

town of  
*Summerville*



Employee Benefits Guide  
2016–2017



## Welcome to your 2016-2017 Employee Benefits Guide

We are committed to providing employees with a benefits program that is both comprehensive and competitive. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist you in providing for the health, well-being and financial security of you and covered dependents. Helping you understand the benefits the Town of Summerville offers is important to us. That is why we have created this Employee Benefits Guide.

### Benefits Guide Overview

This guide provides a general overview of your benefit choices to help you select the coverage that is right for you. Be sure to make choices that work to your best advantage. Of course with choice, comes responsibility and planning. Please take the time to read about and understand the benefit plan thoroughly, and enroll on time.

Included in this guide are summary explanations of the benefits and costs as well as contact information for each provider.

It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you. We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable co-payments and deductibles, how to file claims, pre-authorization requirements, networks and services that may be limited or not covered (exclusions). This guide is not an employee/employer contract. It is not intended to cover all provisions of all plans but rather is a quick reference to help answer most of your questions. Please see your Summary Plan Description for complete details. We hope this guide will give you a clear explanation of your benefits and help you be better prepared for the enrollment process.

The Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, is available, free of charge, by contacting Human Resources or by calling 1-888-408-9142.

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This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request. The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

At Your Service...



## Employee Call Center

Town of Summerville employees have access to a dedicated employee benefit hotline to answer questions about enrollment, coverage, claims and all other concerns regarding their employee benefit package. Our call center is staffed with trained professionals who understand your benefits plan and are dedicated to providing solutions to your problems. Its easy and its free, just call:

**1-888-408-9142 (toll-free)**

Monday – Friday 9am – 5pm EST

email customer service at [CHS\\_CustomerService@ajg.com](mailto:CHS_CustomerService@ajg.com)

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 22 for more details

# Benefit Contacts



Questions?  
We have answers.

Employee Call Center

1-888-408-9142  
Monday - Friday 9 am - 5 pm  
CHS\_CustomerService@ajg.com

## Medical

Blue Cross Blue Shield  
1-800-868-2509  
[www.southcarolinablues.com](http://www.southcarolinablues.com)

## Dental

Delta Dental  
1-800-335-8266  
[www.deltadentalsc.com](http://www.deltadentalsc.com)

## Vision

Physicians EyeCare Plan  
843-579-0508  
[www.physicianseyecareplan.com](http://www.physicianseyecareplan.com)

## Life Insurance

Guardian  
1-800-441-6455  
[www.guardiananytime.com](http://www.guardiananytime.com)

## EAP

Guardian WorkLifeMatters  
1-800-386-7055  
[www.ibhworklife.com](http://www.ibhworklife.com)  
User Name: Matters  
Password: wlm70101

## Flexible Spending Account (FSA)

Guardian  
1-800-541-7846  
[www.guardiananytime.com](http://www.guardiananytime.com)

# Eligibility Details



## Are You Eligible for Benefits?

Full time employees are eligible for benefits on the first of the month following 30 days (FSA eligibility begins on the first of the month following the date of hire). You also have the option to enroll your eligible dependents in some of these plans. Eligible dependents may include: Your spouse, Your children (dependent age limit to 26\*) or when applicable, your unmarried children of any age who are incapable of self-support due to a mental or physical disability and who are totally dependent on you.

\*Certain limitations apply. Please call the Employee Service Hotline for additional information, 1-888-408-9142

## Open Enrollment:

Open enrollment is the period each year to make changes to your benefits. You can change plans as well as add or drop coverage provided your dependent(s) meet all eligibility requirements. Any changes made during open enrollment must remain until the following open enrollment period, unless you experience a qualifying life event.

This plan lets you pay certain benefit premiums before any taxes are deducted from your pay; therefore you pay fewer taxes. All qualifying premiums will automatically default to pre-tax status unless waived during open enrollment.

## When Can I Make Changes?

During each annual enrollment period, you have the opportunity to review your benefit elections and make changes for the coming plan year. For most benefits you may only make changes to your elections during the year if you have a change in a qualifying life event. Life events include: Marriage, divorce; Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, marriage, or reaching the dependent child age limit; Changes in your spouse's employment affecting benefit eligibility; Changes in your spouse's benefit coverage with another employer that affects benefit eligibility; Changes in employee work status.

