



2017 BENEFITS AT A GLANCE



Dear Valued Employee:

We are happy to provide you with this Benefits-At-A-Glance which summarizes your employee benefits for the 2017 plan year. Cherokee County Board of Commissioners recognizes that benefits are an important part of your total compensation package. Our benefit program provides competitive and valuable benefits for you and your dependents.

This document is not just an enrollment guide. It is a resource for you and your family to use throughout the year. In this guide you will find a summary of each of the benefit plans offered to eligible employees and their dependents. Our benefits program is designed to allow you to choose what works best for your needs and your budget, and this information will allow you to make informed decisions regarding the selection and continued management of the services and benefits provided to you as a Cherokee County Board of Commissioners employee.



TABLE OF CONTENTS

Page 1	Eligibility Information
Page 2	Enrollment Information
Page 4	Medical
Page 6	Teladoc
Page 7	Consumer Tip: Know your Options
Page 8	Dental
Page 9	Vision
Page 10	Employer Paid Basic Life & AD&D
Page 11	Voluntary Life and AD&D
Page 12	Short Term Disability (STD)
Page 12	Long Term Disability (LTD)
Page 13	Employee Assistance Program (EAP)
Page 13	Travel Assistance
Page 14	Voluntary Supplemental Policies
Page 15	Flexible Spending Account (FSA)
Page 16	Eligible and Ineligible Medical Expenses
Page 20	Legislative Notices and Requirements
Page 30	Contact Information

IMPORTANT NOTICE TO EMPLOYEES:

This Benefits-at-a-Glance provides a general description of the various benefits available to you through the Cherokee County Board of Commissioners Employee Benefits Program. The details of these plans and policies are contained in the official plan and policy documents. This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

The rates and payroll deductions provided in this illustration are meant for illustrative purposes only and may not reflect final underwriting adjustments. Please refer back to your employer for confirmation of your premium responsibilities.



Employee Eligibility and Enrollment

All full time employees working an average of 30 hours per week are eligible to enroll in benefits. For specific details, please refer to the plan documents. New full time employees' benefits for all lines of coverage will begin on the 1st of the month following 30 days of full time employment.

Dependent Eligibility— Medical Plans

Legislation regulates eligibility requirements for dependent coverage on **Medical insurance plans**. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible dependents include:

- Spouse/Same Sex Spouse
- Dependent children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

The adult child's spouse and children are not subject to coverage.

Dependent Verification of Eligibility

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

- Spouse Verification Documentation: Marriage Certificate
- Child Verification Documentation: Birth Certificate, court document awarding custody or requiring coverage





When You Can Enroll

You can enroll in benefits at the following times:

- During your initial new hire eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event

Please see below section for examples of qualified life events.

Mid-Year Enrollment Changes—Section 125 Cafeteria Plan

Employees may take advantage of, at no cost to them, the tax benefits of a 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck. When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes...you do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

Current IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event. Changes must be reported within 30 days of the actual event. Some common qualifying events may include:

- Marriage, Divorce or Death of Spouse
- Birth, Adoption or change in legal custody
- Loss of other coverage

- Enrollment in the Marketplace Exchange
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

To determine if any of these apply to you, please check with your Human Resources representative.

Please Note: the IRS does not consider financial hardship a qualifying event to drop coverage.

Sample of Savings using pre-tax Deductions:

	<i>Pre-Tax Contributions</i>	<i>Post Tax Contributions</i>
<i>Employee Gross Pay</i>	\$35,000	\$35,000
<i>Pre-Tax Premium</i>	\$417	-
<i>Taxable Income</i>	\$34,583	\$35,000
<i>Assumed Tax Rate¹</i>	25.65%	25.65%
<i>Net Pay</i>	\$25,712	\$26,023
<i>After Tax Premium</i>	-	\$417
<i>Take Home Pay</i>	\$25,712	\$25,605

¹Assumed Tax Rate of 18% Federal Income Tax and 7.65% FICA (Social Security and Medicare)



What's New This Year

- Medical administration is moving from BCBS to CoreSource TPA
- Rx is moving from Express Scripts to US-Rx Care
- Script Sourcing International Pharmacy Program
- Zero Out-of-Pocket Imaging

What's Remaining the Same

- Dental & Vision is staying with BCBS
- Life & Disability is staying with UNUM
- Voluntary Benefit are staying with Colonial

How to Enroll-2017

For the 2017 plan year, Cherokee County BOC will continue to use the online benefit enrollment system.

To enroll, please visit: <http://harmony.benselect.com/Enroll/>

Log in instructions:

- Username/ Employee ID:
Enter your Social Security Number (SSN)
- Password/ Personal Identification Number (PIN): Enter the last four (4) digits of your SSN and the last two (2) digits of your birth year.

© 2012 Colonial Life & Accident Insurance Company Portions © 2012 Selerix Systems. All rights reserved.

"Harmony", "in tune with your benefits", and the logo, separately and in combination, are registered service marks of Colonial Life & Accident Insurance Company. All rights reserved.

"Selerix", "Benefits-Selection" and "BenefitAgent" are registered service marks of Selerix Systems, Inc. All rights reserved.

