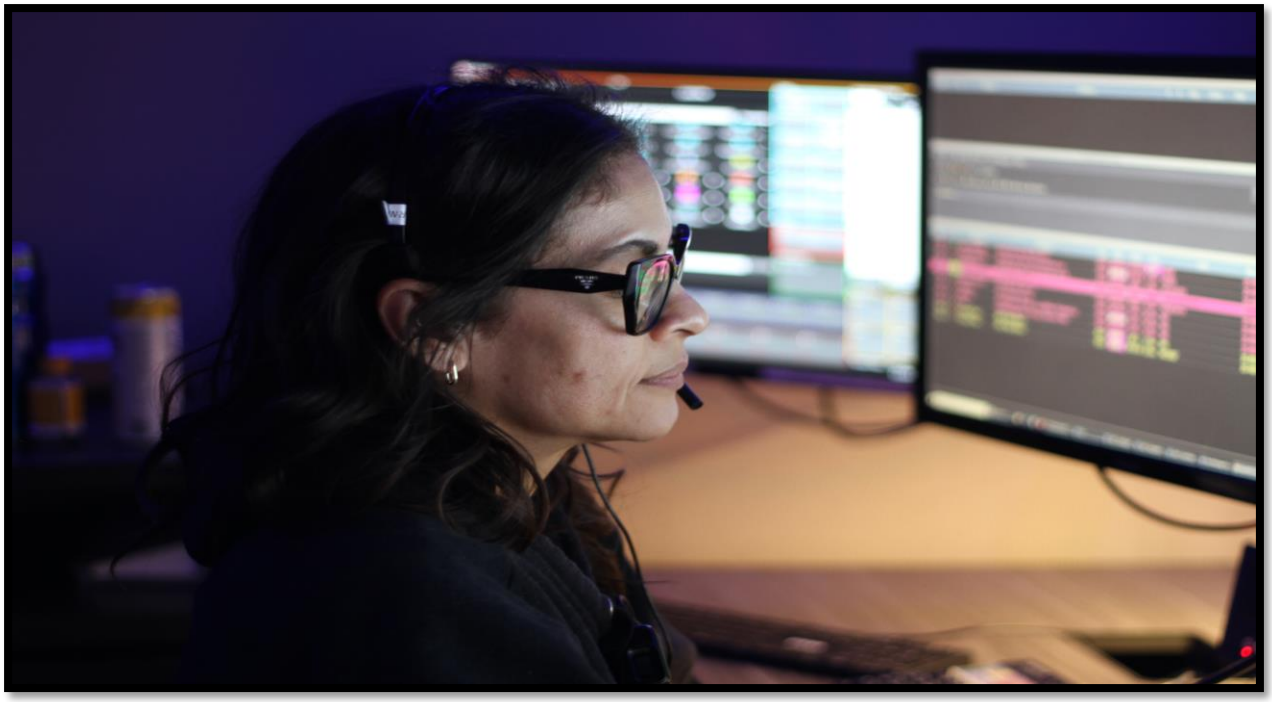
Choose any licensed dentist or specialist for routine, preventive, diagnostic and emergency care, but you'll pay less for covered services with an in-network provider. Cigna Network dentists provide services at lower negotiated rates and offer members discounted fees for all procedures on their fee schedules, even services not covered under your plan.

Calendar Year Maximum	Calendar Year Deductible	Orthodontia Lifetime Maximum
$2,000	$50 Individual / $150 Family	$1,500

Cigna Dental Summary Dental Guard Preferred	In-Network	Out-of-Network
Coinsurance Levels		
Class I: Preventive Expenses Oral exams, cleanings, x-rays, fluoride application, sealants, space maintainers, emergency pain relief	100%; no deductible	100%; no deductible
Class II: Basic Expenses	80%; after deductible	80%; after deductible
Class III: Major Expenses Crowns, dentures, bridges, inlays/onlays	50%; after deductible	50%; after deductible
Class IV: Orthodontia	50%; no deductible	50%; no deductible
Reimbursement	Based on contracted fees	95th percentile of submitted cost

Find a Dental Provider:
Call Cigna: 866-494-2111
Cigna.com
1. Click "Find a Doctor, Dentist or Facility" at the top of the screen.
2. Follow prompts to search by type of dentist or by dentist name.
3. Choose the *'DPPO/EPO > Total Cigna DPPO'* plan.

myCigna
Current Cigna customers can log in to myCigna.com or the myCigna® app to search your current plan's network



The City of Covington offers eligible employees and dependents a vision plan through Cigna in partnership with EyeMed.

A routine eye exam can help your doctor test your vision and spot the early stages of eye disease. Cigna Vision is partnering with EyeMed to offer members a larger network and more robust plan management tools through the myCigna portal.

Cigna Vision Network Serviced by EyeMed

The new vision network will give employees more access to discounted vision care providers (34,000 independent and retailer locations, plus online materials vendors), helping to make vision care even more affordable.

Declining Balance Plan

Declining Balance benefit can be applied (after the 30% in-network savings) towards any covered services and materials until material allowance exhausted, within the stated frequency.

How to Use Your Cigna Vision Benefits

1. Find a Provider.
2. Schedule an Appointment. Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna Vision ID card to verify your eligibility and plan details.
3. Out-of-Network Reimbursement: Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department, PO Box 997561, Sacramento, CA 95899.

Cigna Vision Summary: Standard PPO	In-Network	Out-of-Network
Vision Exams (every 12 months) **Materials Allowance**	$15 copay Up to $200	Up to $45 Up to $128
Frames (every 12 months) sealants, space maintainers, emergency pain relief	Total declining allowance of $200	Total declining allowance of $200
Lenses (every 12 months) Single/Bifocal/Trifocal/Lenticular (UV Coating, Solid & Gradient Tint, Standard Progressive, Standard Scratch Resistance, Standard Polycarbonate, Standard Anti-Reflective Coating)	Total declining allowance of $200	Total declining allowance of $128
Contact Lenses (Conventional/Elective/Therapeutic)	Total declining allowance of $200	Total declining allowance of $128

FIND A VISION PROVIDER

myCigna

1.Go to the Cigna Vision page and select 'View Details'
2.Select 'Find a Cigna Vision Network Eye Care Professional' to search the Directory

Cigna.com

1.Click the 'Find a Doctor' tab at the top
2.Select 'Vision Directory—Routine Eye Exam & Eyewear' from the list

Call Cigna

Call the number on the back of your Vision ID card.

This summary should not be considered a full explanation of benefits. The official plan documents, policies, and certificates of insurance govern in all cases.

Life & Disability

BASIC LIFE AND AD&D INSURANCE - STANDARD (POLICY # 760235)

The City of Covington provides all active, full-time employees working a minimum of 30 hours per week with company paid Basic Life and AD&D insurance of $50,000 at no cost to employees. Employees have the option to purchase Spouse and Child Basic Life benefits for eligible dependents. Refer to the Certificate of Coverage for exact coverage and exclusions.

Life insurance provides a lump sum cash benefit to surviving beneficiaries to cover immediate expenses such as funeral costs or ongoing living expenses. It can 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. For a covered accidental loss of life, your Employee Basic AD&D coverage amount is equal to your Employee Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable. Basic AD&D is not available for dependent coverage.

Age Reduction

Coverage will reduce to 65% at age 70.

Basic Life and AD&D Summary		
Coverage	Benefit	Cost
Employee Life and AD&D	$50,000	Paid for by The City of Covington
Spouse Life	$7,500	$1.88 per month
Children Life	$7,500	$0.68 per month

VOLUNTARY LIFE AND AD&D INSURANCE- STANDARD (POLICY # 760235)

The City of Covington provides all active, full-time employees working a minimum of 30 hours per week with the option to purchase additional life and AD&D insurance for yourself and your eligible dependents. You must purchase employee coverage to be able to purchase dependent coverage. Refer to the Certificate of Coverage for exact coverage and exclusions.