The change to your benefit elections must be consistent with the life event. You have 30 days from the date of the life event to submit an enrollment change form and documentation of the event to Human Resources. In most cases, your election will become effective the first day of the month following the life event once paperwork is received. Birth of a child or adoption is an exception and would begin on the day of birth or adoption. Otherwise, you must wait until the next annual enrollment period to make a change to your elections.

# Medical Plan Snapshot

Administered by BCBS SC

The Medical Plan Snapshot is not intended to cover all provisions of your plan but rather is a quick reference to help answer most of your questions. Please see your Summary Plan Description for complete details or consult with your Human Resources Department.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>MEDICAL AND SURGICAL BENEFITS</b>		
<b>Deductible (Embedded*)</b>	\$500 Individual / \$1,000 Family	\$2,000 Individual / \$4,000 Family
<b>Co-Insurance</b> Shown as percentages below	\$2,500 Individual / \$5,000 Family	\$10,000 Individual / \$20,000 Family
<b>Maximum Out of Pocket</b>	\$6,850 Individual / \$13,700 Family Includes deductible, copays and co-insurance	\$12,000 Individual / \$24,000 Family Includes deductible and co-insurance
<b>Physician Services in the Office</b> Excluding Obstetrical Delivery, Dialysis Treatment and Second Surgical Opinion.	\$20 Primary Care \$40 Specialist <i>Includes Allergy Injections, Office Surgery, Lab and X-ray</i>	Deductible, 50%
<b>Other Physician Services</b> Inpatient/Outpatient hospital, anesthesia services, radiology, pathology, obstetrical delivery, initial new born pediatric exam, all other outpatient/office services	Deductible, 80%	Deductible, 50%
<b>Wellness Benefits</b> – Based on the Health Care Reform Guidelines refer to <a href="http://www.healthcare.gov">www.healthcare.gov</a>	100%	
<b>Mammograms</b> – Must see a provider in Mammography Network and follow specified age guidelines	100%	N/A
<b>Pap Smear/Prostate Screening</b>	100%	
<b>Sustained Health Services</b> (\$300 annual maximum)	\$20 Copay, then 100%	N/A
<b>Inpatient Facility Charges</b>	Deductible, 80%	Deductible, 50%
<b>Skilled Nursing Facility Charges</b> (60 days per year)	Deductible, 80%	Deductible, 50%
<b>Outpatient Facility Charges</b>	Deductible, 80%	Deductible, 50%
<b>Independent Lab &amp; X-ray</b>	100%	Deductible, 50%
<b>Other Services</b> Physical/Occupational Therapy (30 combined visits) Home Healthcare Hospice	Deductible, 80%	Deductible, 50%
<b>Chiropractic Benefits</b> (\$1,000 annual maximum)	\$40 Copay	Deductible, 50%
<b>Ambulance</b>	Deductible, 80%	In-Network Deductible, 80%
<b>Emergency Room Facility Charges</b> **	\$150 Copay	\$150 Copay
<b>Emergency Room Professional Charges</b> **	Deductible, 80%	Deductible, 50%
**Out-of-Network True Emergency Facility and Professional charges are subject to in-network coinsurance and/or co-pay and Out-of-Network Benefit Year Deductible and Out-of-pocket.		
<b>MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS</b>		
<b>Inpatient Facility Charges</b>	Deductible, 80%	Deductible, 50%
<b>Inpatient Professional Charges</b>	Deductible, 80%	Deductible, 50%
<b>Outpatient Facility Charges</b>	Deductible, 80%	Deductible, 50%
<b>Outpatient Professional Charges</b>	Deductible, 80%	Deductible, 50%
<b>Emergency Room Facility Charges</b>	\$150 Copay	\$150 Copay
<b>Emergency Room Professional Charges</b>	Deductible, 80%	In-Network Deductible, 80%
<b>Physician Services in the Office</b>	\$20 Copay, then 100%	Deductible, 50%
<b>PHARMACY BENEFITS</b>		
<b>Prescriptions Mandatory Generic</b> (Includes diabetic supplies and oral contraceptives) Retail (31 day supply) Mail Order (90 day supply)	IN NETWORK ONLY \$15 (Generic) / \$40 (Preferred) / \$70 (Non-Preferred) \$25 (Generic) / \$90 (Preferred) / \$175 (Non-Preferred)	
<b>Specialty Drug</b> 1-800-237-2767 for inquiries regarding this benefit	<b>Caremark Specialty Pharmacy Only</b> \$125 Copay per 31 day supply	
<b>BENEFIT MAXIMUMS</b>		
<b>Annual / Lifetime Maximum</b>	Unlimited	

