City of Southport

Benefits Guide

July 1, 2023-June 30, 2024

Plan Year

Allegacy | Benefit Solutions

A Hilb Group Company

Who is Eligible?

Benefit	Full-Time Employees working 30+ Hours Per Week
Medical	✔
Health Savings Account	✔
Dental	✔
Vision	✔
Short-Term Disability	✔
Voluntary Long-Term Disability	✔
Basic Life and AD&D	✔
Voluntary Life & AD&D	✔
Bay Bridge Accident, Cancer & Critical Illness	✔
Employee Assistance Program	✔

Eligible Dependents
Others in your family may be eligible for coverage under plans listed above. Your eligible dependents include:

- Legal Spouse
- Domestic Partner
- Child up to age 26, regardless of student status (unless otherwise noted)

How do I enroll?

Employees are eligible for benefits on the first of the month following 30 days of full-time employment. Benefit enrollment is handled through the online benefit administration system, Employee Navigator. Please contact Human Resources if you have not registered for access to Employee Navigator. New employees will receive an Employee Navigator email containing instructions on how to set up access. Once registered, additional detailed information regarding benefits enrollment can be found on your employee homepage

How do I make changes?

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next annual enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status. You have 30 days from the date of the qualifying life event to make any changes to your benefit elections.

When does coverage end?

You may be able to continue some of your benefits after you leave City of Southport (see Cobra Statement in the required notices section). Your supplemental policies through Bay Bridge (accident, cancer & critical illness) can be changed to direct bill (at your home), and you can continue paying for them out-of-pocket at the same coverage levels and rates. You are required to contact Bay Bridge within 30 days of your termination date to change your policy to direct bill. You can contact Bay Bridge at 1-800-845-7519. Some life insurance may be continued and requires you to complete continuation paperwork within 30 days of your termination date. You may contact NC League of Municipalities for information about the continuation of life insurance at 919-715-4000.

What if I need help?

If you have general benefit questions and need guidance, please contact one of the Allegacy Benefit Solutions, A Hilb Group representatives below:

- Beth Starling 336-774-3449 bstarling@hilbgroup.com
- Keenia Guessford 336-774-2837 kguessford@hilbgroup.com
- Chad A. Huff 336-774-3448 chuff@ hilbgroup.com

The information contained in this booklet is provided to outline some of the major features of City of Southport's Benefit Plans. It is intended to be a brief overview only. Full Summary Plan Descriptions (SPDs) are available by contacting Human Resources. In the event that the information in this booklet varies from the information in the SPDs, the provisions outlined in the SPD will govern.

Carrier Contacts

Medcost
Medical
1-800-795-1023
www.medcost.com

Companion Life
Dental & Voluntary Life
1-800-753-0404
www.companionlife.com

Superior Vision
Vision
1-800-507-3800
www.superiorvision.com

NC League of Municipalities
Life/AD&D and Short Term Disability
919-715-4000
www.nclm.org

One America
Voluntary Long Term Disability
1-800-553-5318
www.oneamerica.com

Bay Bridge Administrators
Accident, Cancer, and Critical Illness
1-800-845-7519
claims@bbadmin.com

Health Management Systems of America
Employee Assistance Program
1-800-847-7240
www.my-life-resource.com
Username: hmsa / Password: myresource

Employee Contributions

Medical Employee Bi-Weekly (24) Deductions			
Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Base HSA Plan			
$0.00	$216.50	$128.50	$321.00
Buy Up Plan			
$0.00	$274.00	$101.25	$406.25

Dental Employee Bi-Weekly (24) Deductions			
Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
$0.00	$15.61	$28.20	$34.24
Vision Employee Bi-Weekly (24) Deductions			
Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
$0.00	$2.34	$2.34	$5.07