If you choose to purchase additional life insurance coverage, you'll have access to more affordable group rates, plus the convenience of having your premium deducted directly from your paycheck.

Tip: Your voluntary life election can be changed at any point during the plan year.

Voluntary Life and AD&D Summary				
Coverage	**Increments**	**Maximum Benefit Amount**	**Cost**	**Age Reduction**
Employee	$10,000	Lesser of 8 times salary or $500,000	$350,000	65% at age 70
Spouse	$5,000	$250,000; not to exceed 100% of employee election	$50,000	Coverage ends at age 70
Child(ren)	$1,000	$10,000	$10,000	N/A

Waiver of premium

If you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.

What is Evidence of Insurability?

Evidence of Insurability (EOI) is required for employees to purchase insurance above the Guarantee Issue (GI) amount. If you or your spouse have medical conditions that make it difficult to purchase life insurance on your own, this amount is relevant to you. EOI may involve completing a medical questionnaire, obtaining a physical, and receiving carrier approval before your insurance takes effect.

- New Hires — You may apply for coverage up to the Guarantee Issue (GI) through the normal enrollment process. For amounts above the GI, an EOI form must be submitted.
- Marriage, Adoption or Birth — If you are already enrolled in employee life, you can enroll new dependents up to the GI amount as long as you follow normal event deadlines. For amounts above the GI, you must complete the Evidence of Insurability Form and submit it within the normal life event deadlines.
- Open Enrollment Period—If you and/or your spouse are currently enrolled in voluntary life you have the option to increase your life insurance by one increment, up to the GI, without EOI. For increases greater than one increment, EOI is required. For employees who waived coverage as a new hire and are now enrolling for the first time, EOI is required for any election amount.

Disability

LONG TERM DISABILITY - STANDARD

The City of Covington pays the full cost of Long-Term Disability Insurance for eligible employees. Disability coverage starts one year after your date of hire.

Group disability insurance can help pay part of your covered earnings when you can't work for a period of time due to a covered illness or injury. Long Term Disability (LTD) insurance provides income continuation in the event you will be out of work for a long period of time due to an accident or illness.

Long Term Disability Summary	
Benefit Percentage	60% of your monthly earnings up to $10,000
Benefit Duration	Up to social security normal retirement age (SSNRA)
Benefit Waiting	180 days
Minimum Benefit	$100

•Report a Disability Claim

Phone: 800-368-1135

Online: www.standard.com

SHORT TERM DISABILITY - STANDARD

The City of Covington offers eligible employees an option of purchasing Short Term Disability Insurance.

Disability insurance can help pay part of your covered earnings when you can't work for a short period of time due to a covered illness or injury. Short Term Disability (STD) insurance provides income continuation in the event you will be out of work due to an accident or illness.

Short Term Disability Summary	
Benefit Percentage	60% of your weekly earnings up to $1,300
Benefit Duration	Up to 166 days
Benefit Waiting	14 days
Minimum Benefit	$15

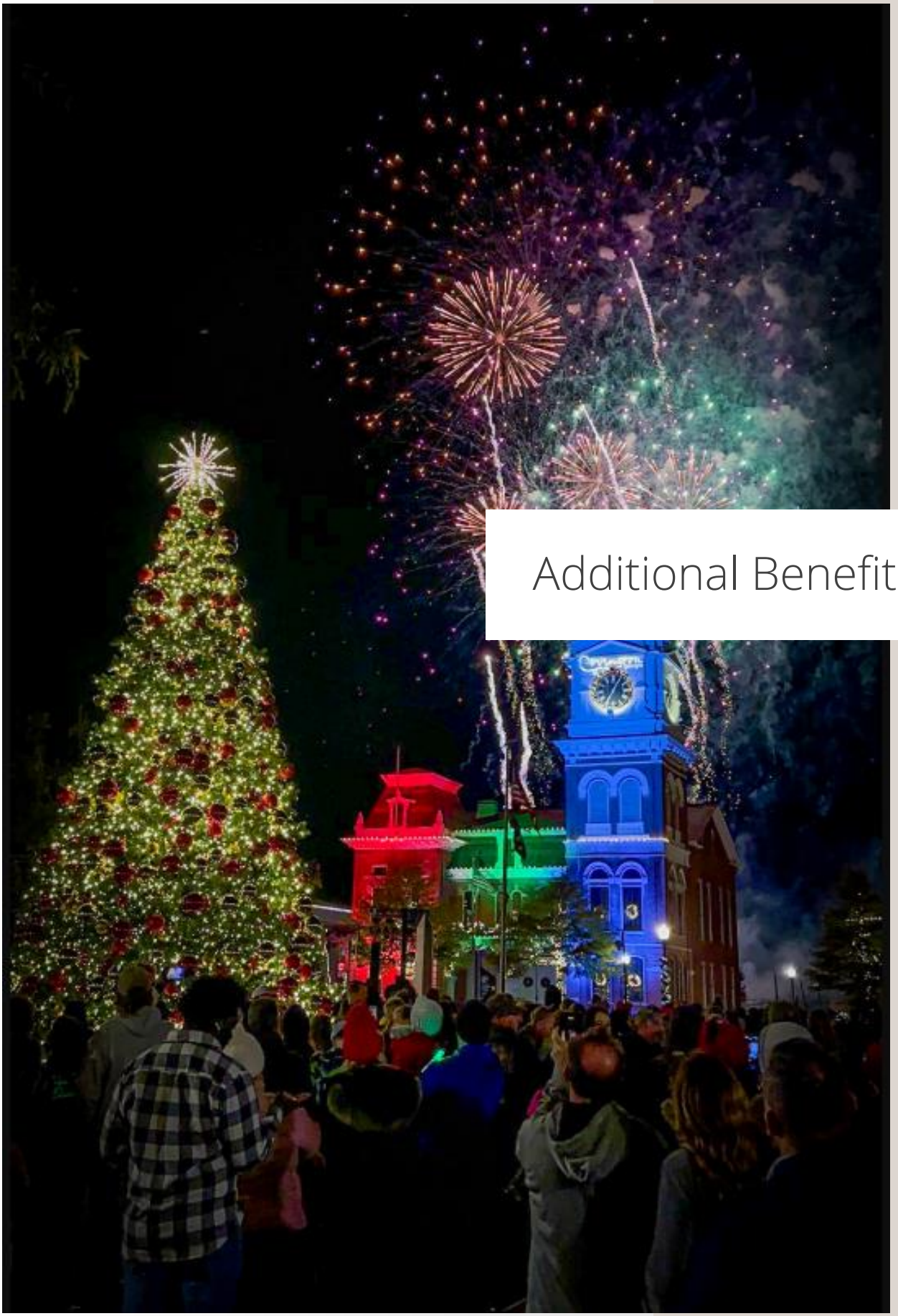
When do I report a disability claim?

The below steps should be taken for a disability claim:

- Always seek appropriate medical attention immediately. Your health and safety come first.
- Contact your employer on or before your first day out of work. Tell them when and how long you expect to be absent.
- When you know you will be out for more than seven days in a row, contact The Standard no later than your seventh day out of work, so we can begin reviewing your claim.

Please have the following information ready before you call:

- Your personal information: name, address, phone number, birth date, date of hire, and Social Security Number, plus your employer's name, address and phone number.
- The date and cause of your disability and when you plan to return to work. If you are pregnant, give your expected delivery date.
- The name, address and phone number of each doctor you are seeing for this absence.



Additional Benefits

Group Accident - Aflac

The Accident Advantage Plus plan from Aflac means that your family has access to added financial resources to help with the cost of follow-up care as well.