[Security Information](#) [Privacy Policy](#)

**Welcome to the Enrollment Site.
Please Log in.**

To use this website, you must have your employee ID or Social Security Number and your confidential Personal Identification Number (PIN). If you have difficulty logging in, please contact the Enrollment Solutions Help Desk at 1-866-875-4772.

Unauthorized use is strictly prohibited.

Employee ID or Social Security Number:

Personal Identification Number (PIN):

LOG IN

[Forgot PIN?](#)

Your signature may be required during your enrollment. Clicking "I Agree" will represent your electronic signature on any documents requiring your consent.

Administrative users: login to the [administrative site](#).



Open Access EPO (Exclusive Provider Organization)

In Network Benefits	In Network Member Cost
Deductible - (Individual / Family)	\$750 / \$2,250
Is Deductible Calendar Year or Policy Year?	Calendar Year
Is Deductible Embedded or Non Embedded	Embedded
Out of Pocket Maximum – (Individual / Family)	\$2,000 / \$6,000
Coinsurance	20%
Prescription Drugs	\$10 / \$35 / \$80
Mail Order Drugs (90 Day Supply)	\$25 / \$50 / \$50
International Pharmacy Program	Brand Only-\$0
Specialty Rx	20% Coinsurance to a max of \$200 per Prescription
Physician Office Visits	
Primary Care Physician	\$25
Specialist	\$30
Referral Needed for Specialist?	No
Preventive Care	
Routine Adult Physical Exams	Covered at 100%
Well Woman Exams	
Routine Mammograms and Colonoscopy	
Well Child	
Diagnostic / Laboratory	
Diagnostic X-ray and Lab Services	Deductible then 20%
Hospitalization / Outpatient Services	
Inpatient Hospitalization (Facility)	\$500 per admission plus deductible then 20%
Outpatient Surgical Care (Hospital Facility)	Deductible then 20%
Emergency Room	\$250
Out of Network Benefits	
Deductible - (Individual / Family)	Not Applicable
Out of Pocket Maximum - (Individual / Family)	Not Applicable
Coinsurance	Not Applicable

Teledoc visits are \$0
For more information on the Teladoc benefit, please see page 6 of this guide.



Employees	
Bi-Weekly Payroll Deductions	
Employee Only	\$46.38
Employee + 1 dependent	\$108.60
Employee + Family	\$162.16

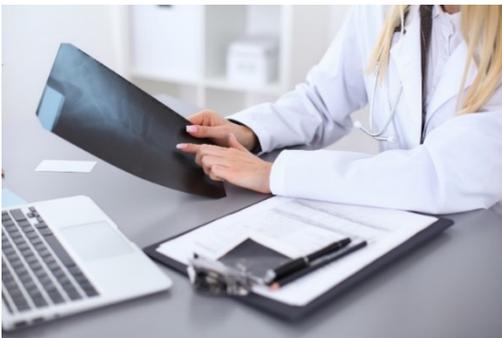
This information summarizes the Cherokee County Board of Commissioners Medical benefits plans and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



Open Access POS

In Network Benefits	In Network Member Cost
Deductible - (Individual / Family)	\$3,000 / \$9,000
Is Deductible Calendar Year or Policy Year?	Calendar Year Deductible
Is Deductible Embedded or Non Embedded	Embedded
Out of Pocket Maximum – (Individual / Family)	\$6,000 / \$12,700
Coinsurance	20%
Prescription Drugs	\$20 / \$35 / \$80
Mail Order Drugs (90 Day Supply)	\$65 / \$65 / \$65
International Pharmacy Program	Brand Only-\$0
Specialty Rx	20% Coinsurance to a max of \$200 per Prescription
Physician Office Visits	
Primary Care Physician	\$40
Specialist	\$40
Referral Needed for Specialist?	No
Preventive Care	
Routine Adult Physical Exams	Covered at 100%
Well Woman Exams	
Routine Mammograms and Colonoscopy	
Well Child	
Diagnostic / Laboratory	
Diagnostic X-ray and Lab Services	Deductible then 20%
Hospitalization / Outpatient Services	
Inpatient Hospitalization (Facility)	\$500 per admit then 20%
Outpatient Surgical Care (Hospital Facility)	Deductible then 20%
Emergency Room	\$250
Out of Network Benefits	
Deductible - (Individual / Family)	\$6,000 / \$18,000
Out of Pocket Maximum - (Individual / Family)	\$9,000 / \$27,000
Coinsurance	40%

Teledoc visits are \$0
 For more information on the Teladoc benefit, please see page 6 of this guide.



Employees	
Bi-Weekly Payroll Deductions	
Employee Only	\$65.88
Employee + 1 dependent	\$154.37
Employee + Family	\$305.06

The information provided in this material should not be viewed as medical advice from Cherokee County Board of Commissioners or Insurance Office of America. If you have questions concerning your medical conditions, drugs, treatment plans or symptoms consult your healthcare provider.

Quality healthcare when and where you need it.

Teladoc gives you access to a national network of U.S. board-certified doctors who are available on-demand 24/7/365 to treat many of your medical issues. Feeling under the weather? Teladoc is just a click or call away!



When should you use Teladoc?

Teladoc's U.S. board-certified doctors can provide treatment for:

- Cold and flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy
- Pink eye

How Teladoc benefits you

Teladoc is healthcare made simple and on your terms.