## BI-WEEKLY DEDUCTION

Employee Only	\$0
Employee + Spouse	\$73.61
Employee + Children	\$60.12
Family	\$102.44

If you choose to go to one of the two Summerville Doctors Care locations for a medical visit, your copay is waived as part of your medical plan.

410 N. Main St.  
Summerville, SC 29483

10160 Dorchester Rd.  
Summerville, SC 29485



We understand the importance of making the right healthcare decisions. These decisions affect the health of you and your family, and they impact your finances. That is why we created My Health Toolkit.

My Health Toolkit is an online resource for tools and information to help you better manage your benefits, wellness, treatment and financial decisions. Whether you need to locate an in-network provider or want to research the cost of a specific surgery - the toolkit has resources to assist you.

As more power is placed in your hands to manage your health care benefits - we are here to help you every step of the way. My Health Toolkit enables you to:

## MANAGE YOUR BENEFITS

- **Claims Summary** - View claims status and an Explanation of Benefits (EOB).
- **Eligibility and Benefits** - Read about your benefits and coverage and check your eligibility.
- **Ask Customer Service** - Send a secure message directly to the customer service area for faster answers to your questions.
- **Authorization Status** - Verify your authorization status for inpatient and outpatient visits.
- **Deductible and Out-of-Pocket Statuses** - Determine how much you've met towards your deductible and out-of-pocket maximums.
- **Request** - A new ID card.

## MAKE INFORMED HEALTH CARE DECISIONS

- **Compare Hospital Quality** - Choose the hospital that is right for you by comparing up to 10 facilities on the number of patients treated, complication rates, average length of stay for certain conditions and procedures, and more.
- **Estimate Treatment Costs** - Research average costs and days of treatment for specific medical conditions or procedures.
- **Compare Drug Costs** - Look up cost and consumer information regarding prescription drugs.
- **Find a Doctor** - Find a network doctor or hospital across the country and around the world.

## IMPROVE YOUR WELLNESS

- **Personal Health Record** - A confidential, online tool providing a summary of your health information, including doctor visits, prescriptions, lab results and much more. You can also keep track of upcoming medical appointments and print a copy of your medical history. Additional features are available based on your benefit plan.
- **Personal Health Assessment** - An online survey that helps identify risk factors and offers ways to improve your health based on your answers.
- **Health Library** - this feature offers medical information, health calculators, self-care channels and nutrition guides to help improve and protect your health status.

Take charge of your health care today; log in to My Health Toolkit by visiting [www.southcarolinablues.com](http://www.southcarolinablues.com). Click on the "Member" tab and then "Log In" under the My Health Toolkit heading. Click on "Register Now" and have your ID number available.



# Blue CareOnDemand<sup>SM</sup> Video Visits

Why wait for the care you need now? Blue CareOnDemand is a faster, easier way to see doctors. You can consult U.S. board-certified physicians 24/7/365 through the convenience of video visits.

## *When to use it*

Blue CareOnDemand is a great solution when:

- You need to see a doctor, but can't fit it into your schedule
- Your doctor's office is closed
- You, or your child, feel too sick to leave the house
- You're traveling

Doctors can treat many of the most common health conditions through video visits, including:

- Cold and flu symptoms
- Allergies
- Bronchitis and other respiratory infections
- Urinary tract infections
- Skin irritations
- Sinus problems
- Migraines
- And more!

They can even write prescriptions, when needed, according to your state's regulations.

## *How to use it*

There are two easy ways to use Blue CareOnDemand:

1. Download the **Blue CareOnDemand** mobile app from the App Store or Google Play
2. Visit [www.BlueCareOnDemandSC.com](http://www.BlueCareOnDemandSC.com)

## *Register now*

You will need to register and create a patient profile on your first visit to the mobile app or website. So grab your BlueCross membership card and register now — the next time you need care, the doctor is only a few clicks away!



