Financial Network -2020 Benefits Enrollment

This enrollment guide has been designed to provide you with information about each plan in the benefit package and to help guide you through the choices you have. Reviewing the information contained in this guide will help you to choose the benefits that fit your needs and lifestyle.

During open enrollment, you have the opportunity to change, add or cancel any of your benefits. In addition, you may add or change the dependents you cover under your benefits. For medical, dental and life coverage's, changes you make during open enrollment are effective January 1, 2020. Open enrollment runs from October 1 through October 18. Confirmations will be sent by October 25. After October 31 you will not be able to make changes to your benefit elections for another year, unless you have a Qualified Change in Status. **All elections are for the calendar year. There is no midyear termination allowed. This is an ERISA Plan. All premiums listed are MONTHLY - NOT ANNUALLY.**

Please review this brochure, and then complete the enrollment form. A confirmation statement and invoice will be emailed to you by October 25, 2019.

For 2020, all changes must be documented during open enrollment with an updated form and an updated ACH Debit/Credit Card forms. Changes will be updated and confirmed with Statements sent on October 25, 2019.

Questions:

amy.ahrens@ahrensnaefconsulting.com
FAX: 866-817-3969,
Telephone: 770-966-9247,

Financial Network Group Health Plan,
3226 Citation Avenue, NW,
Kennesaw, GA 30144

What You Will Find Inside…

Important Dates: For 2020 Plan Year

Enrollment:	October 1 thru October 18
Confirms E-mailed:	October 25
Final Changes Due:	October 31
Annual Fees Drafted:	November
2020 Premiums Begin:	December

Important Information

All Financial Network Plan participants must complete the forms attached and submit either electronically, via fax or mail within 31 days of their hire date. All participants who do not complete the forms, as requested, will have a delay in receiving new cards and plan information.

Please Review all documents in this e mail and review the plan designs available to each plan participant.

1. ACH , Authorization for Debit –is required for all premium payments
2. Invoices are sent out annually with a monthly breakdown of premiums and plans participated in.
3. All participants are required to pay the initial enrollment fee the month the benefit begins
4. Existing participants are required to pay the annual enrollment fee and the monthly administrative fee.
5. all plan contracts are available for review on our plan website. Plan language and forms needed. Contracts and documents will not be sent out; all are available electronically

Plan Eligibility

If you are a full-time employee (exempt and non-exempt), scheduled to work at least 20 hours per week, you are eligible for health and welfare benefits on the first day of hire. You may also cover eligible dependents, including:

- Your legal spouse or domestic partner,
- Your unmarried dependent child(ren) until his or her 26th birthday,
- Natural and legally adopted children, children placed with you for adoption, or any other children for whom you or your spouse is named legal guardian, according to a letter of guardianship,
- Biological or legally adopted children for whom the plan is obligated under a Qualified Medical Child Support Order (QMCSO) to provide medical coverage.

Fees

Annual Enrollment Fee:	$475.00 per participant
Monthly fees:	Amount reflected on Confirmation Statement

The annual fee is drafted at the time of initial enrollment and each year in November.

Dental - Standard

By providing coverage for routine preventive care, a comprehensive dental plan encourages employees to maintain a healthy lifestyle and good oral hygiene by seeking dental check-ups on a regular basis.

This chart provides a brief summary of the benefits provided by Standard.

All contracts and certificates are available on our benefits website.

Benefit Provisions	Plan A	Plan B
Deductibles:		
Single	$50	$50
Family	$150	$150
Preventive	100%	100%
Basic	80% after ded	80% after ded
Major	50% after ded.	50% after ded.
Orthodontia	50% after ded.	50% after ded.
Annual Maximum	$1,250	$2,500
Orthodontia Lifetime Maximum	$1,250	$2,000
Rollover	$250	$400
PPO Bonus	$100	$100
Orthodontia Limiting Age	19	Adults and Children
Coverage Level		
Employee Only	48.68/mo	65.52/mo
Employee + Spouse	95.60/mo	128.56/mo
Employee + Child(ren)	130.16/mo	173.92/mo
Employee + Family	177.04/mo	237.00/mo

VISION SERVICE PLAN	BENEFITS
Eye Exam	$0 copay
Material Copay	$0 copay
Frames	Covered once every 24 months
Lenses	Covered once every 12 months
Contact Lenses- in lieu of frame	$180 Allowance
Monthly Premium	
Single	**$10.68**
Employee+1	**$19.80**
Family	**$30.20**

Vision – Vision Service Plan

VSP is the provider of your vision coverage. The chart details the benefits available.