- Request a consultation anytime online or by phone.
- Teladoc doctors respond within 22 minutes, on average.
- Talk to a doctor from home, work, or while traveling.
- Save money by avoiding expensive urgent care or ER visits.

Member stories

"I was at work not feeling well but didn't want to leave work. So I decided to call Teladoc. It was a wonderful experience! The doctor called me back within 30 minutes. I spoke with him for about 15 minutes and he wrote me a prescription that I was able to pick up on my way home from work at my local pharmacy! It was very convenient. Teladoc saved me money and I didn't have to miss time from work."

— Ann

Why wait for the care you need?

Teladoc is happy to provide information about your consultation to your primary care physician.

TeladocSM

CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

24/7/365 on-demand access to
U.S. BOARD-CERTIFIED DOCTORS

Visit us: www.Teladoc.com or Call us: 1-800-Teladoc (835-2362)

Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services. 03292011

BE INFORMED! WHAT ARE YOUR OPTIONS?



Care Center	Why would I use this care center?	What type of care would they provide?	What are the cost and time considerations?
Doctor's Office \$	You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide preventive and routine care, manage your medications and refer you to a specialist, if necessary.	<ul style="list-style-type: none"> • Routine checkups • Immunizations • Preventive services • Manage your general health 	<ul style="list-style-type: none"> • Often requires a copayment • and/or coinsurance • Normally requires an appointment • Little wait time with scheduled appointment
Convenience Care Clinic \$	In situations where you may not be able to get in to see your primary care doctor and your condition is not urgent or an emergency, you may want to consider a Convenience Care Clinic . Convenience Care Clinics are conveniently located in malls or some retail stores, such as CVS Caremark, Walgreens, Wal-mart and Target, and offer services without the need to schedule an appointment. These services are often provided at a lower out of pocket cost than at urgent care clinics and emergency room visits. Services at these types of clinics are usually available to patients 18 months of age or older.	<ul style="list-style-type: none"> • Common infections (Sore or strep throat, Urinary tract and bladder infections, Earaches and ear infections, pink eye • Minor fevers • Cough, colds, and flu • Nasal Congestion • Allergy Symptoms • Skin issues(rashes, ringworm, and chicken pox) • Head Lice • Insect bites • Minor burns, cuts, and scrapes • Sprains and Strains 	<ul style="list-style-type: none"> • Often requires a copayment and/or coinsurance similar to office visit • Walk in patients welcome with no appointments necessary but wait times can vary
Urgent Care Centers \$\$	In situations where you need medical care fast, but a trip to the emergency room is not necessarily required you may want to consider an Urgent Care Center . At urgent care centers you can be treated for many minor medical issues, usually at a lower cost and on quicker turn around than an emergency room.	<ul style="list-style-type: none"> • Migraines • Severe back pain • Vomiting and diarrhea • Minor broken bones • Fevers • Asthma attacks • Severe cough • Eye irritations • Animal bites • Wounds requiring stitches 	<ul style="list-style-type: none"> • Often requires a copayment and/or coinsurance usually higher than an office visit • Walk in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first
Emergency Rooms \$\$\$	In situations where you think that you or a covered dependent may be experiencing a true medical emergency you should go to the nearest Emergency Room or call 911. An emergent medical condition usually results in serious jeopardy to your health, impairment of bodily functions, or serious dysfunction of organs.	<ul style="list-style-type: none"> • Loss of consciousness • Chest pain • Severe trouble breathing • Sudden loss of vision, numbness or difficulty speaking • Severe abdominal pain • Coughing or vomiting blood • Severe bleeding • Severe burns • Head trauma • Major broken bones • Seizures/ convulsions 	<ul style="list-style-type: none"> • Often requires a much higher copayment and/or coinsurance than an office visit or urgent care visit • Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first

The information provided in this material should not be viewed as medical advice from Cherokee County Board of Commissioners or Insurance Office of America. If you have questions concerning your medical conditions, drugs, treatment plans or symptoms consult your healthcare provider.



BlueCross BlueShield Dental PPO

Summary of Benefits		
Annual Deductible	\$50 / \$150	
Annual Benefit Maximum	\$1200	
Orthodontia Lifetime Maximum	\$1,000	
Network	PPO Network	
	In-Network	Out of Network**
Type A-Diagnostic and Preventative Services (Deductible is waived)		
Oral Evaluations	100%	100%
Prophylaxis: Cleanings		
Fluoride Treatment		
Bitewing X-rays, Full Mouth X-rays		
Sealants		
Space Maintainers		
Type B-Basic Services		
Fillings	80%	80%
Endodontics		
Simple Extractions		
Palliative Emergency Treatment		
Occlusal Guards (one per year)		
Type C-Major Services		
Periodontal Services	50%	50%
Inlays/ Crowns/ Bridges		
Oral Surgery		
Dentures		
Orthodontia Services		
Diagnostics and Treatments	50%	50%

****If you choose to go out-of-network, the reimbursement level will be based on the reasonable and customary charges from dentists in the same area.**

Employees	
Bi-Weekly Payroll Deductions	
Employee Only	\$6.50
Employee + Spouse	\$18.25
Employee + Child(ren)	\$17.22
Employee + Family	\$26.11