# Dental Plan

Administered by Delta Dental

Delta Dental PPO		Delta Dental PPO	Delta Dental Premier	Non-Participating Provider
Calendar Year Deductible	<ul style="list-style-type: none"> <li>Applied to Basic and Major Services</li> </ul>	\$50 Individual \$150 Family	\$50 Individual \$150 Family	\$50 Individual \$150 Family
Annual Maximum	<ul style="list-style-type: none"> <li>Applied to Preventive, Basic and Major Services</li> </ul>	\$1,500	\$1,500	\$1,500
Preventive Care	<ul style="list-style-type: none"> <li>Bitewing X-rays, one set per benefit period</li> <li>Emergency Palliative Treatment</li> <li>Oral Examinations, twice in any benefit period</li> <li>Prophylaxis (cleanings), twice in any benefit period</li> <li>Sealants for dependent children under age 16, once in three years</li> <li>Topical fluoride treatments for dependent children under age 19, once in any 6 month period</li> </ul>	100%	100%	100%
Basic Care	<ul style="list-style-type: none"> <li>Fillings</li> <li>Full mouth X-Rays, once in any 36 month period</li> <li>Periapical X-Rays, as required</li> <li>Periodontal Maintenance, twice in any benefit period (subject to your prophylaxis frequency limitation)</li> <li>Simple Extractions</li> <li>Space Maintainers for dependent children under age 16, initial appliance only</li> </ul>	100%	80%	80%
Major Care Six (6) Month Waiting Period	<ul style="list-style-type: none"> <li>Bridges, once in 7 years</li> <li>Dentures, once in 7 years</li> <li>Endodontics</li> <li>General Anesthesia</li> <li>Implants as well as bone grafts, are a covered benefit. Limited to once in 5 years</li> <li>Inlays/Onlays/Crowns, once in 5 years</li> <li>Non-Surgical Periodontics</li> <li>Oral Surgery (excluding extractions)</li> <li>Surgical Extractions</li> <li>Surgical Periodontics</li> </ul>	60%	50%	50%
Orthodontia Twelve (12) Month Waiting Period	<ul style="list-style-type: none"> <li>Orthodontia for dependent children under age 19</li> </ul>	50% up to \$1,000 Lifetime Maximum. No Deductible.	50% up to \$1,000 Lifetime Maximum. No Deductible.	50% up to \$1,000 Lifetime Maximum. No Deductible.

BI-WEEKLY DEDUCTION	
Employee Only	\$0
Employee + Spouse	\$7.82
Employee + Children	\$9.14
Family	\$13.74

# Vision Benefit

Administered by - Physicians EyeCare Plan

## In-Network Benefits

- Comprehensive eye exam every 12 months with a \$10 copay.
- \$150 material allowance every 12 months towards glasses and/or contact lens with a one-time \$10 copay.
- After your material allowance has been used, receive a 20% discount on glasses and a 15% discount on contact lens at most providers.
- Discounts of 10%-20% on refractive surgery including LASIK at participating providers.
- \$49 standard contact lens fitting fee or 15% discount off the usual and customary fitting for non-standard contact lens\*\* at most providers.
- No claims or paperwork to file.

## Out-of-Network Benefits

If you choose to use an out-of-network provider, you will be reimbursed the following amounts:

- Exam including contact lens fitting: \$50 less exam copay
- Materials: 65% of the material allowance that was used, less material copay

Please submit a claim form (available at [www.physicianseyecareplan.com](http://www.physicianseyecareplan.com)) along with your itemized receipts to: Physicians Eyecare Plan, 48 Courtenay Dr., Charleston, SC 29403

## Savings

You may be able to deduct premiums from your paycheck on a pre-tax basis and thereby reduce the amount of taxes withheld from your paycheck. Ask your human resources professional for more information.

## Important Information

- New members will be mailed a membership card.
- Find an in-network provider by going to [www.physicianseyecareplan.com](http://www.physicianseyecareplan.com).
- Check your eligibility, print a replacement ID card, download an out-of-network claim form and find answers to frequently asked questions by going to [www.physicianseyecareplan.com](http://www.physicianseyecareplan.com).
- To make an appointment, call an in-network provider and let them know that you are a PEP member.
- You are responsible for payment to the in-network provider for any amount exceeding the material allowance, any copays and any contact lens fitting fees.
- This is a routine vision program. Medical and surgical treatments of the eyes are not covered benefits.
- Material allowance does not cover non-prescription lenses, non-prescription or cosmetic contact lenses, or non-prescription sunglasses.
- Members will not be able to terminate coverage during their 12 month plan except for a termination resulting from a change in employment or family status.