- **The Aflac Group Accident Advantage Plus plan benefits:**
- Transportation and Lodging benefits
- Emergency Room Treatment Benefit
- Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma, paralysis
- Accidental Death Benefit
- Accidental Dismemberment Benefit

Features:

- Coverage is guaranteed issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available for you, your spouse and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment – most claims are processed in about four business days.

Group Critical Illness – Aflac

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

COVERED CRITICAL ILLNESSES:

Guaranteed Issue:

Employee $30,000

Spouse $15,000

CANCER (Internal or Invasive) 100%
HEART ATTACK (Myocardial Infarction) 100%
STROKE (Apoplexy or Cerebral Vascular Accident) 100%
MAJOR ORGAN TRANSPLANT 100%
CORONARY ARTERY BYPASS SURGERY[2] 25%
RENAL FAILURE (End-Stage) 100%
COMA, SEVERE BURNS, PARALYSIS, LOSS OF SIGHT, LOSS OF SPEECH, LOSS HEARING, BENIGN BRAIN TUMOR - 100%
CARCINOMA IN SITU[2] 25% (if has not spread)
SKIN CANCER - $250 PCY
ADVANCED ALZHEIMER & PARKINSON DISEASE - 25%

FIRST-OCCURRENCE BENEFIT
After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts available from $5,000 to $50,000. Spouse coverage is also available in benefit amounts up to $25,000. If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase Spouse coverage.

ADDITIONAL OCCURRENCE BENEFIT
If an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered critical illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months.

RE-OCCURRENCE BENEFIT
If an insured collects full benefits for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months, or for cancer, 12 months treatment free. Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless the Insured has gone treatment free for 12 months.

CHILD COVERAGE AT NO ADDITIONAL COST
Each Dependent Child is covered at 50 percent of the primary insured amount at no additional charge.

$50 HEALTH SCREENING BENEFIT (Employee and Spouse only, 30 day waiting period from date of enrollment)
After the waiting period, an insured may receive a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under your certificate. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the certificate remains in force. This benefit is payable for the covered Employee and Spouse. This benefit is not paid for Dependent Children.

Group Hospital Indemnity – Aflac

Hospital Admission Benefit – per confinement (once per covered sickness or accident per calendar year for each insured)
Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment.
We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accident injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth). **BENEFIT AMOUNT: $1,000**

Hospital Confinement – per day (maximum of 31 days per confinement for each covered sickness or accident for each insured)
Payable for each day that an insured is confined to a hospital as an inpatient as a result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat the confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by ore than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.
BENEFIT AMOUNT: $100

Hospital Intensive Care Benefit – per day (maximum of 10 days per confinement for each covered sickness or accident for each insured)
Payable for each day when an insured is confined to a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat the confinement as the same period of confinement. **BENEFIT AMOUNT: $200**
This benefit is payable in addition to the Hospital Confinement Benefit.

Successor Insured Benefit
If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.

In order to receive benefits for accidental injuries due to a covered accident, an insured must be admitted within six months of the date of the covered accident (in Washington, twelve months).

Additional Benefits

IDENTITY THEFT PROTECTION - IDENTITYFORCE

IdentityForce through Sontiq offered through Cigna protect millions of American workers from the devastation of identity theft.
Now is the time to protect what is most important. As our digital footprint 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. They are here to provide you with award-winning identity theft protection built to proactively monitor, alert, and help fix any identity theft compromises.

No one should have to deal with a lifetime of damage that could result from identity theft. We all likely know someone who has already been a victim of identity theft themselves, or had their good name compromised. Security incidents, scams, and fraud continue to grow as our world becomes increasingly digitalized and virtual, and protecting personal information is essential. IdentityForce not only proactively monitors the Dark Web, credit reports, and real-time fraud issues, but they will help fix any compromises to personal information. They will make sure a customer's identity is restored without the burden of phone calls and paperwork.

Privacy and Security

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

Credit Monitoring

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

Restoration Services

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

How to enroll in IdentityForce:
1.Employees enrolled in Cigna medical who are registered on myCigna.com will receive an enrollment link email directly from IdentityForce
2.Call IdentityForce at 833-580-2523 or visit cigna.identityforce.com/starthere

Additional Benefits

LINE OF DUTY BENEFITS

The City offers an additional $50,000 or 100% of the AD&D benefit to public safety officers who put their lives on the line to protect The City of Covington. For more information, please call 800.633.8575.

How Line of Duty Benefits Work

Line of Duty Benefits provide an additional insurance benefit on top of Life Insurance and AD&D. For example, a firefighter who has basic life coverage with the City responds to a building fire. A gas leak occurs, causing an explosion that results in the firefighter's death. In this example, the firefighter's beneficiaries would receive the following: Life and AD&D benefit of $100,000 plus a $50,000 Line of Duty Benefit for a total payment of $150,000.

This benefit can also apply to major injuries. For example, a police officer who has basic Life and AD&D with the City is involved in a high-speed chase that ends in a collision, resulting in the loss of sight in one of their eyes. In this example, the police officer would receive the AD&D benefit for loss of the sight of one eye, plus a $50,000 Line of Duty Benefit.

LIFE SERVICES TOOLKIT

The Standard's Life Services Toolkit, provided by Health Advocate, is available to all employees.

Employee Access

Get access to information and tools to help make decisions on topics such as:

- Estate Planning Assistance: Online tools to help with preparing a will and creating documents such as living wills, powers of attorney and advance directives.
- Financial Planning: Consult online services to help you manage debt, mortgage and loan payments, and take care of other financial matters with confidence.
- Health and Wellness: Articles about nutrition, stress management and wellness help employees lead healthier lives.
- Identity Theft Prevention: thwart identity thieves & resolve issues if theft occurs.
- Funeral Arrangements: Access guidance on how to begin, funeral costs, finding funeral-related services and arrangements.

LIFE SERVICES TOOLKIT

standard.com/mytoolkit

Employee Services username: assurance

Beneficiary Services username: support

800.378.5742

SERVICES FOR YOUR BENEFICIARY

Life insurance beneficiaries can access services for 12 months after receiving the Life claim letter. Accelerated Death Benefit recipients can access services for 12 months after the date of payment. These supportive services help your beneficiary cope after a loss:

- Grief Support: Care Managers with advanced training are on call to provide confidential grief sessions by phone or in person.
- Legal Services: In addition to online estate planning tools, beneficiaries can obtain legal assistance from experienced attorneys.
- Financial Assistance: Schedule telephone sessions with financial counselors who can help with issues such as budgeting strategies, and credit and debt management.
- Support Services: Receive help planning a funeral or memorial service. Work Life advisors can guide them to resources to help manage household repairs and chores, find childcare and elder care providers or organize a move or relocation.
- Online Resources: Access additional services and features on the Life Services Toolkit website, including online resources about funeral arrangements and costs and funeral-related services.

TRAVEL ASSISTANCE PROGRAM

Travel Assistance Benefits Include:

- Credit card and passport replacement
- Missing baggage and emergency cash coordination
- Assistance with the return of your personal vehicle if emergency transportation services leave it stranded
- Replacing medications/lost corrective lenses
- Advancing funds for hospital admission
- Evacuation in case of a natural disaster and social/political unrest
- Return travel companion if travel is disrupted due to emergency hospitalization
- Care of minor children if left unattended because of a hospitalization
- Access to medical care providers, interpreter services, local attorneys
- Assistance with bail bonds

TRAVEL ASSISTANCE

Phone: 800.872.1414
(US, Canada, Puerto Rico, Virgin Islands, Bermuda)

Phone: 609.986.1234

Text: 609.334.0807

Email: medservices@assistanceamerica.com

CIGNA PROGRAMS

The City of Covington believes prevention is the key to leading healthy and productive lives, and we are committed to helping our employees improve their health. Register at myCigna.com to access Cigna's free support tools.