You may also access www.vsp.com for more information.

Hearing Aid Discounts – TruHearing

If you have elected vision coverage, you and your dependents are also eligible for Hearing Aid Discounts.

VSP participants and dependents can save up to $2,400 on a pair of hearing aids**.**
Learn more at vsp.truhearing.com or call 877-396-7194 and mention VSP.

TruHearing provides members with:

- 3 provider visits for fitting, adjustments and cleanings
- A 45 day money back guarantee
- 3 yr manufacturer's warranty for repairs ; onetime loss/damage
- 48 free batteries per hearing aid.

Life Insurance - Unum

You may purchase coverage of up to 3 times your base salary. You may also purchase Dependent Life Insurance for your spouse, and/or children. Accidental Death and Dismemberment is also available.

For new participants after January 1, Evidence of Insurability (EOI) is required for coverage in excess of $300,000. Existing participants are grandfathered with their current elections. Spouse coverage equal to 100% of the Employee is available up to $500,000. EOI is also required if you are increasing your current amount.

Coverage

Employee Life/Accidental Death and Dismemberment

- Basic Life of $25,000 11.90/mo. - mandatory
- Voluntary life 1,2 or 3 times up to $750,000. Those with coverage currently in excess of $750,000 will be grandfathered. Life elections for both Employee and Spouse Coverage will be based on the following premium chart
-

Age	Mo. Prem/$1,000
15-24	0.11
25-29	0.11
30-34	0.13
35-39	0.14
40-44	0.19
45-49	0.25
50-54	0.37
55-59	0.58
60-64	0.82
65-69	1.32
70-74	2.11
75+	6.42

- Benefit reduces to 50% at age 70.

Spousal Life

- Coverage equal to 100% of employee life up to $500,000.
- EOI is required for $25,000 or greater.

Child(ren) Life

Coverage	5,000	10,000
Mo. Premium	2.70	5.40

To help you determine your specific coverage needs, ask yourself questions such as:

- Does my family depend on me as a sole source of income?
- What other financial resources will my family have?
- Will my insurance be enough to cover my family's expenses?

Disability - Unum

Short-Term Disability (STD)

The Financial Network Group Health Plan will continue insuring the Short-Term Disability plan with Aetna. Benefits begin on the 15th calendar day of disability. Benefits may then continue for up to 11 weeks. Max annual salary covered is $300,000.

Note: All state mandated disability (short term disability) plans are coordinated in conjunction with the appropriate state law and max benefit limits.

Long-Term Disability (LTD)

You are also eligible for Long-Term Disability Insurance. Benefits begin after 90 consecutive calendar days of disability. Max annual salary covered is $300,000.

STD

- Benefits Begin After 15 days
- 60% of Base Income
- $3,500/week Max Benefit
- .26/$10 weekly covered benefit

LTD

- Benefits Begin After 90 Days
- 60% of Base Income.
- $15,000/month Max Benefit
- .60/$100monthly covered payroll.

Accident Insurance

Accident Insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

Evidence of Insurability is required for those previously eligible.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly

Who can get coverage?

You	If you're actively at work
Your Spouse	Ages 17-64
Your Children	Dependent children from birth until their 26th birthday, regardless of marital or student status

How much does it cost?

Monthly Premium	
You	$22.35
You and your spouse	$38.46
You and your child(ren)	$41.62
You, your spouse and child(ren)	$57.73

Critical Illness Insurance

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you'll receive a benefit payment in one lump sum. You can use the money however you want.