Medical Plans

NCLM Medcost Medical Plan		
In Network Benefit Highlights	**Base HSA Plan**	**Buy Up Plan**
	NCLM HDHP HSA 1500 Q	**NCLM 500 25/50**
Physician Services		
Primary Care Physician Office Visit	Deductible then 20%	$25
Specialist Office Visit	Deductible then 20%	$50
Preventive Medical Services: Routine preventive screenings, well-baby/child, and women's preventive care	0% (Plan covers 100%)	0% (Plan covers 100%)
Hospital/Emergency		
Emergency Room	Deductible then 20%	$150
Urgent Care	Deductible then 20%	Facility: Ded then 20% PCP: $25 Specialist: $50
Inpatient Hospitalization Services	Deductible then 20%	Deductible then 20%
Outpatient Facility & Physician Charges	Deductible then 20%	Deductible then 20%
Prescription Drugs		
Tier 1	Deductible then 20%	$5
Tier 2	Deductible then 20%	$30
Tier 3	Deductible then 20%	$50
Tier 4	Deductible then 20%	$75
Deductibles and Maximums		
Individual Annual Deductible	$1,500	$500
Individual Annual Out-of-Pocket Maximum	$3,500	$2,500
Family Annual Deductible	$3,000	$1,000
Family Annual Out-of-Pocket Maximum	$7,000	$5,000

Health Savings Account

(You are only eligible for the Health Savings Account if you choose the Base HDHP HSA Plan)

An HSA is a tax-favored trust or account that can be contributed to by, or on behalf of, an eligible individual for the purpose of paying qualified medical expenses. For example, individuals can use their HSAs to pay for expenses covered under their HDHPs until their deductibles have been met, or they can use their HSAs to pay for qualified medical expenses not covered by their HDHPs, such as dental or vision expenses.

HSAs provide a triple tax advantage—contributions, investment earnings, and amounts distributed for qualified medical expenses are all exempt from federal income tax, Social Security/Medicare tax, and most state income taxes. Due to an HSA's potential tax savings, federal tax law includes strict rules for HSA contributions. **You are not eligible for a Health Savings Account if you are covered under other medical insurance that is non-HDHP, enrolled in Medicare, or eligible to be claimed as a dependent on another person's tax return.**

Contribution Limits

- For 2023, $3,850 for individuals with self-only coverage and $7,750 for individuals with family coverage.
- City of Southport will contribute $625 quarterly to employees Health Savings Accounts. The contribution will be made on the first day at the beginning of a quarter. These amounts combined with your individual amounts deposited cannot exceed the 2023 contribution limits.
- Individuals who are age 55 or older may make an additional $1,000 "catch-up" contribution to help save for retirement.

Contribution Rules

- For each month an individual is HSA-eligible, he or she may contribute one-twelfth of the applicable maximum contribution limit for the year. This limit is called the general monthly contribution rule. The applicable maximum contribution limit depends on whether the individual has self-only HDHP coverage or family HDHP coverage on the first day of the month.
- The full-contribution rule is an exception to the general rule that the maximum amount of HSA contributions for a year is determined monthly, based on the individual's HSA eligibility for that month. The full-contribution rule applies regardless of whether the individual was an eligible individual for the entire year, had HDHP coverage for the entire year, or had disqualifying non-HDHP coverage for part of the year. However, an individual who relies on this special rule must generally remain HSA-eligible during a 13-month testing period, with exceptions for death and disability. The full-contribution rule applies to both the general monthly contribution limit and to the additional HSA catch-up contribution limit for eligible individuals who reach age 55 by the end of the year.
- A special contribution limit applies to married spouses when either spouse has family HDHP coverage.

Qualified Medical Expenses

QMEs include the costs of diagnosis, cure, mitigation, treatment or prevention of disease and the costs for treatments affecting any part or function of the body. These expenses include payments for medical services rendered by physicians, surgeons, dentists and other medical practitioners. They include the costs of equipment, supplies and diagnostic devices needed for these purposes. For a complete list of qualified medical expenses, please refer to IRS Code Section 213(d).

Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Dental Benefits

Companion Dental Benefits*	
Type 1 Procedures: Diagnostic & Preventative Services	**100% UCR** • Oral exams • Cleanings – 2 per 12 months • Bitewing X-rays – 1 per 12 months • Space Maintainers • Pain Treatment
Type 2 Procedures: Basic Services	**80% UCR** • Fillings • Anesthesia • Simple & Surgical Extractions • Endodontics • Oral Surgery • Periodontics
Type 3 Procedures: Major Services	**50% UCR** • Crowns • Inlays • Onlays • Dentures • Bridges • Implants • Perio Trays
Type 4 Procedures: Orthodontia Services	**50% UCR** $1,000 Lifetime Maximum Dependent Child(ren) up to age 19
Plan Year Deductible	$50 Per Individual $150 Per Family
Plan Year Maximum	$1,000

*This is a summary of benefits only. Please refer to the policy for comprehensive benefit details. Payment is based upon allowable charges in the area in which the service is rendered. Any dentist charge above the allowable charge is not a covered expense.