Cigna One Guide

Cigna One Guide® provides access to guided consultations through telephone, mobile app, and 'Click-to-Chat' for choosing benefits, reducing health expenses through reward programs, and building a personal health team of doctors, clinicians, and coaches. Call the number on the back of your medical ID card to talk to a personal guide today.

- Resolve health care issues
- Find the right In Network hospitals, dentists and health care providers
- Save time and money
- Get cost estimates and avoid surprise expenses
- Get the most out of your plan
- Understand your bills

My Health Assistant

Cigna offers access to My Health Assistant as a part of your health plan. This service is an online personal coaching service powered by WebMD with programs that can jump-start your goals and help you start feeling healthier and happier. My Health Assistant on myCigna.com includes online health management programs that can help you turn unhealthy behaviors into healthier achievements by establishing goals and tracking your progress. Log in to myCigna.com, click the My Health tab and select 'Programs & Resources.

- Control stress • Enjoy exercise • Manage COPD • Manage heart failure • Quit tobacco • Manage asthma
- Lose weight • Manage diabetes • Manage heart disease • Eat better

Cigna's Total Behavioral Health Program

If you or a loved one has been diagnosed with a behavioral health condition, this comprehensive program from Cigna provides help with life events, and offers dedicated support, lifestyle coaching, and online tools. Visit myCigna.com or call 800.274.7603. Services to help manage life events. * Receive (3) face to face sessions

- Virtual behavioral care with a licensed mental health professional at no additional charge • Lifestyle management programs
- On-demand coaching and personalized learning • Behavioral support and awareness webinars

CIGNA VIRTUAL CARE (TELEHEALTH)

Register for a myCigna account to access virtual care and connect with quality board-certified doctors, pediatricians, licensed counselors and psychiatrists. Members can get minor medical virtual care 24/7/365 from anywhere via video or phone or schedule a behavioral/mental health virtual care appointment online in minutes.

Virtual Medical Care

Board-certified doctors/pediatricians can diagnose, treat and prescribe medications for minor medical conditions. To connect with an MDLIVE virtual provider, visit myCigna.com and click on the 'Talk to a doctor' callout. Medical conditions include:

- Allergies • Bronchitis • Diarrhea • Fever • Nausea • Rashes • Joint ache • Sinus infections
- Asthma • Cold / flu • Earaches • Headaches • Pink eye • Shingles • Sore throats • Skin infections

Virtual Behavioral Health Care

Licensed counselors and psychiatrists can diagnose, treat and prescribe medications for certain nonemergency conditions. To locate a Behavioral Health provider, visit myCigna.com, go to 'Find Care & Costs' and enter 'Virtual counselor' under 'Doctor by Type,' or call the number on the back of your Cigna ID card. Behavioral Health conditions can include:

- Addictions • Grief/Loss • Trauma/PTSD • Eating disorders • Bipolar disorders • Relationship issues
- Depression • Stress • Life changes • Panic disorders • Parenting issues • Postpartum depression

Schedule an Appointment

1. Access MDLIVE by logging into myCigna.com and clicking on 'Talk to a doctor.' You can also call MDLIVE at 888.726.3171.
2. Select the type of case you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE.
3. Follow the prompts for an on-demand urgent care visit to make an appointment for primary or behavioral care.

HEALTHY REWARDS

Get discounts on the health products and programs you use every day, ranging from Weight Management, Nutrition and Fitness, to Vision and Hearing Care, Nicotine Cessation and Alternative Medicine. Just use your Cigna ID wallet card when you pay and let the savings begin.

Log into your myCigna.com account and navigate to Healthy Rewards Discount Program or call 800.870.3470

OMADA

Omada is a digital lifestyle program that inspires healthy habits through technology and support programs.

The goal is to help you accomplish the changes that matter most in the areas of eating, activity, stress and sleep. Omada is available at no additional cost.

If you or your covered adult dependents are enrolled in the company medical plan through Cigna, are at risk for diabetes or heart **Omada features:**

- Interactive program to guide your journey
- Wireless smart scale to monitor your progress
- Weekly online lessons to empower you
- Professional Omada health coach for added support
- Small online peer group to keep you engaged

ACTIVE & FIT DIRECT PROGRAM

Cigna members have access to discounts on health programs through Cigna Healthy Rewards program.

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

Memberships are $28 per month (plus a $28 enrollment fee) which allows you access to multiple local gyms in the Active & Fit network. You have access to standard fitness centers for just $28 and/or premium exercise studios with 20-70% discounts plus access to digital workout videos. Take the steps below to get started today!

Login to myCigna.com
↓
Wellness
↓
Exercise
↓
Healthy Rewards
↓
Gym Memberships and Digital Workouts

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.

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 through myCigna. com or the free myCigna mobile App.

1. STAY ON TOP OF PREVENTIVE CARE

What is preventive care?
Preventive care is a specific group of services recommended when you don't have any symptoms and haven't been diagnosed with a related health issue. It includes your periodic wellness exam (check-up) and specific tests, certain health screenings, and most immunizations. Most of these services typically can take place during the same visit. You and your health care provider will decide what preventive services are right for you, based on your age, gender, personal health history, and current health.

Why do I need preventive care?

Preventive care can help you detect problems at early stages, when they may be easier to treat. It can also help you prevent certain illnesses and health conditions from happening. Even though you may feel fine, getting your preventive care at the right time can help you take control of your health.

Which preventive services are covered?
Many plans cover preventive care at no additional cost to you when you use a health care provider in your plan's network. Use the provider directory on myCigna.com for a list of in-network health care providers and facilities.

2. FIND THE BEST PROVIDERS

The Cigna Care Designation is one decision-making tool you can use to choose a doctor.
Before we award a doctor the Cigna Care Designation, we 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. When you use the myCigna online directory to find a doctor, you will see top-performing doctors are shown with the Cigna Care Designation symbol. This gives you an evaluation of quality and cost-efficiency that you can trust.

Cigna Tier 1 Providers
Each year Cigna evaluates provider performance in certain medical specialties. Providers with top results in delivering quality, cost-efficient care become Tier 1. Under your plan, every time you use a Tier 1 in-network provider you will have a lower coinsurance or copay.

Get help choosing a hospital, too! Just look for the Centers of Excellence Designation. Choose an in-network hospital that's right for you. Hospitals that demonstrate better health outcomes at lower costs for one of the reviewed conditions earn our top rating — the Cigna Centers of Excellence designation.

3. STAY IN-NETWORK

Costs will be lower if you choose to see doctors, hospitals and facilities in Cigna's network. When you are scheduled for surgery, ensure that the surgeon, anesthetist, and facility are *all* In-Network. 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. myCigna and Cigna One Guide can help you stay in-network, maximize savings, and avoid any surprises.

4. FIND THE MOST COST EFFECTIVE RX

How to search for an In-Network Provider:
The provider directory on myCigna.com shows you results based on your health plan network and your location.

1. Log in to myCigna.com and select the 'Find Care & Costs' Tab
2. Find care and cost estimates in your area by 'Primary Care, Doctor by Type, Doctor by Name, Reason for Visit or Locations'
3. Select 'Doctor by Type' and enter a specialty or type of doctor

Example: type "Primary Care Provider"> Results for In Network primary care providers near your area will be displayed.

When you fill a prescription at an in-network pharmacy, what you pay depends on your cost-share for the medication and your annual deductible. If you're enrolled in a Health Reimbursement Account (HRA) or Health Savings Account (HSA) plan through Cigna, you may be able to use your funds to help pay for your eligible out-of-pocket expenses. Review your plan materials for more information.

Here are three ways to spend less on medication:
1. Buy generic. When it comes to prescription medications, you usually have a choice between a brand name medication and its generic equivalent. Generics offer the same strength and active ingredients as the brand name medication but often cost much less. Always check with your doctor or pharmacist to understand your options.