Evidence of Insurability is required for those previously eligible.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions. If you have a different condition later, you can receive another benefit.
- This insurance pays you once for each eligible illness. However, the diagnoses must be at least 90 days apart, and the conditions can't be related to each other. Can I buy coverage now?
- It's more affordable when you buy it through your employer.
- The cost is conveniently deducted from your paycheck.
- You can keep coverage if you leave the company or retire. You'll be billed at home.

Monthly Premium per $1,000 of Coverage		
Age	Non-Tobacco	Tobacco
0-24	$0.58	$0.87
25-29	$0.63	$1.05
30-34	$0.83	$1.48
35-39	$1.13	$2.17
40-44	$1.60	$3.19
45-49	$2.20	$4.40
50-54	$2.90	$5.88
55-59	$3.82	$7.49
60-64	$4.89	$8.97
65-69	$5.50	$9.35
70-99	$9.86	$15.07

Monthly Premium for Wellness Benefit	
Employee and Children	$1.60
Spouse	$1.60

Available Discounts

The Financial Network Benefit Program offers many discounts.

- 15% off Brooks Brothers regularly priced merchandise every day
- Amusement park tickets
- Broadway theatre tickets, movie tickets
- Sporting events
- Car Rentals (Alamo, Avis etc.)
- Hotels (Hilton, IHG etc.)
- Zoos, Aquariums and Museums
- Travel websites (Expedia, Orbitz etc.)
- Merchant gift certificates
- Online shopping and service discounts with select partners
- For pet insurance discounts go to www.petinsurance.com/nbg and sign up through the online enrollment. Rates given will reflect discount

See Enrollment Instructions Below

working ADVANTAGE — *providing employee discount and reward programs to corporations nationwide*

Register for your free account today!

1. Go to: www.workingadvantage.com or To order by phone, call (800) 565-3712.
2. Click on **Register** in the orange box at the top of the page
3. Click **Employee Click Here**
4. Enter **Member ID# 381749710 (Ahrens Naef Consulting)** and create your account with your e-mail address and password of your choice.
5. Take advantage of online offers immediately!

Corporate Perks

1. Go to: http://ahrensnaefconsulting.corporateperks.com
2. Login/**Register** at Ahrens Naef Consulting Perks
3. Register with your email address and use the company code **ahrensnaefconsulting12**

SAVE SAVE SAVE

Brooks Brothers

- You will receive a **15%** when you enroll online at: membership.BrooksBrothers.com and follow the enrollment instructions. Enter the following information:
  Organization ID #: 13401 (Ahrens Naef Consulting)
  Organization Enrollment PIN #: 49085
- Print out a temporary shopping pass.
- You will receive your personalized Corporate Membership Card in approximately 3-5 business days.

Instructions for the 2020 Open Enrollment

After you have reviewed this guide and your benefit options, ***if you wish to make changes, you are ready to enroll. If you do not wish to make any changes, your plan will continue as is for 2020, based on your 2019 elections. A confirmation of your 2020 elections will be sent by October 25, 2019. Corrections will be sent out by October 31, 2019. All new premiums will be taken beginning in December and the annual fee will be taken in November 2019.***

1. Complete the applicable enrollment form in your enrollment packet or on line. Follow the instructions carefully.

- You will need to provide Social Security Numbers and birth dates for your spouse and eligible dependent children if you plan to cover them.
- You will need to designate a beneficiary for the life insurance coverage. It is helpful but not required to provide Social Security numbers for beneficiaries. By providing a Social Security Number, you help to ensure that the person making a claim against your life insurance policy is indeed your intended beneficiary.

2. Keep a copy of your form for your records.

3. Return your signed enrollment form to Human Resources/Amy Ahrens - no later than October 18, 2019.

Forms may be submitted

	Click The Submit Button on the form or Enter your elections on line by going to the website. You can click forgot password to retrieve your password.
	Fax: 866-817-3969, Telephone: 770-966-9247
	Financial Network Group Health Plan 3226 Citation Avenue, NW Kennesaw, GA 30144.

REMEMBER

Open enrollment runs until October 18, 2019.

Don't wait until the last day to enroll.