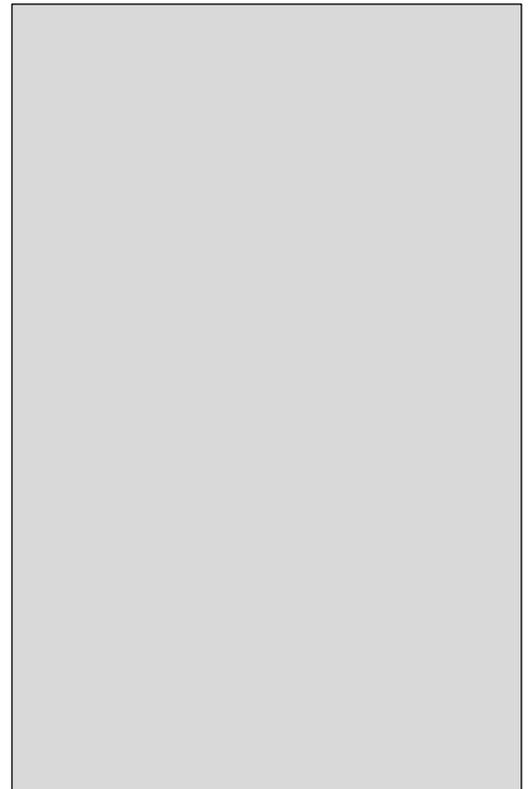
This information summarizes the Cherokee County Board of Commissioners Dental benefits plans and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



BlueCross BlueShield Blue View Vision Plan

Benefit	In-Network	Out-of-Network Allowance	Frequency
Routine Eye Examination	\$10 copayment	\$21 allowance	12 months
Materials Copay			
Eyeglass Frames	\$150 allowance then 20% discounted remaining balance	\$75 allowance	12 months
Standard Eyeglass Lenses			
Single Vision	\$10 copayment	\$18 allowance	12 months
Bifocal	\$10 copayment	\$32 allowance	12 months
Trifocal	\$10 copayment	\$56 allowance	12 months
Elective Contact Lenses (in lieu of eyeglasses)			
Conventional Contact Lenses	\$120 allowance then 15% discount off remaining balance	\$72 allowance	12 months
Disposable Contact Lenses	\$120 allowance	\$72 allowance	12 months
Medically Necessary Contact Lenses			
Contact Lens	Covered in full	\$200 allowance	12 months

Employees	
Bi-Weekly Payroll Deductions	
Employee Only	\$3.13
Employee + Spouse	\$6.24
Employee + Child(ren)	\$5.89
Employee + Family	\$9.02



This information summarizes the Cherokee County Board of Commissioners Vision benefits plans and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



Employer Paid

Unum Basic Group Term Life/ AD&D

Benefit Summary	
Life Benefit	
Amount	Class 1-Active Employees: 1 times annual salary (from \$25,000 to a maximum of \$200,000) Class 2-Retirees up to age 65: \$25,000
AD&D Benefit	
Amount	Class 1-Active Employees: 1 times annual salary (from \$25,000 to a maximum of \$200,000) Class 2-Retirees up to age 65: \$25,000
Benefit Reduction	
Benefits will reduce:	65% of the original amount at age 65 50% of original amount at age 70

Cherokee County BOC pays 100% of the premium for your Basic Life and AD&D coverage.



This information summarizes the Cherokee County Board of Commissioners Basic Life and AD&D benefits plans and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



Unum Voluntary Term Life and AD&D

Benefit Summary	
Employee Life Benefit	
Amount	\$50,000 increments to a maximum of 5 times salary or \$500,000
Guarantee Issue	\$250,000
Spouse Life Benefit	
Amount	\$25,000, \$50,000 or \$100,000
Guarantee Issue	\$50,000
Child Life Benefit	
Amount	\$10,000
Guarantee Issue	\$10,000
AD&D Benefit	
Amount	Same as elected life benefit
Benefit Reduction	
Benefits will reduce:	At age 65: 65% of the original amount At age 70: 50% of the original amount

How to Calculate your Voluntary Life Premium:

Premium is based on coverage units of \$1,000.

Formula:
 $(\text{Benefit Volume} \times \text{Rate}) / 1000 = \text{Monthly Premium}$

Example:

- 40 year old employee elects \$200,000 in coverage

Monthly premium = $(\$200,000 \times .47) / 1000 = \95.00

Payroll Deduction = $(\$95.00 \times 12) / 26 = \43.85 per bi-weekly paycheck.

Coverage	Age	Employee Monthly Tobacco Rate	Employee Monthly Non-Tobacco Rate	Spouse Rates (Based on SP DOB)
		Per \$1,000	Per \$1,000	Per \$1,000
Optional Life Employee and Spouse (based on employee age)	Under 25	\$0.163	\$0.091	\$0.102
	25-29	\$0.163	\$0.091	\$0.102
	30-34	\$0.225	\$0.104	\$0.112
	35-39	\$0.318	\$0.138	\$0.142
	40-44	\$0.475	\$0.194	\$0.224
	45-49	\$0.797	\$0.318	\$0.400
	50-54	\$1.285	\$0.535	\$0.656
	55-59	\$1.795	\$0.817	\$0.948
	60-64	\$2.210	\$1.106	\$1.454
	65-69	\$3.901	\$2.173	\$2.684
	70-74	\$6.483	\$4.057	\$4.672
	75+	\$6.489	\$4.057	\$4.672
Optional AD&D		\$0.04 /\$1,000		
Optional Dependent Child(ren)		\$ 0.27 Per \$1,000(covers all dependent children)		