**SAVE UP TO 70% ON YOUR VISION CARE COST THROUGH NETWORK BENEFITS.**

BI-WEEKLY DEDUCTION	
Employee Only	\$3.60
Employee + Spouse	\$6.32
Employee + Children	\$6.37
Family	\$10.52

# Life Insurance

**100%  
EMPLOYER  
PAID**

Administered by Guardian

## Basic Term Life

Benefit Amount	\$10,000
Reduction Schedule	35% at age 65, an additional 25% at age 70, an additional 15% at age 75 and a final 10% at age 80

## Basic Accidental Death & Dismemberment

Benefit Amount	\$10,000
Reduction Schedule	35% at age 65, an additional 25% at age 70, an additional 15% at age 75 and a final 10% at age 80





### John's Status

Married  
Two fed./state exemptions  
Bimonthly salary: \$1000

Health Care FSA: \$70 per pay period

John's daughter needs braces that will cost \$1,200 next year. His major medical deductible is \$250. Plus, he needs glasses, which cost \$230.

Based on these expenses, John knows he'll be spending at least \$1,680 on non-covered medical expenses over the course of the year.

Dental Care	\$1,200
Major Med. Deductible	\$250
Vision Care	\$230
<b>Total</b>	<b>\$1,680</b>

per year or  
\$70 per pay period

### Medical Care FSA

Read John's example on how a Medical Care FSA can save you money!

Maximum contribution per benefit year \$2,500.

	Before Health Care FSA reim.	After Health Care FSA reim.
Gross pay	\$1000.00	\$1000.00
Pre-tax Health Care FSA	-0-	-\$70.00
Taxable Income	\$1000.00	\$930.00
FICA, fed. & state taxes	-\$176.71	-\$159.46
Net pay	\$823.29	\$770.54
Health care expenses	-70.00	-0-
<b>Spendable income</b>	<b>\$753.29</b>	<b>\$770.54</b>

Illustration based on 2011 South Carolina tax tables.

### Mary's Status

Married  
Two fed./state exemptions  
Bimonthly salary: \$1000  
Eligible expenses:  
dep. care/\$150

Mary has one child. She pays \$300 per month (\$150 per pay period) for day care. Here's how a dependent care plan can help her.

Mary chooses to have \$150 each pay period deducted from her gross salary. When she incurs qualifying dependent care expenses, she simply files a claim and is reimbursed from the account. Because her taxable income is now lower, her taxes are less. After Mary is reimbursed from her account, her total spendable income increases by \$36.97 each pay period. Annually, Mary has increased her spendable income by \$887.28.

### Dependent Care FSA

Read Mary's example on how a Dependent Care FSA can save you money!

Maximum contribution per benefit year \$5,000.

	Before Dep. Care FSA reim.	After Dep. Care FSA reim.
Gross pay	\$1000.00	\$1000.00
Pre-tax Dependent Care FSA	-0-	-\$150.00
Taxable Income	\$1000.00	\$850.00
FICA, fed. & state taxes	-\$176.71	-\$139.74
Net pay	\$823.29	\$710.26
Dependent Care expense	-150.00	-0-
<b>Spendable income</b>	<b>\$673.29</b>	<b>\$710.26</b>

Illustration based on 2011 South Carolina tax tables.

# Go online!

For helpful information about your Guardian flexible spending account (FSA)

You can find helpful information about your Guardian FSA right at your fingertips through Guardian Anytime. Guardian Anytime ([www.GuardianAnytime.com](http://www.GuardianAnytime.com)) is our secure website where you can access information about any of your Guardian coverages. Now, you can also access information about your health care, dependent care or transportation FSA. It's available to you 24 hours a day, 7 days a week.