If you have not enrolled and submitted your paperwork by October 31, 2019, you will not be able to make changes to your benefits until the 2020 enrollment period, unless you have a qualified change of status.

FORMS

FINANCIAL NETWORK GROUP HEALTH PLAN

2020 Annual Enrollment Form

Employee Information

Last Name:	First Name:	MI:

Address:	City:	St:	Zip:

Date of Birth:	Social Security Number:	Phone:	Coverage Effective Date:

Email Address:	Annual Salary $ (or prior yr earnings)	☐ Full-Time ☐ Part-time Hours/Wk

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)	Gender: ☐ Male ☐ Female	Does your spouse work? ☐ Yes ☐ No	Do you have coverage elsewhere (such as your spouse's employer)? ☐ Yes (complete box D) ☐ No

(A) Dental

Choose One	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
☐ Dental Plan- Plan A ☐ Dental Plan- Plan B ☐ Waive Coverage	☐ $48.68/mo ☐ $65.52/mo	☐ $ 95.60/mo ☐ $128.56/mo	☐ $130.16/mo ☐ $173.92/mo	☐ $177.04/mo ☐ $237.00/mo

(B) Vision

Choose One	☐ Employee Only	☐ Employee & One	☐ Employee & Family
☐ Vision Plan ☐ Waive Coverage	$10.68/mo	$19.80/mo	$30.20/mo

(C) List All Eligible Family Members Enrolled For Dental, Vision

Name *(Last, First, MI):*	Gender M F	Birth Date *(Mo./Day/Yr.)*	Social Security #.	Relationship

(D) Information About Other Group Dental Coverage you will continue

Name *(Last, First, MI):*	Dental	Other Employer	Name and Number of Plan
	☐		
	☐		

(E) Disability (Salary must equal amount entered on page one) Note: EOI required if increasing coverage

☐ Short Term Disability ☐ Waive	(Enter Salary Amount) $	• Benefit equals 60% of weekly salary up to a $3,500 benefit. • Rate is $0.26 per $10 of weekly benefit covered.
☐ Long Term Disability ☐ Waive	(Enter Salary Amount) $	• Benefit equals 60% up to a $15,000 maximum monthly benefit) • Rate is $0.60 per $100 of monthly covered payroll

Please remember in addition to your monthly premium there is an annual enrollment fee of $475/participant as well as a monthly participant administration fee reflected on Confirmation Statement

IMPORTANT: Complete both pages of this form

(F) Life Insurance/Accidental Death & Dismemberment (Salary equals amount entered on page one) If life amount is greater than $300,000 Evidence of Insurability form is required)

F1. Basic Life $25,000: List Your Beneficiaries For Life and AD&D Insurance. Monthly Premium: $11.90

Primary *(Last/First/MI):*	Relationship:
Contingent *(Last/First/MI):*	Relationship:

F2. Additional Life/AD&D	☐ **1 X Salary**	☐ **2 X Salary**	☐ **3 X Salary**	☐ **WAIVE**

Age	Mo. Rate/$1,000	Age	Mo. Rate/$1,000
15-24	.11	50-54	.37
25-29	.11	55-59	.58
30-34	.13	60-64	.82
35-39	.14	65-69	1.32
40-44	.19	70-74	2.11
45-49	.25	75+	6.42

List Your Beneficiaries For Life and AD&D Insurance for the above elected coverage.

Primary *(Last/First/MI):*	Relationship:
Contingent *(Last/First/MI):*	Relationship:

If more than one primary or contingent beneficiary is to be specified, attach beneficiary information on a separate page. Unless otherwise specified, payment will be shared equally by all primary beneficiaries who survive the Insured; if none, by all contingent beneficiaries who survive. The right to change the beneficiary is reserved unless otherwise stated. If you are married, but choose someone other than your spouse as beneficiary, have your spouse sign below to acknowledge the other beneficiary.