This information summarizes the Cherokee County Board of Commissioners Group Supplemental Life and AD&D benefits plans and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



Employer Paid Unum Short Term Disability

Benefit Summary	
Benefits	
Elimination Period	Accident: 7 days Illness: 7 days
Weekly Benefit	60%
Maximum Benefit Period	Base: 8 weeks Buy-Up: 9-26 weeks
Maximum Weekly Benefit	\$1,000
Minimum Weekly Benefit	\$25
Definitions	
Definition of Disability	Partial disability with zero day residual benefits



Employer Paid Unum Long Term Disability



Benefit Summary	
Benefits	
Elimination Period	180 Days
Monthly Benefit	60%
Maximum Benefit Period	To age 65
Maximum Monthly Benefit	\$6,000
Minimum Monthly Benefit	10% or \$100, whichever is greater
Definitions	
Definition of Disability	24 month own occupation

Cherokee County BOC pays 100% of the Base Plan premium for your STD and LTD disability coverages.

This information summarizes the Cherokee County Board of Commissioners STD and LTD benefits plans and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



Unum Travel Accident Insurance

Worldwide emergency travel assistance services are available to you through Unum. When traveling for business or pleasure, in a foreign country or just 100 miles or more away from home, you and your family can count on getting help in the event of a medical emergency.

- Hospital admission guarantee
- Emergency medical evaluation
- Medically supervised transportation home
- Transportation for a friend or family member to join hospitalized patient
- Prescription replacement assistance
- Multilingual crisis management professionals
- Medical referrals to western-trained English speaking medical providers
- Care and transport of unattended minor children



Employer Paid Work-Life Balance EAP

Your work-life balance employee assistance program can help you find a solution for the everyday challenges of work and home as well as more serious issues involving emotional and physical well-being.

- Childcare and/or Eldercare referrals
- Personal relationship information
- Health information and online tools
- Legal consultations with licensed attorneys
- Financial planning assistance
- Stress Management
- Career Development

Telephonic consultations-Speak confidentially with a master's level consultant to clarify your need, evaluate your options and create an action plan.

Face-to-face meetings-Meet with a local consultant up to three times per issue for short term problem resolution.

Educational materials-Receive information through our online library of downloadable materials and interactive tools.

This information summarizes the Cherokee County Board of Commissioners Travel Accident and EAP benefits plans and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.





Colonial Life Voluntary Supplemental Plans

Congratulations! You have the opportunity to apply for payroll deducted personal insurance products! These benefits are designed to enhance your current benefits portfolio and can be customized to fit your individual needs!

- Premiums paid through payroll deduction
- Cash benefits paid directly to you from Colonial Life
- Benefits paid regardless of other in-force coverage

Hospital Confinement Insurance – Offsets the gaps created by co-payments and deductibles in your major medical plan. The policy provides a lump sum benefit of \$1,000 for a covered hospital confinement. Or if an out-patient surgery the benefit paid either \$500 or \$1,000 depending on the qualified surgery performed. An annual \$50 health screening benefit per covered insured is included. **Example: for a \$1,000 hospital confinement benefit, employee ages 17-49 would pay \$8.54 bi-weekly. Ages 50-59 would pay \$11.82 bi-weekly.**

Accident Insurance – helps fill in the gaps created by increasing out of pocket costs related to on or off the job accidental injuries such as dislocations, fractures, and emergency dental work. Benefits include emergency room treatments, follow up visit with doctor, and rehabilitation costs and much more.

Employees	
Bi-Weekly Payroll Deductions	
Employee Only	\$7.73
Employee + Spouse	\$10.27
Employee + Child(ren)	\$12.92
Employee + Family	\$15.46

Cancer Insurance – Helps to offset out-of-pocket medical and nonmedical expenses related to cancer that most medical plans may not cover such as hospital confinement, chemotherapy, radiation, experimental treatment, surgical procedures, transportation and lodging. Included in the plan; a \$5,000 initial diagnosis of cancer benefit rider, and a \$75 benefit for specified screening tests.

Employees	
Bi-Weekly Payroll Deductions	
Employee Only	\$12.23
Employee + Spouse	\$20.31

Critical Illness Insurance – provides a financial cushion with a \$5,000-\$50,000 lump sum benefit with the first diagnosis of any of the following critical illnesses: Heart Attack, Stroke, Major Organ Transplant, End State Renal Failure, Blindness, or Coronary Artery bypass Surgery (25%). **Example: for \$25,000 on Employee only, non-tobacco, a 29 year old would pay \$5.53 bi-weekly.**

Term Life Coverage – enable you to tailor coverage for your individual needs and help provide financial security for our family members by offering a benefit amount with low-cost fixed rates and fixed term. Your premiums and death benefit will not change during the selected term. Example: For a 10 year term, \$100,000 of coverage for a 35 year old non-smoker would cost \$7.08 bi-weekly.

This information summarizes the Cherokee County Board of Commissioners Voluntary Supplemental benefits plans and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



FSA Administered by Ameriflex

Flexible Spending Accounts (FSAs) have become a popular vehicle for reducing rising health care costs. By contributing pre-tax dollars into an FSA, you can save an average of 20% on eligible expenses every year.

