

# Financial Network -2021 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, 2021. Open enrollment runs from October 1 through October 16. Confirmations will be sent by October 23. 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 23, 2020.

For 2021, 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 23, 2020.

## 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

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## Important Dates: For 2021 Plan Year

<b>Enrollment:</b>	October 1 thru October 16
<b>Confirms E-mailed:</b>	October 23
<b>Final Changes Due:</b>	October 31
<b>Annual Fees Drafted:</b>	November
<b>2021 Premiums Begin:</b>	December

The information in this brochure is intended to explain the process for enrolling in Financial Network Group Health Plan's benefits program. The benefits described apply to regular full-time employees. As always, the terms and conditions of any benefit plan are determined by official plan documents. In the event of any discrepancy between the information provided in this Enrollment Guide and the official plan documents, the official plan documents will govern. None of this information should be interpreted as a guarantee of employment. The Financial Network Group Health Plan reserves the right to amend, modify, or terminate any benefit plan at any time.

## 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 26<sup>th</sup> 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 - Unum

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 Unum.

All contracts and certificates are available on our benefits website.

Benefit Provisions	Plan A	Plan B
<b>Deductibles:</b>		
Single	\$50	\$50
Family	\$150	\$150
<b>Preventive</b>	100%	100%
<b>Basic</b>	80% after ded	80% after ded
<b>Major</b>	50% after ded.	50% after ded.
<b>Orthodontia</b>	50% after ded.	50% after ded.
<b>Annual Maximum</b>	\$1,250	\$2,500
<b>Orthodontia Lifetime Maximum</b>	\$1,250	\$2,000
<b>Rollover</b>	\$250	\$400
<b>Orthodontia Limiting Age</b>	19	Adults and Children
Coverage Level		
Employee Only	46.15/mo	62.11/mo
Employee + Spouse	90.63/mo	121.87/mo
Employee + Child(ren)	123.39/mo	164.88/mo
Employee + Family	167.83/mo	224.68/mo

VISION	BENEFITS
<b>Eye Exam</b>	\$10 copay
<b>Material Copay</b>	\$10 copay
<b>Frames</b>	Covered once every 12 months
<b>Lenses</b>	Covered once every 12 months
<b>Contact Lenses- in lieu of frame</b>	\$200 Allowance
<b>Monthly Premium</b>	
<b>Single</b>	<b>\$ 8.43</b>
<b>Employee+1</b>	<b>\$16.25</b>
<b>Family</b>	<b>\$27.77</b>

## Vision – Unum

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

You may also access [www.unum.com](http://www.unum.com) for more information.

## Hearing Aid Discounts – Unum

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

### Benefits for the entire family

» Available at no additional cost to Unum Dental and Vision members with enrollment in any group or individual product.

» 30-60% discounts off major name brand hearing instruments and accessories.

» 40% savings on hearing aid batteries shipped directly to your home.

» On-call support for questions, managed by professional hearing counselors.

## 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 13.30/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
- .29/\$10 weekly covered benefit

#### LTD

- Benefits Begin After 90 Days
- 60% of Base Income.
- \$15,000/month Max Benefit
- .67/\$100 monthly 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?

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

### How much does it cost?

Monthly Premium	
<b>You</b>	\$22.35
<b>You and your spouse</b>	\$38.46
<b>You and your child(ren)</b>	\$41.62
<b>You, your spouse and child(ren)</b>	\$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](http://www.petinsurance.com/nbg) and sign up through the online enrollment. Rates given will reflect discount

### See Enrollment Instructions Below



providing employee discount and reward programs to corporations nationwide

Register for your free account today!

1. Go to: [www.workingadvantage.com](http://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**






- You will receive a **15%** when you enroll online at: [membership.BrooksBrothers.com](http://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 2021 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 2021, based on your 2020 elections. A confirmation of your 2021 elections will be sent by October 23, 2020. Corrections will be sent out by October 31, 2020. All new premiums will be taken beginning in December and the annual fee will be taken in November 2020.**

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 16, 2020.

### 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 16, 2020.

**Don't wait until the last day to enroll.**

If you have not enrolled and submitted your paperwork by October 31, 2020, you will not be able to make changes to your benefits until the 2022 enrollment period, unless you have a qualified change of status.



# FORMS

## FINANCIAL NETWORK GROUP HEALTH PLAN

### 2021 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)	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time Hours/Wk	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have coverage elsewhere (such as your spouse's employer)? <input type="checkbox"/> Yes (complete box D) <input type="checkbox"/> No	

#### (A) Dental

Choose One	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
<input type="checkbox"/> Dental Plan- Plan A	<input type="checkbox"/> \$46.15/mo	<input type="checkbox"/> \$ 90.63/mo	<input type="checkbox"/> \$123.39/mo	<input type="checkbox"/> \$167.83/mo
<input type="checkbox"/> Dental Plan- Plan B	<input type="checkbox"/> \$62.11/mo	<input type="checkbox"/> \$121.87/mo	<input type="checkbox"/> \$164.88/mo	<input type="checkbox"/> \$224.68/mo
<input type="checkbox"/> Waive Coverage				

#### (B) Vision

Choose One	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & One	<input type="checkbox"/> Employee & Family
<input type="checkbox"/> Vision Plan	\$ 8.43/mo	\$16.25/mo	\$27.77/mo
<input type="checkbox"/> Waive Coverage			

#### (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
	<input type="checkbox"/>		
	<input type="checkbox"/>		

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

<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Waive	(Enter Salary Amount) \$	<ul style="list-style-type: none"> <li>Benefit equals 60% of weekly salary up to a \$3,500 benefit.</li> <li>Rate is \$0.29 per \$10 of weekly benefit covered.</li> </ul>
<input type="checkbox"/> Long Term Disability <input type="checkbox"/> Waive	(Enter Salary Amount) \$	<ul style="list-style-type: none"> <li>Benefit equals 60% up to a \$15,000 maximum monthly benefit)</li> <li>Rate is \$0.67 per \$100 of monthly covered payroll</li> </ul>

**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: \$13.30**

Primary (Last/First/MI):	Relationship:			
Contingent (Last/First/MI):	Relationship:			
<b>F2. Additional Life/AD&amp;D</b>	<input type="checkbox"/> 1 X Salary	<input type="checkbox"/> 2 X Salary	<input type="checkbox"/> 3 X Salary	<input type="checkbox"/> 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:
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**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.

<b>BANK NAME</b>	_____	<b>AMOUNT</b>	_____
<b>CITY, STATE</b>	_____		
<b>ROUTING NUMBER</b>	_____	<b>ACCOUNT NO.</b>	_____

**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 5.5% convenience fee per transaction, for the processing of the premium(s).

**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.**

<b>Name – as printed on the card</b>		<b>Stated Amount to be charged, without Convenience Fee</b>	
<b>Type of Card</b>	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Amex	<b>Expiration of Card</b>	
<b>Credit Card Number</b>		<b>CV(3 or 4 digit code) Located on back of card</b>	
<b>Zip Code</b>			

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** \_\_\_\_\_