2. Compare drug costs at different pharmacies. Login to 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.

3. Ask your doctor about getting a 90-day (three-month) supply of your prescription. You'll make fewer trips to the pharmacy for refills. And you're more likely to stay healthy because with a 90-day supply on-hand, you're less likely to miss a dose. 90-day prescriptions may be filled using Cigna Home Delivery Pharmacy or select in-network retail pharmacies.

To get started using home delivery, log into the myCigna App or myCigna.com. Click on the Prescriptions tab and select 'My Medications' from the dropdown menu. Then click the button next to your medication name to move your prescription(s).

5. SHOP FOR THE BEST OUTPATIENT FACILITIES FOR DIAGNOSTIC TESTS

MRI, CT and PET scans can cost much less at some facilities. Make a more informed choice about where you get your services. Cigna's team can find the most cost-effective facility for a service. Cigna will help you compare costs for hundreds of procedures. Call Cigna customer service anytime at 800-244-6224.

How to search for outpatient facilities:
The provider directory on myCigna.com shows you the costs of services within your location.

1. Log in to myCigna.com and select the 'Find Care & Costs' Tab

2. Find care and cost estimates in your area by 'Primary Care, Doctor by Type, Doctor by Name, Reason for Visit or Locations
Example: Select 'Reason for Visit' and enter the procedure *'Shoulder MRI Scan with Dye'.* Then select 'Facilities' to view the results for facility costs near your area.

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

National averages of participating facilities; actual costs will vary. The information provided is intended to be general information. It is not intended as medico) advice. You should consider all relevant factors and consult with your treating doctor when selecting a provider for care.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City of Covington provides all eligible employees with six free counseling sessions through its EAP program with Curalinc.

Curalinc EAP provides comprehensive mental health support and wellness resources to employees, offering various access points, including 24/7 counseling, digital behavioral health platforms, and work-life support. EAP services aim to help employees address issues like stress, depression, anxiety, substance use, and work-life balance.

Services provided includes but not limited to:

- Short term counseling for employees and household members
- Fitness Coaching
- Self guided digital therapy
- Financial and legal consultations
- Referrals for childcare, elder care, pet care, home improvement or auto repair
- 24/7 access
- Easy online access to live chat and email at support@curalinc.com

Download the mobile app today!

1-888-881-5462

curalinc HEALTHCARE

RETIREMENT

Defined Contribution 401(A) Plan (Voya)

ELIGIBILITY: Full Time employee, effective date of hire (6-year vesting schedule)
WHAT: City will contribute 4%-6% of employee's base pay (depending on the job class). City will match up to 2%-5% of employee's contribution to 457(b) Program (depending on years of service & job class).

Deferred Compensation (457 Plan) (Voya)

ELIGIBILITY: Employee is automatically enrolled
WHAT: Employee is automatically enrolled at 4%. Employee may increase, decrease or opt out of this benefit. A maximum of voluntary pre-tax contributions can be made up to $23,500 for 2025. Employees 50 and older can make up to $7,500 in catch-up contributions to 457(b) plans, for a total maximum contribution of $31,000

TUITION REIMBURSEMENT

Dependent upon the availability of funds as provided by the Mayor and Council. Limit of $5,250 per calendar year.
ELIGIBILITY: Full Time employee, employees who are in working test status or on disciplinary probation are *not* eligible for educational assistance.

WHAT: Tuition Reimbursement applies to tuition, books and pre-approved school related fees.

EMPLOYEE ASSISTANCE PROGRAM

ELIGIBILITY: All employees, effective from date of hire.
100% Employer paid
WHAT: Provides confidential counseling and referral to employees dealing with problems in the areas of marriage, family, financial, drug/alcohol abuse, and work relationships.

LONG TERM DISABILITY

ELIGIBILITY: All employees, effective 1 year from date of hire.
100% Employer paid
WHAT: 60% income continuation if you are ever unable to work due to an accident or illness

LIFE INSURANCE

ELIGIBILITY: Full Time employee, starting 1st of the month following hire date
100% Employer paid
WHAT: $50,000.00

VACATION (*PER FISCAL YEAR)

ELIGIBILITY: Full Time employee, effective from date of hire.

8 HOUR PERSONNEL

0 years - 5 years of service - 80 hours
6 years - 10 years of service - 120 hours
11+ years of service - 160 hours
20+ years of service - 1 day for every 10 years in addition to the 160 hours

FIRE PERSONNEL (24 HR SHIFT)

0 years - 5 years of service - 104 hours
6 years - 10 years of service - 152 hours
11+ years of service - 224 hours
20+ years of service - 1 day for every 10 years in addition to the 224 hours

POLICE PERSONNEL (10/12 HR SHIFT)

0 years - 5 years of service - 86 hours
6 years - 10 years of service - 129 hours
11+ years of service - 172 hours
20+ years of service - 1 day for every 10 years in addition to the 172 hours

MILITARY LEAVE

ELIGIBILITY: Full Time employee, effective from date of hire.
WHAT: Will be granted according to law.

JURY DUTY

ELIGIBILITY: Full Time employee, effective from date of hire.
WHAT: Paid based on regularly scheduled hours spent on jury duty.

SICK

ELIGIBILITY: Full Time employee, effective from date of hire.

8 HOUR PERSONNEL

Accrual at the rate of 3.69 hours bi-weekly

FIRE PERSONNEL (24 Hour Shift)

Accrual at the rate of 5.58 hours bi-weekly

POLICE & 911 DISPATCHERS

(10/12 Hour Shift)
Accrual at the rate of 3.88 hours bi-weekly

PAID HOLIDAYS

New year's Day
Martin Luther King Day
Memorial Day
Juneteenth
Independence Day
Labor Day
Veteran's Day
Thanksgiving x2
Christmas X2

BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - City of Covington, GA
Open Access Plus Plan
OAP HDHP Pre-65 Retirees
Effective - 07/01/2025

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your plan's deductibles, out-of-pockets and benefit level limits accumulate on a contract year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted.	
Plan Coinsurance	Plan pays 100%	Plan pays 70%
Maximum Reimbursable Charge	Not Applicable	110%
Plan Deductible	Individual: $3,300 Individual +1: $3,300 Family: $6,600	Individual: $5,200 Individual +1: $5,200 Family: $10,400

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards both your in-network and out-of-network deductibles.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.
- This plan includes a combined Medical/Pharmacy plan deductible.
- 3-month carryover deductible provision included but does not credit the out-of-pocket amount.
- In-Network Generic preventive drugs and products included in the Preventive Package will not be subject to deductible. This may apply to drugs for: Asthma, Cholesterol Lowering, Depression, Diabetes (including diabetic supplies but excluding continuous glucose monitor supplies), Heart Disease and Stroke, High Blood Pressure, Osteoporosis, Prenatal Vitamins.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $3,300 Individual +1: $3,300 Family: $6,600	Individual: $6,600 Individual +1: $6,600 Family: $13,200

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	Plan pays 100% ^	Not Covered
MDLIVE Primary Care Services	Plan pays 100% ^	Not Covered
MDLIVE Specialty Care Services	Plan pays 100% ^	Not Covered