You may participate in the following Flexible Spending Accounts:

Health Care Flexible Spending Account

Employees use pre-tax dollars to pay for insurance deductibles, co-payments, glasses and contact lenses, orthodontia, over-the-counter medications, and hundreds of other health care-related expenses not covered by their insurance plans. The maximum contribution amount for period 01/01/2017 through 12/31/2017 is \$2,550.

Dependent Care Flexible Spending Account

Employees use pre-tax dollars to be reimbursed for work-related day care expenses for their children or dependent adults. The maximum contribution amount for period 01/01/2017 through 12/31/2017 is \$5,000 if you are married and filing a joint return or if you are a single parent. If you are married but filing separately, the annual maximum contribution is \$2,550.

The following table offers an example of the savings experienced by participating in an FSA:

	FSA Participant	FSA Non Participant
Annual Gross Income	\$31,000	\$31,000
FSA Deposit for Reoccurring Expenses	-\$2,500	-\$0.00
Taxable Gross Income	=\$28,500	=\$31,000
Federal & Social Security Tax	-\$6,455.25	-\$7,021.50
Annual Net Income	=\$22,044.75	=\$23,978.50
Cost of recurring Expenses	-\$0.00	-\$2,500.00
Spendable Income	=\$22,044.75	=\$21,478.50

Please note: Under the ACA/ healthcare reform effective January 1, 2011, claims for over-the-counter medicine or drug expenses (other than insulin) **cannot be reimbursed without a prescription**. This rule does not apply to items for medical care that are not medicines or drugs.

For a complete list of Eligible Expenses reimbursable with an FSA account, as well as a complete list of Ineligible Expenses, please visit the following IRS link:

www.irs.gov/publications/p502/ar02.html#en_US_publink1000178947

This information summarizes the Cherokee County Board of Commissioners Flexible Spending Account and is for illustrative purpose only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



Qualified Medical Expenses

The Internal Revenue Service defines qualified medical care expenses as amounts paid for the diagnosis, cure or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

Under a rule that went into effect January 1, 2011, claims for over-the-counter medicine or drug expenses (other than insulin) cannot be reimbursed without a prescription. This rule does not apply to items for medical care that are not medicines or drugs.

- Abortion
- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical examination
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment
Installed for a person with a disability
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Crutches
- Dental treatment
- Diagnostic devices
- Disabled dependent care expenses
- Drug addiction treatment
- Eye exam
- Eye glasses
- Eye surgery
- Fertility enhancement (in vitro fertilization or surgery)
- Guide dog or other service animal
- Health institute fees (if prescribed)
- Intellectually or developmentally disabled care, treatment or special home
- Laboratory fees
- Lactation expenses
- Lead-based paint removal (if a child in the home has lead poisoning)
- Learning disability care or treatment
- Legal fees associated with medical treatment
- Lifetime care, advance payments or “founder’s fee”
- Lodging at a hospital or similar institution
- Long-term care
- Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent
- Medical information plan
- Medications, if prescribed
- Nursing home fees
- Nursing services
- Operations
- Osteopath
- Oxygen
- Physical examination
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychologist
- Special education
- Sterilization
- Stop-smoking programs
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Tuition for special education
- Vasectomy
- Vision correction surgery

Unfortunately, **we cannot provide a definitive list of “qualified medical expenses” however the following list includes common qualified medical expenses. This list is subject to change in accordance with IRS regulations.** To see a full list of current qualified medical expenses please visit: <http://www.irs.gov/pub/irs-pdf/p502.pdf>.



- Weight-loss program if it is a treatment for a specific disease
- Wheelchair
- Wig
- X-ray

- Veterinary fees
- Weight-loss program (unless for a specific disease diagnosed by a physician)

Ineligible Medical Expenses

The following list includes examples of products and services that are **NOT eligible for reimbursement** according to the IRS. **Please note that this list is not all-inclusive, and is subject to change.**

- Babysitting, childcare and nursing services for a normal, healthy baby
- Controlled substances or illegal drugs
- Cosmetic surgery
- Dancing lessons
- Diapers or diaper service
- Electrolysis or hair removal
- Funeral expenses
- Future medical care (except advance payments for lifetime care, or long-term care)
- Hair transplant
- Health coverage tax credit
- Household help
- Illegal operations or treatments
- Insurance premiums (with a few exceptions)
- Maternity clothes
- Medication from other countries
- Nonprescription drugs and medicine, except insulin (over-the-counter medicine is eligible for reimbursement with a prescription)
- Nutritional supplements, unless recommended by a medical practitioner as treatment for a specific medical condition
- Personal use items (e.g., toothbrush, toothpaste, dental floss)
- Swimming lessons
- Teeth whitening



Unfortunately, **we cannot provide a definitive list of “qualified medical expenses”** however the following list includes **common qualified medical expenses**. This list is subject to change in accordance with IRS regulations. To see a full list of current qualified medical expenses please visit: <http://www.irs.gov/pub/irs-pdf/p502.pdf>.



Commonly Used Terms

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A **co-payment**, or **copay**, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

ELIMINATION PERIOD: This is the time period between injury or illness and the receipts of benefit payments.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EVIDENCE OF INSURABILITY (EOI): This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

EPO: Exclusive Provider Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency. A primary care provider is not necessary. Out of Network care is not covered.