Vision Benefits

Copays	
Exam	$10
Materials[1]	$20
Contact lens fitting (standard & specialty)	$25

Services/frequency	
Exam	12 months
Frame	12 months
Contact lens fitting	12 months
Lenses	12 months
Contact lenses	12 months

(based on date of service)

Benefits through Superior National network

	In-network	Out-of-network
Exam (ophthalmologist)	Covered in full	Up to $44 retail
Exam (optometrist)	Covered in full	Up to $39 retail
Frames	$140 retail allowance	Up to $56 retail
Contact lens fitting (standard[2])	Covered in full	Not covered
Contact lens fitting (specialty[2])	$50 retail allowance	Not covered
Lenses (standard) per pair		
Single vision	Covered in full	Up to $26 retail
Bifocal	Covered in full	Up to $34 retail
Trifocal	Covered in full	Up to $50 retail
Progressive lens upgrade	See description[3]	Up to $50 retail
Polycarbonate for dependent children	Covered in full	Not Covered
Contact lenses[4]	$120 retail allowance	Up to $100 retail

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] *Materials co-pay applies to lenses and frames only, not contact lenses*

[2] *Standard contact lens fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Specialty contact lens fitting applies to new contact wearers and/or a member who wear toric, gas permeable, or multi-focal lenses.*

[3] *Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay.*

[4] *Contact lenses are in lieu of eyeglass lenses and frames benefit*

Discount features

Discounts on covered materials[5]

These discounts apply to the glasses and contacts that are covered under the vision benefits.

Frames:	20% off amount over allowance
Conventional contacts	20% off amount over allowance
Disposable contact	10% off amount over allowance

Lens type*	Member out-of-pocket[5]
Scratch coat	$15
Ultraviolet coat	$12
Tints, solid	$15
Tints, gradient	$18
Polycarbonate	$40
Blue light filtering	$15
Digital single vision	$30
Progressive lenses	
Standard/Premium/Ultra/Ultimate	$55 / $110 / $150 / $225
Anti-reflective coating	
Standard/Premium/Ultra/Ultimate	$50 / $70 / $85 / $120
Polarized lenses	$75
Plastic photochromic lenses	$80
High Index (1.67 / 1.74)	$80 / $120

* The above table highlights some of the most popular lens type and is not a complete listing. This table outlines member out-of-pocket costs[5] and are not available for premium/upgraded options unless otherwise noted.

Discounts on non-covered exam, services and materials[5]

Exams, frames, and prescription lenses:	30% off retail
Contacts, miscellaneous options:	20% off retail
Disposable contact lenses:	10% off retail
Retinal imaging:	$39 maximum out-of-pocket

Laser vision correction (LASIK)[5]

Laser vision correction (LASIK) is a procedure that can reduce or eliminate your dependency on glasses or contact lenses. This corrective service is available to you and your eligible dependents at a special discount (20-50%) with your Superior Vision plan. Contact QualSight LASIK at (877) 201-3602 for more information.

Hearing discounts[5]

A National Hearing Network of hearing care professionals, featuring Your Hearing Network, offers Superior Vision members discounts on services, hearing aids and accessories. These discounts should be verified prior to service.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

North Carolina residents: Please contact our customer service department if you are unable to secure a timely (at least 30 days) appointment with your provider or need assistance finding a provider within a reasonable distance (30 miles) of your residence. Adjustments to your benefits may be available

[5]Not all providers participate in Superior Vision Discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if he/she offers the discount and member out-of-pocket features. The discount and member out-of-pocket features are not insurance. Discounts and member out-of-pocket are subject to change without notice and do not apply if prohibited by the manufacturer. Lens options may not be available from all Superior Vision providers/all locations.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.

Disability Benefits

Short-Term Disability with NC League of Municipalities

- Benefit amount is 60% of insured's weekly earnings
- Benefit is payable beginning the 8th day of accident and the 8th day of sickness.
- Maximum benefit period is 26 weeks.
- You must be actively working a minimum of 30 hours per week to be eligible for coverage.