From Guardian Anytime, you can login to your FSA account to:

- View your current FSA elections
- View a summary of your account
- View your claims history
- Download and print plan materials

(After you log into [www.GuardianAnytime.com](http://www.GuardianAnytime.com), from your homepage you'll be able to access your FSA tools by clicking on the FlexPlan link on the right. Your user ID and password are the same as your Guardian Anytime user ID and password.)

**Save yourself time – go online!** If you haven't already registered for Guardian Anytime, it's simple. Just go to [www.GuardianAnytime.com](http://www.GuardianAnytime.com). You'll be online in minutes.

## Using your card is as easy as 1-2-3!

### Step 1 Activate and sign your Benny Card(s)

- After you receive your card(s) in the mail, call the number on the card sticker to activate it.
- Wait 48 hours after activation to use your card. (Your full-year FSA health care amount is available upon activation.)

### Step 2 Use your Benny Prepaid MasterCard Card

Your Benny Card can be used to pay for *eligible expenses* only for you and your dependents at pharmacies, your doctor's office and vision centers. (Refer to your lists of eligible and ineligible medical care and over-the-counter medical care expenses.)

- At the merchant, separate your eligible items from non-eligible items.
- Present your Benny Card for payment for eligible items.
- If there are *sufficient* funds in your account, the card swipe transaction will be approved and the amount of the FSA-eligible purchases is deducted from your account balance.
- If your expenses are more than your FSA balance, the card swipe transaction will be declined and the clerk will ask for another form of payment. (You may be able to use your Benny Card for the exact amount left in your account and use another form of payment for the difference – check with the merchant.)

### Step 3 Check your balances

- You can check your FSA balance by calling the phone number or logging onto the website on the back of your card.
- Checking your balances will help you know whether you have sufficient funds in your account to cover your expenses before you make a purchase.

#### REMINDER – SAVE ALL ITEMIZED RECEIPTS

You may be contacted by your plan administrator to submit certain receipts to verify expenses in order to comply with IRS guidelines. Make sure to save your receipts!

Follow-up letters requesting itemized receipts may be sent to you in the following instances:

1. When benefit plan data is not available and when the card is used to pay a coinsurance bill from a provider (for amounts not covered by insurance).
2. When the employee or dependents are not covered by the employer plan.
3. To verify items that are purchased at a dental, medical or vision location are FSA eligible.

## For even greater convenience use your Benny Card at one of these merchants

What could be more convenient than using your Benny Card to pay for Flexible Spending Account (FSA)-eligible health care expenses? Using your Benny Card at:

- Drugstore.com
- Sam's Club
- Walgreens
- Wal-Mart

By shopping at one of these merchants, your FSA-eligible items are automatically verified at the time of purchase. (Your receipt will identify the FSA-eligible items with an "H" or "F"). You won't need to provide receipts to verify the eligibility of most purchases!

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	In-Network <b>\$500</b> person/ <b>\$1,000</b> family. Out-of-Network <b>\$2,000</b> person/ <b>\$4,000</b> family. Does not apply to emergency room facility charges, prescription drugs or preventive care.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. In-Network <b>\$6,850</b> person/ <b>\$13,700</b> family. Out-of-Network <b>\$12,000</b> person/ <b>\$24,000</b> family.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, Out-of-Network copays, chiropractic services, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. See <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> or call <b>1-800-810-BLUE (2583)</b> for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services and Other Covered Services section. See your policy or plan document for additional information about <b>excluded services</b> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$20 Copay per visit	50% Coinsurance	Second surgical opinion, dialysis, radiation and chemotherapy are covered In-Network at 20% Coinsurance.
	Specialist visit	\$40 Copay per visit	50% Coinsurance	Second surgical opinion, dialysis, radiation and chemotherapy are covered In-Network at 20% Coinsurance.
	Other practitioner office visit	20% Coinsurance	50% Coinsurance	Chiropractic services are limited to \$1,000 per benefit year.
	Preventive care/screening/immunization	No Charge	Not Covered	See <a href="http://www.healthcare.gov">www.healthcare.gov</a> for preventive care guidelines. There may be additional benefits available. See your Employer for details.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If you need drugs to treat your illness or condition	Generic drugs (Retail)	\$15 Copay per prescription	Not Covered	90 day supply. A separate copay will apply for each 31 day supply.
	Generic drugs (Mail Order)	\$25 Copay per prescription	Not Covered	90 day supply.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>	Preferred brand drugs (Retail)	\$40 Copay per prescription	Not Covered	31 day supply.
	Preferred brand drugs (Mail Order)	\$90 Copay per prescription	Not Covered	90 day supply.
	Non-preferred brand drugs (Retail)	\$70 Copay per prescription	Not Covered	31 day supply.
	Non-preferred brand drugs (Mail Order)	\$175 Copay per prescription	Not Covered	90 day supply.
	Specialty drugs	\$125 Copay per prescription	Not Covered	31 day supply. Available at Caremark Specialty Pharmacy only.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	Pre-authorization is required for some outpatient surgeries. Penalty for not obtaining pre-authorization is 50% of the allowable charge.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	_____none_____
<b>If you need immediate medical attention</b>	Emergency room services	\$150 Copay per visit	\$150 Copay per visit	Copayment will be waived if admitted.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	_____none_____
	Urgent care	\$40 Copay per visit	50% Coinsurance	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Physician/surgeon fee	20% Coinsurance	50% Coinsurance	_____none_____