IN NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.



MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

OUT OF NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

POS (Point of Service): Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.



Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the qualifying event.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Current employees and their dependents are eligible for special enrollment if:

- *The employee or dependent lost eligibility for other coverage because:

 - *The coverage was provided under COBRA, and the entire COBRA coverage period was exhausted;*
 - *The coverage was non-COBRA coverage and the coverage terminated because of loss of eligibility for coverage; or*
 - *The coverage was non-COBRA coverage and employer contributions for the coverage were terminated.**

A loss of eligibility for coverage includes, but is not limited to, the following:

- *Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of these events;*
- *In the case of coverage offered through a health maintenance organization (HMO) in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual);*
- *In the case of coverage offered through an HMO in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and no other benefits package is available to the individual; and*
- *A situation where a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.*

Loss of eligibility does not include a loss resulting from the failure of the employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

To request special enrollment or obtain more information, please contact Human Resources.



COBRA Continuation of Coverage

Federal law requires that most group health plans give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

These events include the death of a covered employee, termination or a reduction in the hours of a covered employee's employment, divorce of a covered employee and spouse, and a child's loss of dependent status under the plan.

COBRA coverage is usually more expensive than coverage for active employees, since many employers pay a part of the cost. The maximum amount charged to qualified beneficiaries cannot exceed 102 percent of the full premium or cost to the plan.

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace. **After 60 days your special enrollment period for the Marketplace will end and you may not be able to enroll, so you should take action right away.**

Family Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

The FMLA applies to:

- Private employers with 50 or more employees in at least 20 weeks of the current or preceding calendar year;
- Public agencies, including state, local and federal employers; and
- Local education agencies (covered under special provisions).

An employee is eligible for FMLA leave if he or she:

- Worked for the employer for at least 12 months (which need not be consecutive);
- Has worked at least 1,250 hours for the employer during the 12-month period immediately before the leave; and
- Is employed at a location where the employer has at least 50 employees within a 75-mile radius.

Group health plan coverage during FMLA leave is maintained on the same terms as if the employee had continued to work, if these benefits were provided before the leave was taken. An employee may be required to pay the regular portion of premiums during FMLA leave.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

USERRA applies to all employers, regardless of size (including state, local and federal government employers). If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.



If you are absent from work for less than 31 days, you are not be required to pay more for coverage than the share charged to employees who are actively at work. For longer absences, you may be charged no more than 102 percent of the full premium or cost to the plan.

Health Insurance Marketplace

The healthcare reform law creates a new Marketplace for purchasing health insurance coverage, also called an exchange. Federal subsidies for eligible individuals will be available through the Marketplace. Eligibility is determined based on many factors, including income as well as access to other coverage. You will not be eligible for subsidies if you are offered coverage through your employer that is deemed “affordable” and provides “minimum value” in accordance with regulations. To ensure that taxpayers receive the right amount of subsidies, Marketplaces report certain information to the IRS. At the end of the year, the subsidy amount will be recalculated using the taxpayer’s household income as reported on his or her tax return, and any difference in the amounts will be reconciled. If the taxpayer’s income has increased from the amount that he or she reported to the Marketplace, and as a result received a larger subsidy than he or she was entitled to, that individual may have to repay part of their subsidy.

The Marketplace open enrollment period may or may not correspond with your employer’s open enrollment period. Purchasing coverage through the Marketplace may or may not be a qualifying event to change or drop your coverage through your employer. Please check with Human Resources for further details.

Certain events may allow you to enroll in the Marketplace after the open enrollment period. These events include but are not limited to: loss of minimum essential coverage, marriage, birth, or placement for adoption, employer coverage is non-qualifying, gaining citizenship or qualifying immigration status.

More information on the health care reform law and the Marketplaces is available at www.healthcare.gov.

Individual Shared Responsibility

Under healthcare reform, individuals without minimum essential health coverage could be assessed a penalty starting in 2014 unless an exemption is applicable. Employer sponsored coverage is generally minimum essential coverage.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules establish a uniform, minimum level of privacy protections for all health information. The rules allow health care providers, health plans, and health care clearinghouses (Covered Entities) to use and disclose your personally identifiable health information (PHI) for purposes of treatment, payment or health care operations. In general, any use or disclosure not considered treatment, payment or a health care operation requires your written authorization, unless an exception applies.

If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices immediately after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices in order to understand your rights and know who to contact if you feel your privacy rights have been violated. Contact Human Resources to request a copy of the HIPAA privacy notice.

Women’s Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain



reconstructive surgery and other post-mastectomy benefits.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- *All stages of reconstruction of the breast on which the mastectomy was performed;*
- *Surgery and reconstruction of the other breast to produce a symmetrical appearance;*
- *Prostheses; and*
- *Treatment of physical complications of the mastectomy, including lymphedema.*

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Therefore, the deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

Statement of Rights under the Newborn’s and Mother’s Health Protection Act

The Newborns’ and Mothers’ Health Protection Act (NMHPA) provides protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. The NMHPA sets limits on benefits that are provided for hospital stays after childbirth.