Voluntary Long-Term Disability with One America

Option 1

- Benefit amount is 30% of insured's monthly earnings to a maximum of $3,000 per month.
- $100 minimum benefit.
- Elimination period of 180 days applies (no benefits paid during this time).
- Definition of disability is 24 Months Regular Occupation.
- Policy includes a 6 month look back for pre-existing conditions. Disabilities that occur within the first 12 months due to the pre-existing conditions are excluded.
- You must be actively working a minimum of 30 hours per week to be eligible for coverage.

Option 2

- Benefit amount is 60% of insured's monthly earnings to a maximum of $3,000 per month.
- $100 minimum benefit.
- Elimination period of 180 days applies (no benefits paid during this time).
- Definition of disability is 24 Months Regular Occupation.
- Policy includes a 6 month look back for pre-existing conditions. Disabilities that occur within the first 12 months due to the pre-existing conditions are excluded.
- You must be actively working a minimum of 30 hours per week to be eligible for coverage.

*If you declined coverage when you were first eligible you will need to submit a Statement of Insurability form for review. OneAmerica will then decide to approve or deny your coverage based on your health history.

To estimate your payroll deduction amount:

	Example*	Option 1	Option 2
1. Maximum covered monthly earnings	$10,000	$10,000	$5,000
2. Enter your monthly earnings	$2,500		
3. Enter the lesser of Step 1 or Step 2	$2,500		
4. Divide Step 3 by 100	$25		
5. Using your age as of 07/01, find the corresponding rate from the chart below	0.14		
6. Multiply Step 4 by your age rate	$3.50		
7. Multiply Step 6 by 12 and divide by 26 to determine your estimated payroll deduction amount	$1.62		

*Example based on a 35 year old electing option 1 earning $2,500 per month.

Age Category:	Option 1	Option 2
0 - 19	$.140	$.240
20 - 24	$.140	$.240
25 - 29	$.140	$.240
30 - 34	$.140	$.240
35 - 39	$.140	$.240
40 - 44	$.320	$.890
45 - 49	$.320	$.890
50 - 54	$.320	$.890
55 - 59	$.320	$.890
60 - 64	$.600	$1.670
65 - 69	$.600	$1.670
70 - 74	$.600	$1.670
75 +	$.600	$1.670

Basic Life/AD&D

Provided By NC League of Municipalities

- Flat benefit amount of $20,000
- Dependent Life is available in the following amounts:
  - Spouse Benefit: $2,500
  - Dependent Children Benefit
    - 14 days to 6 months-$1,000
    - 6 months to age 19 or to age 26 if full time student-$2,500
  - Dependent Life per pay period deduction is $0.53 bi-weekly (24).
- Basic life reduces as you age with first reduction at age 65.
- Includes Conversion Privilege.
- You must be actively working a minimum of 30 hours per week to be eligible for coverage.

Voluntary Term Life/AD&D

Provided By Companion

- Employee may choose increments of $5,000 up to a maximum of $500,000. Benefit amount cannot exceed 7 times annual salary.
- Employee's spouse may elect coverage in increments of $5,000 up to a maximum of $150,000. Spouse's benefit cannot exceed 50% of employee's benefit amount.
- Employee & Spouses voluntary life/ad&d reduce with age, first reduction starts at age 65.
- Employee may also elect dependent child coverage in the amounts of $2,500, $5,000, $7,500 or $10,000. Benefit amount cannot exceed 100% of the employee's benefit. AD&D coverage is not available for children. Rate is $0.25 per $1,000 per month.
- Employee must elect coverage for dependents to be eligible.
- You must be actively working a minimum of 30 hours per week to be eligible for coverage. Your dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26.
- Includes Conversion Privilege and Portability.
- Evidence of insurability form is required for late entrants and employees who elect over the guaranteed issue. Guaranteed issue for newly eligible employees under age 70 is $125,000. Newly eligible spouse's under age 70 is $50,000. Children's guaranteed issue is 100% of the employee's benefit, up to $10,000.