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Specialty Care Physician Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^
• Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). • Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting. **NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Convenience Care Clinic		
Convenience Care Clinic	Plan pays 100% ^	Plan pays 70% ^
Preventive Care		
Preventive Care Birth through age 5	Plan pays 100%	PCP: Plan pays 70% Specialist: Plan pays 70%
Ages 6 and older	Plan pays 100%	PCP: Plan pays 70% ^ Specialist: Plan pays 70% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. • Annual Limit: Unlimited		
Immunizations Birth through age 5	Plan pays 100%	PCP: Plan pays 70% Specialist: Plan pays 70%
Ages 6 and older	Plan pays 100%	PCP: Plan pays 70% ^ Specialist: Plan pays 70% ^
Mammogram, PAP, and PSA Tests	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.		
Inpatient		
Inpatient Hospital Facility Services	Plan pays 100% ^	Plan pays 70% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100% ^	Plan pays 70% ^
Inpatient Professional Services	Plan pays 100% ^	Plan pays 70% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient		
Outpatient Facility Services	Plan pays 100% ^	Plan pays 70% ^
Outpatient Professional Services	Plan pays 100% ^	Plan pays 70% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Emergency Services		
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan pays 100% ^	Plan pays 100% ^
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	Plan pays 100% ^	Plan pays 100% ^
Ambulance	Plan pays 100% ^	Plan pays 100% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Ambulance - Mental Health and Substance Use Disorder	Plan pays 100% ^	Plan pays 100% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 120 days	Plan pays 100% ^	Plan pays 70% ^
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100% ^	Plan pays 70% ^
Outpatient Facility	Plan pays 100% ^	Plan pays 70% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100% ^	Plan pays 70% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 100% ^	Plan pays 70% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Cigna Health and Life Insurance Co.: Open Access Plus - HDHP Pre-65 Retirees

Coverage Period: 07/01/2025 - 06/30/2026
Coverage for: Individual/Individual + Family | Plan Type: OAP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $3,300/individual or $6,600/family For out-of-network providers: $5,200/individual or $10,400/family Combined medical/behavioral and pharmacy deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, out-of-network preventive care & immunizations through age 5, in-network generic preventive drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $3,300/individual or $6,600/family For out-of-network providers: $6,600/individual or $13,200/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

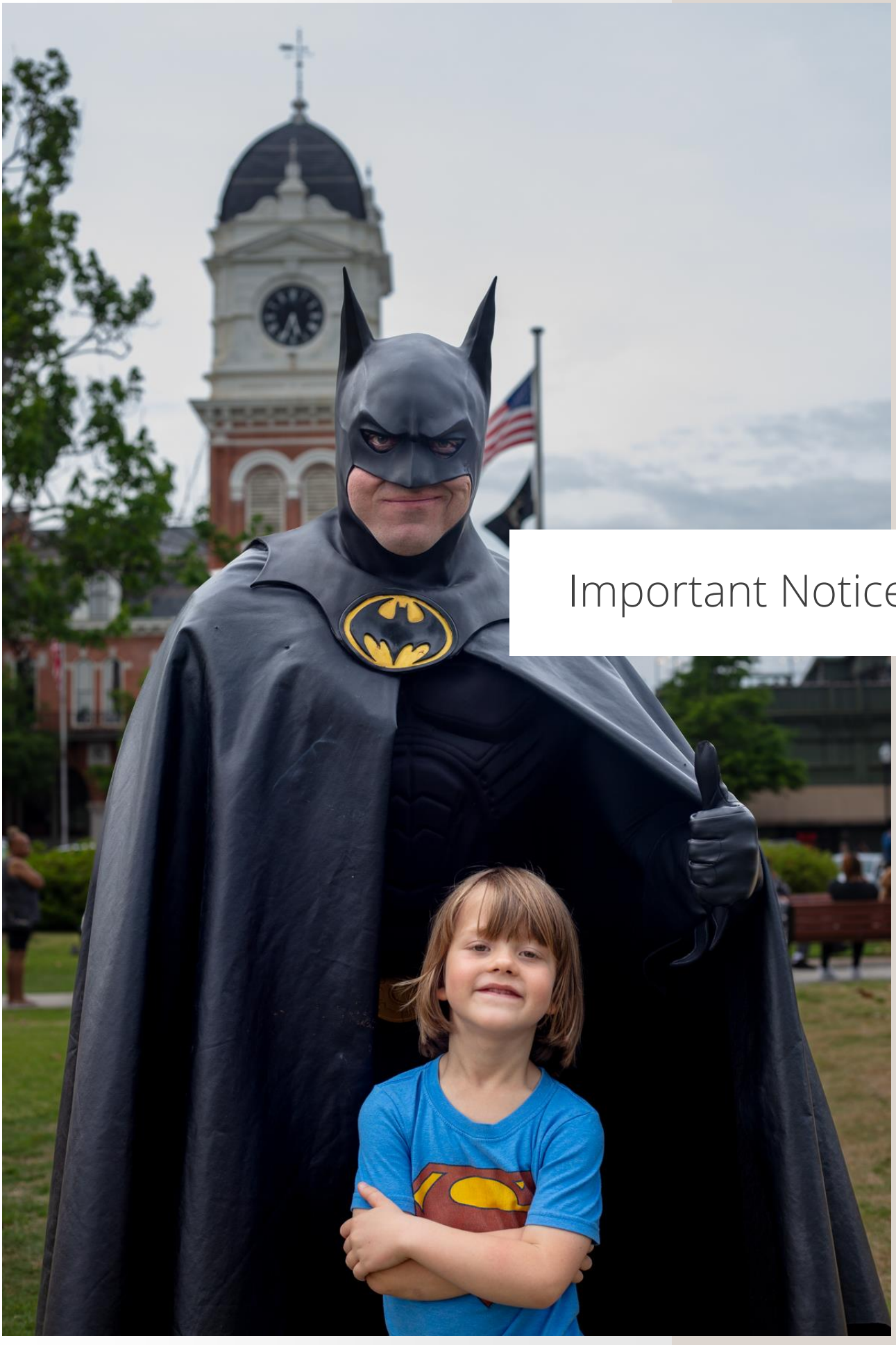
Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge/office visit No charge/MDLIVE visit	30% coinsurance	None
	Specialist visit	No charge/visit	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/visit** No charge/screening** No charge/screening** No charge/immunizations** No charge/immunizations** **Deductible does not apply	30% coinsurance/visit** 30% coinsurance/visit 30% coinsurance/ screening** 30% coinsurance/ screening 30% coinsurance/ immunizations** 30% coinsurance/ immunizations **Deductible does not apply	Coverage birth through age 5 Coverage age 6 and older Coverage birth through age 5 Coverage age 6 and older Coverage birth through age 5 Coverage age 6 and older You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	50% penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail & home delivery 90 days)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail & home delivery 90 days)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$20 copay/prescription (retail 30 days), $40 copay/prescription (retail & home delivery 90 days)	$20 copay/prescription (retail 30 days), $40 copay/prescription (retail & home delivery 90 days)	
	Non-preferred brand drugs (Tier 3)	$35 copay/prescription (retail 30 days), $70 copay/prescription (retail & home delivery 90 days)	$35 copay/prescription (retail 30 days), $70 copay/prescription (retail & home delivery 90 days)	
	Specialty drugs (Tier 4)	25% coinsurance/prescription (retail & home delivery 30 days)	25% coinsurance/prescription (retail & home delivery 30 days)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	30% coinsurance	50% penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	No charge/visit	No charge/visit	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	No charge/visit	No charge/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	30% coinsurance	50% penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit No charge/all other services	30% coinsurance/office visit 30% coinsurance/all other services	50% penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	No charge	30% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 120 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/PCP visit No charge/Specialist visit	30% coinsurance/PCP visit 30% coinsurance/ Specialist visit	Coverage is limited to annual max of: 36 days for Cardiac rehab services.
	Habilitation services	No charge/PCP visit No charge/Specialist visit	30% coinsurance/PCP visit 30% coinsurance/ Specialist	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital



Important Notices

Important Notices

CHILDREN'S HEALTH INSURANCE PROGRAM

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1.877.KIDS.NOW or insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

WOMEN'S HEALTH AND CANCER RIGHTS

Under the Women's Health and Cancer Rights, any plan participant who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following:

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

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services are subject to deductibles and coinsurance amounts that are consistent with those of other benefits under the plan.