However, nothing in the law or regulations requires a mother to give birth in a hospital or stay in the hospital for a specific period of time after giving birth. Also, group health plans may not be required to provide any benefits for hospital stays related to childbirth.

However, if the plan provides these benefits, it must comply with the NMHPA’s minimum requirements.

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

The NMHPA and the final regulations do not apply to health insurance coverage (and group health plans that provide benefits only through health insurance coverage) in certain states that have adopted laws similar to the NMHPA. Contact your Plan Administrator or Human Resources for specific details regarding your coverage.

Michelle’s Law

On January 1, 2010 an important new law became effective. The new law, known as “Michelle’s Law”, expands coverage and notice obligations for eligible college students.

What does the law require? All group health plans must allow a college student with a “serious illness or injury” to remain eligible for active dependent coverage for 12 months, even if he or she no longer qualifies as a full-time student. The specific requirements are:

- *The Individual must be covered as a full time student, as defined in the plan, at a postsecondary educational institution immediately before any serious illness or injury.*
- *The student must experience a serious illness or injury that requires a medically necessary leave of absence or a medically necessary change in enrollment status from full-time to part-time.*



- *A physician must verify the illness or injury in writing and certify the leave or change in enrollment status as medically necessary.*
- *The Health Plan must allow the student to remain covered as an active participant/dependent for 12 months after the leave of absence begins. The regular premium will apply during these 12 months.*
- *The 12 months, however, does not extend coverage beyond another independent event that would end active/dependent status, such as the parent's termination of employment or the student exceeding the plan's age limit.*
- *COBRA coverage would not be offered until after the 12 month special period has expired, unless the student returns to full time status and remains eligible under other terms of the plan.*

Expansion of Women's Prevention Care Coverage

The Affordable Care Act (ACA) requires health plans to cover certain preventive care services for participants at no extra cost, even if the deductible hasn't been met. This requirement includes additional preventive care for women.

The following items are included in this coverage:

- *Well-woman visits (annual preventive care visits in which women under 65 obtain recommended preventive services)*
- *Gestational diabetes screenings for women 24 to 28 weeks pregnant, and women who are considered high risk*
- *Human papillomavirus (HPV) testing for women aged 30 and older, once every three years*
- *Annual counseling for HIV and sexually transmitted infections, plus annual HIV testing for all sexually active women*
- *Contraceptives and contraceptive counseling. (Certain religious employers, such as churches, are not required to cover contraceptives)*
- *Breast-feeding support, supplies and counseling*
- *Domestic violence screening and counseling*

Be sure to check your plan's specific rules before receiving care. The preventive care rules do not apply to health plans that have "grandfathered" status under the ACA.

Though plans are required to provide these services free of charge, they do have the option of using cost-control measures, such as requiring that a patient pays for a brand name drug even if a comparable generic drug is available, or charging a copayment for preventive services received at out-of-network facilities.

Contact your Plan Administrator or Human Resources for a full list of preventive health services.

Important Notice: Medicare D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer 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. Your employer has determined that the prescription drug coverage offered by the group 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 group coverage may or may not be affected.

If you do decide to join a Medicare drug plan and drop your current group coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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 group coverage 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.

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

Contact your Human Resources Employee Benefits Administrator 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 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.
- 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.

(OMB 0938-0990)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds



from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcpf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

LEGISLATIVE REQUIREMENT NOTICES



Phone: 1-888-695-2447	
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/Access_Nebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-

	administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

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
1-866-444-EBSA (3272)

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



Paperwork Reduction Act Statement-As it pertains to this CHIP Notice:

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebesa.opr@dol.gov and reference the **OMB Control Number 1210-0137**.

CARRIER CONTACT INFORMATION



CARRIER/LINE OF COVERAGE	CUSTOMER SERVICE	WEBSITE/NETWORK
Medical CoreSource	877-279-5285 Teladoc: 800-835-2362	www.mycoresource.com www.teladoc.com
Pharmacy US Rx Care	877-200-5533	www.us-rxcare.com
International Pharmacy ScriptSourcing	866-488-7874	Not Applicable
Imaging Zero Out of Pocket	855-281-2141	www.zerooutofpocket.com
Dental BlueCross BlueShield of Georgia	855-397-9267	www.bcbsga.com/mydental/
Vision BlueCross BlueShield of Georgia	866-723-0515	www.bcbsga.com/vision/
Employer Paid Basic Life & AD&D Unum	866-679-3054	www.unum.com
Voluntary Life and AD&D Unum	866-679-3054	www.unum.com
Short Term Disability (STD) Unum	678-493-6018	humanresources@cherokeega.com
Long Term Disability (LTD) Unum	866-679-3054	www.unum.com
Travel Accident Insurance Unum	1-800-872-1414	www.unum.com/travelassistance
Work-Life Balance EAP Unum	800-854-1446 (English) 877-858-2147 (Spanish)	www.unum.com
Voluntary Supplemental Policies Colonial Life	800-325-4368	www.coloniallife.com
Flexible Spending Accounts Ameriflex	888-868-3539	www.myameriflex.com

CHEROKEE COUNTY CONTACT INFORMATION

For assistance with benefits questions, membership card issues, claims, and billing issues please contact the Human Resources Department per the contact information below:

Tracy Chambers

Direct Line: 678-493-6018

E-mail: Tchambers@cherokeega.com