Spouse's Signature: Date:

F3. Spouse Life EOI on amounts greater than $25,000 (Premium Based on Age Chart above.)	☐ Enter Amt $_____ (must not exceed EE Election) ***Amount must be in increments of $5,000.***	☐WAIVE

Spouse Name:	Sp DOB:	Sp SSN:

F4. Child Life	☐ $5,000 ($2.70/mo)	☐ $10,000 ($5.40/mo.) *	☐WAIVE

If child life is elected, please provide dependent information in Section D above

(G) Mid-Year Change Information

To add or delete dependents or make a plan change midyear, (1) check the qualifying event allowing the change and (2) indicate the date of the event below: Event allowing dependent addition and some plan changes (event must have been within the last 31 days): The change in election must be consistent with the event. ☐Marriage ☐ Birth of child ☐ Court-ordered custody/support/legal guardianship ☐ Adoption/Pre-adoptive placement. (If dependent has or had other coverage within last 63 days, provide Certificate of Creditable Coverage.) ☐Dependent lost eligibility for other coverage due to, specify:

The Date of Event is the last date of the other coverage:

Event allowing/requiring dependent deletion and some plan changes: The change in election must be consistent with the event. (Notify Amy Ahrens when a covered dependent loses eligibility (within no more than 30 days). Notice for COBRA continuation within 60 days.

☐Death of Dependent ☐Divorce/legal separation ☐Change in support order ☐Other loss of dependent status due to, specify:

The Date of Event is the last date of the other coverage:

(H) Authorization

I have been given the opportunity to enroll in the Financial Network Group Benefit Plan. I authorize Financial Network Group Benefit Plan to make any necessary deductions from my pay for elected coverages. Medical, and dental and other health and disability deductions will be deducted pre-tax from my pay unless I contact Human Resources to indicate a different election. I understand that I cannot change my benefit enrollment elections until the next open enrollment period unless I have a qualified change in status (which must be reported to Human Resources within 31 days of the event). I authorize payment of medical benefits to preferred providers where applicable, for those charges covered by my group insurance benefits. I authorize release, for the term of my coverage, to or by my physician or health care provider of any medical information including copies of medical records, or insurance carrier with information necessary to establish student eligibility. This authorization will remain valid during my term of coverage under my group insurance plan or 12 months, whichever is less. I or my authorized representative may request a copy of this authorization and a photocopy of this authorization will be considered valid.

Employee Signature (typed name serves as signature) Date

Forms may be submitted by clicking blue button:

Please remember in addition to your monthly premium there is an annual enrollment fee of $475/participant as well as a participant administration fee reflected on Confirmation Statement

Financial Network Group Health Plan

AUTHORIZATION AGREEMENT
Direct Withdrawals /Direct Deposits
(ACH Debits/Credits)

I (we) hereby authorize FINANCIAL NETWORK GROUP HEALTH PLAN, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any credit entries in error to my (our) ☐ Checking or ☐ Savings account (select one) at the financial institution, hereinafter called BANK, and to credit the same to such account.

BANK NAME _____ **AMOUNT** _____

CITY, STATE _____

ROUTING NUMBER _____ **ACCOUNT NO.** _____

Please remember in addition to your monthly premium there is an annual enrollment fee of $475/participant as well as a monthly participant administration fee.

***Any NSF will result in an additional $50 fee. ***

Attach a voided check for verification

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

_____ _____

Printed Name **Office Location and Name**

_____ _____

Signature (typed name serves as signature) **Date**

_____

Effective Plan Date:

FINANCIAL NETWORK GROUP HEALTH PLAN

Credit Card Processing

I (we) hereby authorize FINANCIAL NETWORK/GROUP HEALTH PLAN, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any credit entries in error to my (our) – credit card. All credit card payments will be charged a 5.0% convenience fee per transaction, for the processing of the premium(s). (Amex is a charge of 5.5%)

Please remember in addition to your monthly premium there is an annual enrollment fee of $475/participant as well as a monthly participant administration fee.

Name – as printed on the card _____

Stated Amount to be charged, without Convenience Fee _____

Type of Card

- ☐ Visa
- ☐ MasterCard
- ☐ Amex

Expiration of Card _____

Credit Card Number _____

CV(3 or 4 digit code) ***Located on back of card*** _____

Zip Code _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

PRINTED NAME (S)_____

SIGNED NAME _____

DATE _____