MEDICARE PART D NOTICE

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Covington has determined that the prescription drug coverage offered by Cigna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current City of Covington coverage will not be affected. See Annual Creditable Coverage Notice, which outlines the prescription drug plan provisions / options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current City of Covington coverage, be aware that you and your dependents may not be able to get this coverage back.

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare Prescription Drug coverage, log onto www.medicare.gov, call 1.800.MEDICARE (1.800.633.4227), or call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more information, visit socialsecurity.gov, or call 1.800.772.1213.

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

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact you HR Department.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE:

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

HIPAA NOTICE OF PRIVACY PRACTICE REMINDER

The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities").

Health Plans. Individual and group plans that provide or pay the cost of medical care are covered entities. Health plans include health, dental, vision, and prescription drug insurers, health maintenance organizations ("HMOs"), Medicare, Medicaid, Medicare+Choice and Medicare supplement insurers, and long-term care insurers (excluding nursing home fixed-indemnity policies). Health plans also include employer-sponsored group health plans, government and church-sponsored health plans, and multi-employer health plans. There are exceptions—a group health plan with less than 50 participants that is administered solely by the employer that established and maintains the plan is not a covered entity.

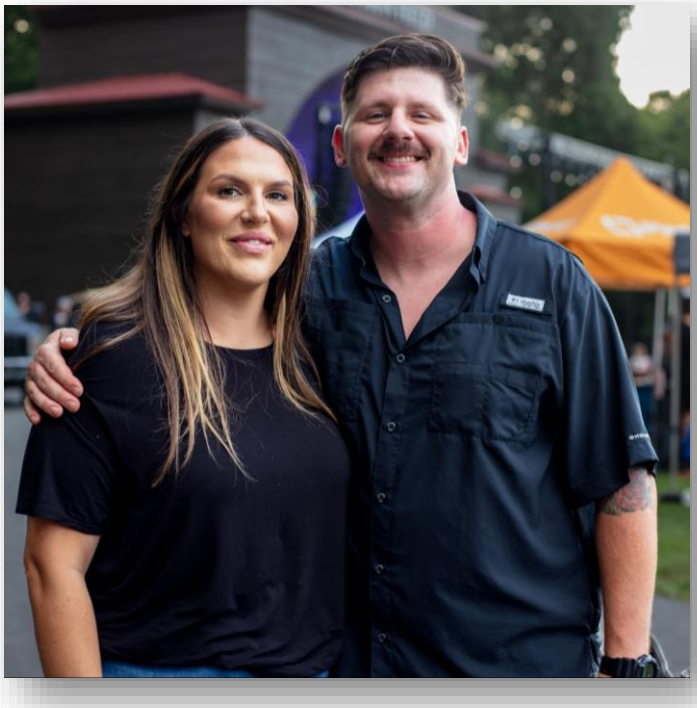
Two types of government-funded programs are not health plans: (1) those whose principal purpose is not providing or paying the cost of health care, such as the food stamps program; and (2) those programs whose principal activity is directly providing health care, such as a community health center, or the making of grants to fund the direct provision of health care. Certain types of insurance entities are also not health plans, including entities providing only workers' compensation, automobile insurance, and property and casualty insurance. If an insurance entity has separable lines of business, one of which is a health plan, the HIPAA regulations apply to the entity with respect to the health plan line of business.

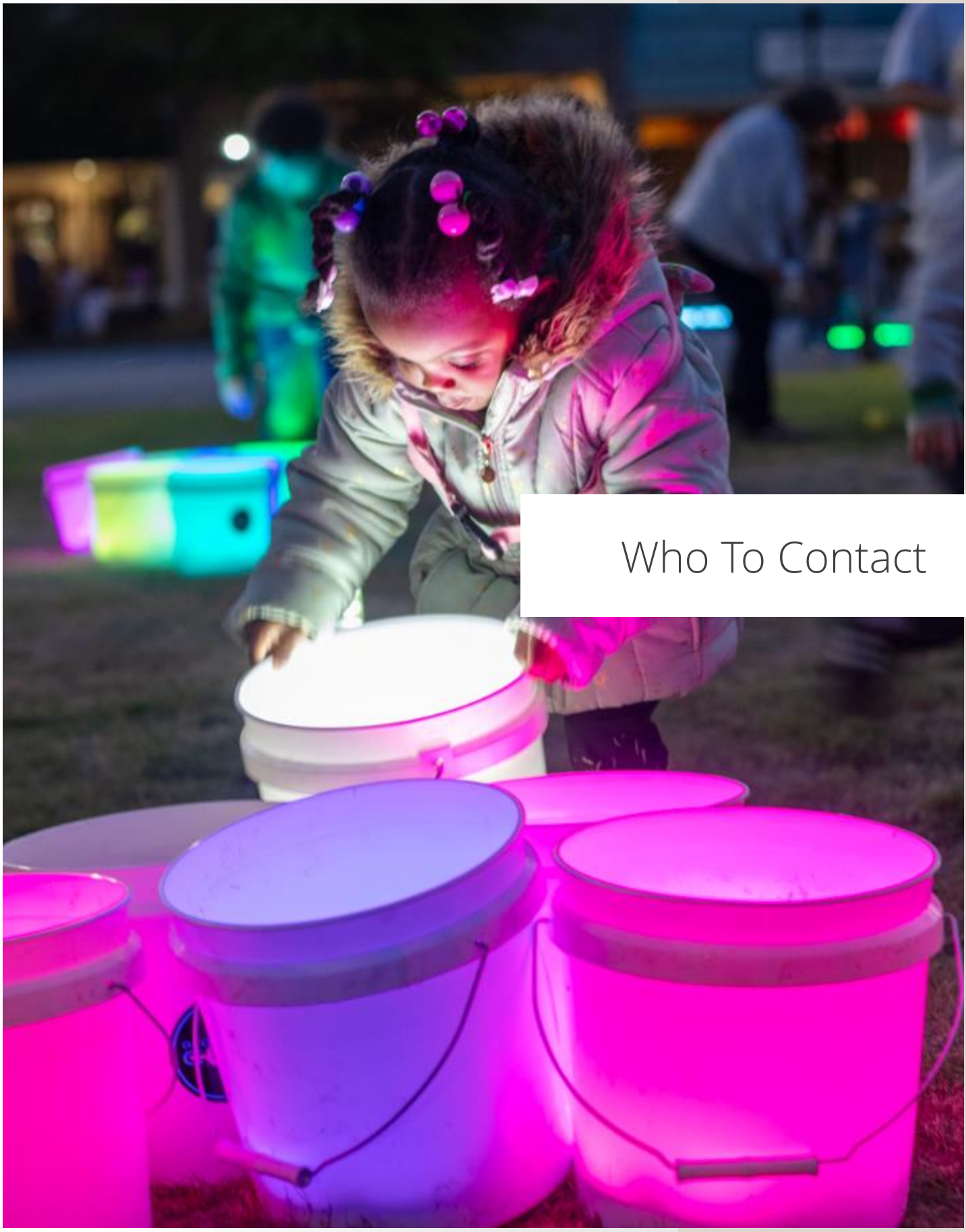
EEOC WELLNESS NOTICE

New rules published under the Americans with Disabilities Act (ADA) require employers that offer wellness programs that collect employee health information to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. The EEOC has published the sample notice below to help employers comply with the ADA:

NOTICE REGARDING WELLNESS PROGRAM

The City of Covington's voluntary wellness program is available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.