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	20% Coinsurance	50% Coinsurance	\$20 Copay per office visit, In-Network. Pre-authorization is required for outpatient services. Penalty for not obtaining pre-authorization is 50% of the allowable charge.
	Mental/Behavioral health inpatient services	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Substance use disorder outpatient services	20% Coinsurance	50% Coinsurance	\$20 Copay per office visit, In-Network. Pre-authorization is required for outpatient services. Penalty for not obtaining pre-authorization is 50% of the allowable charge.
	Substance use disorder inpatient services	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$20 Copay per visit	50% Coinsurance	No additional copayment for ongoing routine care.
	Delivery and all inpatient services	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% Coinsurance	50% Coinsurance	Limited to 60 visits per benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	20% Coinsurance	50% Coinsurance	Occupational Therapy & Physical Therapy limited to a combined 30 visits per benefit year. Speech Therapy limited to 20 visits per benefit year. Limitations are combined with Habilitation services.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Habilitation services	20% Coinsurance	50% Coinsurance	Occupational Therapy & Physical Therapy limited to a combined 30 visits per benefit year. Speech Therapy limited to 20 visits per benefit year. Limitations are combined with Rehabilitation services.
	Skilled nursing care	20% Coinsurance	50% Coinsurance	Limited to 60 days per benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Durable medical equipment	20% Coinsurance	Not Covered	Purchase or rentals of \$500 or more require pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges.
	Hospice service	20% Coinsurance	50% Coinsurance	Limited to 6 months per episode. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	See your Employer for benefit details.
	Glasses	Not Covered	Not Covered	See your Employer for benefit details.
	Dental check-up	Not Covered	Not Covered	See your Employer for benefit details.

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Eye Care (Child)
- Routine Foot Care

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Weight Loss Programs

#### Other Covered Services. (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Most coverage provided outside the U.S. See [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)
- Non-emergency care when traveling outside the United States.

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-760-9290. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact any or all of the following:

- 1-800-760-9290 or visit us at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)
- The South Carolina State Department of Insurance at 1-800-768-3467 or visit [www.doi.sc.gov](http://www.doi.sc.gov)

**Language Access Services:**

To obtain assistance in your specific language, call the customer service number shown on the first page of this notice.

Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng *customer service* na makikita sa unang pahina ng paunawang ito.

Chinese: 如需中文服务, 请致电列于本通知首页的客户服务号码。

Navajo: T'áá Dinéji shíł hane'go shiká i'doolwoł ninízingo éi Nidaalnishígíí Áká Anidaalwo'ígíí, customer service, bich'i' hodílnih. Bik'ebgo bich'i' hane'ígíí éi díí naaltsoos neiyi'nílgíí akáa'gi siłtsoozígíí bikáá' íshjááh.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby  
(normal delivery)**

- Amount owed to providers: \$7,540
- Plan pays \$5,520
- Patient pays \$2,020

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$500
Copays	\$20
Coinsurance	\$1,350
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,020</b>

These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-760-9290.

**Managing type 2 diabetes  
(routine maintenance of  
a well-controlled condition)**

- Amount owed to providers: \$5,400
- Plan pays \$3,810
- Patient pays \$1,590

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$500
Copays	\$770
Coinsurance	\$240
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,590</b>

## Questions and answers about the Coverage Examples:

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### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

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### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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### Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

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### Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

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### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

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### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-760-9290 or visit us at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-800-760-9290 to request a copy.