Who To Contact

Reasons to Contact the NFP Service Center

- **Understanding Your Benefits:** We can assist with questions about deductibles, copayments, and coinsurance. We can explain waiting periods, elimination periods, and eligibility rues.
- **Enrollment Assistance:** Our Benefits Call Center representative can guide you through every step of the enrollment process, whether it's an online enrollment or paper enrollment form.
- **Order ID Cards:** We can directly contact the insurance carrier and have your replacement card delivered in 10 to 15 business days.
- **Claim Resolution and Research:** We can help you understand your explanation of Benefits (EOB) and contact the insurance carriers on your behalf. We can assist with appealing a denied claim, help you request a Prior Authorization (PA) from your physician, help you file out-of-network claims, and assist with reimbursement for medical assistance while traveling outside of the United States.
- **Locate In-Network Providers:** Staying in-network saves money. We can help you find in-network providers for medical, dental, and vision coverage, whether you're at home or traveling.
- **Explain Qualifying Events:** Most benefit plans require a Qualifying Event (like marriage, birth of a child, or other life event) to change your election outside of open enrollment. We work with your employer to ensure your change follows the plan rules, is requested within the appropriate timeframes, and is properly documented.
- **Annual Enrollment Information:** We can provide details about when open enrollment begins and ends, and if your plan designs or payroll deductions are changing.
- **Confirmation Statements:** We can provide copies of your online enrollment confirmation statement or a copy of your paper enrollment form at any time.
- **Request Copies of Necessary Forms:** We can provide medical claim forms, out-of-network claim forms, evidence of insurability forms, short and long-term disability claim forms, and any other necessary forms.

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

Contact us at 1.844.626.8435 or nfpSEcustomerservice@NFP.com

Please note: benefits reduce by 65% at age 70.
Ex: If you have $20,000 of life insurance, your benefit will decrease to $13,000 when you turn age 70.

Semi-Monthly Voluntary Life and AD&D Costs (24 Pay Periods)											
Rate / $1,000	***$0.17***	***$0.19***	***$0.26***	***$0.37***	***$0.57***	***$0.89***	***$1.34***	***$2.24***	***$4.22***	***$7.93***	***$14.76***
Employee Age	**18 - 34**	**35 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**	**65 - 69**	**70 - 74**	**75-79**	**80 - 84**
$10,000	$0.83	$0.93	$1.28	$1.83	$2.83	$4.43	$6.68	$11.18	$21.08	$39.63	$73.78
$20,000	$1.65	$1.85	$2.55	$3.65	$5.65	$8.85	$13.35	$22.35	$42.15	$79.25	$147.55
$30,000	$2.48	$2.78	$3.83	$5.48	$8.48	$13.28	$20.03	$33.53	$63.23	$118.88	$221.33
$40,000	$3.30	$3.70	$5.10	$7.30	$11.30	$17.70	$26.70	$44.70	$84.30	$158.50	$295.10
$50,000	$4.13	$4.63	$6.38	$9.13	$14.13	$22.13	$33.38	$55.88	$105.38	$198.13	$368.88
$60,000	$4.95	$5.55	$7.65	$10.95	$16.95	$26.55	$40.05	$67.05	$126.45	$237.75	$442.65
$70,000	$5.78	$6.48	$8.93	$12.78	$19.78	$30.98	$46.73	$78.23	$147.53	$277.38	$516.43
$80,000	$6.60	$7.40	$10.20	$14.60	$22.60	$35.40	$53.40	$89.40	$168.60	$315.60	$590.20
$90,000	$7.43	$8.33	$11.48	$16.43	$25.43	$39.83	$60.08	$100.58	$189.68	$317.00	$663.98
$100,000	$8.25	$9.25	$12.75	$18.25	$28.25	$44.25	$66.75	$111.75	$210.75	$396.25	$737.75

To calculate your premium for Voluntary Life:

1. Choose a benefit amount from the left column of the rate chart.
2. Find the 'employee age' at the time of enrollment along the top.
3. Your premium cost is where the age row and benefit column intersect.

To calculate costs for benefit amounts over $100,000

Monthly Cost = (Benefits Volume x Rate) / 1000

Per Pay Period Cost = (Monthly Cost x 12) / 24

City of Covington

COVINGTON georgia

	STANDARD RATE Employee Per Pay Check	WELLNESS RATE Employee Per Pay Check
POS- Medical		
Employee	$182.95	$157.95
Employee + Spouse	$360.55	$335.55
Employee + Child(ren)	$314.56	$289.56
Employee + Family	$491.91	$466.91
HSA-Medical		
Employee	$106.94	$81.94
Employee + Spouse	$210.70	$185.70
Employee + Child(ren)	$175.23	$150.23
Employee + Family	$218.79	$193.79
Dental		
Employee	$5.42	
Employee + Spouse	$11.76	
Employee + Child(ren)	$10.76	
Employee + Family	$13.76	
Vision		
Employee	$0.70	
Employee + Spouse	$1.41	
Employee + Child(ren)	$1.42	
Employee + Family	$2.24	
Life		
Employee		Taken out of 2nd paycheck of the month
Employee + Spouse	$1.88	
Employee + Child(ren)	$0.68	
Employee + Family	$2.56	

Accident	Employee Per Pay Check
Employee	$7.09
Employee + Spouse	$12.25
Employee + Child(ren)	$15.68
Employee + Family	$20.84

Hospital Indemnity	Employee Per Pay Check
Employee	$6.56
Employee + Spouse	$13.34
Employee + Child(ren)	$10.39
Employee + Family	$17.17

AFLAC CRITICAL ILLNESS

Employee Age	$10,000	$20,000	$30,000
18-24	$1.72	$3.44	$5.15
25-29	$2.06	$4.12	$6.17
30-34	$2.59	$5.18	$7.77
35-39	$3.22	$6.44	$9.66
40-44	$4.34	$8.67	$13.01
45-49	$6.13	$12.26	$18.39
50-54	$8.80	$17.60	$26.40
55-59	$12.24	$24.49	$36.73
60-64	$17.68	$35.16	$52.73
65-69	$26.11	$52.23	$78.34
70+	$39.69	$79.39	$119.08

Spouse Age	$5,000	$10,000	$15,000
18-24	$.86	$1.72	$2.58
25-29	$1.03	$2.06	$3.09
30-34	$1.30	$2.59	$3.89
35-39	$1.61	$3.22	$4.83
40-44	$2.17	$4.34	$6.51
45-49	$3.07	$6.13	$9.20
50-54	$4.40	$8.80	$13.20
55-59	$6.12	$12.24	$18.36
60-64	$8.79	$17.58	$26.37
65-69	$13.06	$26.11	$39.17
70+	$19.85	$39.69	$59.54

Short Term Disability – Rate per $10 of weekly benefit

Employee Age	Rate
<25	$0.266
25 – 29	$0.400
30 - 34	$0.440
35 - 39	$0.223
40 - 44	$0.232
45 - 49	$0.258
50 - 54	$0.279
55 - 59	$0.410
60 - 64	$0.424
65 - 69	$0.505
70+	$0.519

To calculate your premium for Short Term Disability

1. Take your annual salary and divide it by 52 (weeks in a year)
2. Take your weekly salary and multiply it by .6. This is your weekly benefit amount.
3. Take your weekly benefit amount and multiply it by the rate in the table above, based on your age as of July 1, 2025.
4. This is your monthly cost. To calculate your per pay period cost, multiply your monthly cost by 12 and then divide by 24.

Contact Information

If you have any questions regarding our benefits, feel free to contact any of our providers directly.

BENEFITS SPECIALIST Trinekka Miller - City of Covington	770.385.6830 tmiller@cityofcovington.org
BENEFIT ENROLLMENT QUESTIONS NFP	844.626.8435 nfpSEcustomerservice@nfp.com
MEDICAL/DENTAL/VISION Cigna	800.244.6224 www.mycigna.com
BASIC LIFE AD&D VOLUNTARY LIFE AD&D SHORT TERM/LONG TERM DISABILITY Standard	800.368.1135 www.standard.com
HEALTH SAVINGS ACCOUNT HSA Bank	hsabank.com 800.357.6246
EAP Curalinc	888.881.5462 support@curalinc.com
HOSPITAL INDEMNITY/ACCIDENT/CRITICAL ILLNESS AFLAC	800.992.3522