# Legal Notices

## IMPORTANT NOTICE FROM THE TOWN OF SUMMERVILLE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Town of Summerville and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. Town of Summerville has determined that the prescription drug coverage offered by our Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Town of Summerville coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Town of Summerville coverage, be aware that you and your dependents will not be able to get this coverage back until the next enrollment period unless you experience a qualified life event. Note that your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan and keep your coverage under the Town of Summerville Plan.

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

You should also know that if you drop or lose your current coverage with Town of Summerville

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.

### Summary of Options for Medicare Eligible Employees (and/or Dependents)

Medical and prescription drug coverage are offered as a package under the Town of Summerville plan (you cannot elect medical coverage without prescription drug coverage).

1. Continue medical and prescription drug coverage under the Town of Summerville Plan and do not elect Medicare D coverage. Impact - your claims continue to be paid by the Town of Summerville plan.

2. Continue medical and prescription drug coverage under the Town of Summerville plan and elect Medicare D coverage. Impact - As an active employee (or dependent of an active employee) the Town of Summerville plan continues to pay primary on your claims (pays before Medicare D).

3. Drop the Town of Summerville plan coverage and elect Medicare Part D coverage. Impact - Medicare is your primary coverage. You will not be able to rejoin the Town of Summerville plan until the next open enrollment period unless you experience a qualified life event.

### For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Town of Summerville changes. You also may request a copy of this notice at any time.

### For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit [www.medicare.gov](http://www.medicare.gov) Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: October 2016

Name of Entity/Sender: Town of Summerville

Contact--Position/Office:

Gallagher Benefit Services

Address:

115 Central Island Street Suite 100 | Charleston, SC 29492

Phone Number: 800-522-8541

### HIPAA PRIVACY NOTICE

#### Protecting Your Health Information Privacy Rights

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. Please contact your medical plan carrier to request a copy of the Notice.



# Legal Notices

## THE TOWN OF SUMMERVILLE INITIAL NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

**Loss of Other Coverage-** If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. You will be required to submit a signed statement that this other coverage as the reason for waiving enrollment originally. To be eligible for this special enrollment opportunity you must request enrollment within 31 days after your other coverage ends or after the employer stops contributing towards the other coverage.

**New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption-** If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

**Medicaid Coverage-** The Town of Summerville group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. **TERMINATION OF MEDICAID OR CHIP COVERAGE-** If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.

2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP-** If the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the Benefits Hotline at 888-408-9142.

## THE TOWN OF SUMMERVILLE INITIAL NOTICE OF GROUP HEALTH PLAN'S PRE-EXISTING CONDITION LIMITATION

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended within a six-month period. Generally this six-month period ends the day before your cover-

age begins. The pre-existing condition exclusion does not apply to pregnancy nor to an individual under age 19.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage that you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to the Benefits Hotline at 888-408-9142.

## NOTICE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. This new law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services.

These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:

- Interfere with a woman's rights under the plan to avoid these requirements, or
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and co-pays consistent with other coverage provided by the plan.

If you have any questions about the current plan coverage, please contact the Benefits Hotline at 888-408-9142.

## KNOW YOUR COBRA NOTIFICATION RESPONSIBILITIES

It is your responsibility to notify the benefits department within 30 days if you get divorced or have a dependent that is no longer eligible for coverage under the terms of our plan (for example, a child reaches age 26).

Your dependents have continuation rights for group health plan coverage under the federal law known as COBRA. If you fail to notify the {Human Resources Benefits Office } within the required time, your dependents may be left with no coverage under our plan. Please see your COBRA Notice or your group health plan summary plan de-

scription for additional information. Your premium for coverage varies depending on the level of coverage you select. You can minimize the amount of premium you pay by removing ineligible dependents from your coverage within the allowed time frame.

## PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility

**SOUTH CAROLINA – Medicaid**  
Website: <http://www.scdhhs.gov>  
Phone: 1-888-549-0820

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either

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

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
<http://www.cms.hhs.gov/>  
1-877-267-2323, Menu Option 4, Ext. 61565



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