Age Category	Monthly Premium Rate per Thousand Dollars of Insurance Coverage	Coverage Amount and Monthly Premium						
	Rates per $1,000	$10,000	$25,000	$50,000	$75,000	$100,000	$150,000	$200,000
Under 30	$0.12	$1.20	$3.00	$6.00	$9.00	$12.00	$18.00	$24.00
30-34	$0.13	$1.30	$3.25	$6.50	$9.75	$13.00	$19.50	$26.00
35-39	$0.15	$1.50	$3.75	$7.50	$11.25	$15.00	$22.50	$30.00
40-44	$0.20	$2.00	$5.00	$10.00	$15.00	$20.00	$30.00	$40.00
45-49	$0.32	$3.20	$8.00	$16.00	$24.00	$32.00	$48.00	$64.00
50-54	$0.56	$5.60	$14.00	$28.00	$42.00	$56.00	$84.00	$112.00
55-59	$0.82	$8.20	$20.50	$41.00	$61.50	$82.00	$123.00	$164.00
60-64	$1.55	$15.50	$38.75	$77.50	$116.25	$155.00	$232.50	$310.00
65-69	$2.42	$24.20	$60.50	$121.00	$181.50	$242.00	$363.00	$484.00
70+	$4.44	$44.40	$111.00	$222.00	$333.00	$444.00	$666.00	$888.00

Worksite Benefits

Accident, Cancer, and Critical Illness with Bay Bridge Administrators

Accident

Accident coverage is supplemental coverage that can complement your health insurance and help cover your out-of-pocket expenses. When you carry this coverage, you are paid a total cash benefit that is based on the amount listed for each covered benefit and/or treatment, if you have a covered accident. Please see policy certificate for all plan details.

Health Screening Benefit: Benefit paid for eligible health screening tests - $100 (2 tests per insured per year)

Accident Indemnity	Premier	Premier Plus
Health Screening Benefit	$100 two per year	$100 two per year
Physicians Office/Urgent Care	$100	$200
Physician Follow up Visit	1/$75	2/$75
Emergency Room Treatment	$200	$300
X-Ray	$200	$300
Hospital Confinement	$1,000/$400	$2,000/$600
Intensive Care	$1,000/$200	$2,000/$300
Outpatient Surgical Facility	$250	$300
Ambulance	$200/$600	$400/$1,200
Fractures & Dislocations	Up to $2,000 closed Up to $4,000 open	Up to $4,000 closed Up to $8,000 open
Burns	$250 to $1,000	$500 to $2,000
Lacerations	$100	$200
Physical Therapy	10/$30	10/$40
Transportation/Lodging	$0.30 per mile/$100 per day	$0.30 per mile/$150 per day
Blood, Plasma & Platelets	$300	$500
Coma	$20,000	$40,000
Major Diagnostic Imaging	$100	$100
Accidental Death	$40,000 Employee $20,000 Spouse $20,000 Child(ren)	$60,000 Employee $30,000 Spouse $30,000 Child(ren)
Accidental Dismemberment	$7,500 Single $15,000 Multiple	$10,000 Single $20,000 Multiple
Coverage	Off-the-job Coverage	

Exclusions & Limitations

This is not a complete disclosure of plan qualifications and limitations. Benefits and riders may vary by state and may not be available in all states. In addition to any benefit-specific exclusion, benefits will not be paid for any loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following, unless coverage is specifically provided for by name in insurance certificate:

- An injury incurred while working for pay or profit (Off-Job coverage only);
- Intentionally self-inflicted injury, suicide, or any attempt or threat while sane or insane;
- Participating in war or any act of war whether declared or undeclared;
- Commission or attempt to commit a felony;
- Commission of or active participation in a riot, insurrection, or terrorist activity;
- Engaging in an illegal activity or occupation;
- Flight in, boarding, or alighting from an aircraft or any craft designed to fly above the earth's surface, including any travel beyond the earth's atmosphere except a fare-paying passenger on a regularly scheduled commercial or charter airline;
- Travel in or on any on-road and off-road motorized vehicle except a golf cart that does not require licensing as a motor vehicle;
- Practicing for or participating in any semi-professional or professional competitive athletic contest, including officiating or coaching, for which the covered person receives any compensation or remuneration;
- Sickness, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- Travel or activity outside the contiguous United States, Alaska, Hawaii and the territories and possessions of the United States, Canada, or Mexico;
- Voluntary ingestion or inhalation of any narcotic, drug, poison, gas, or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage;
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the State in which the covered accident occurred;
- Experimental or investigational procedures; and
- Care that is not recommended and approved by a physician

Coverage Levels	Bi-Weekly (24) Premium	
	Premier	Premier Plus
Employee Only	$7.47	$11.40
Employee + Spouse	$12.56	$18.66
Employee + Child(ren)	$14.84	$24.27
Family	$22.88	$37.28

Cancer

Your health and financial peace of mind are important. You and your loved ones can rest a little easier knowing you have extra financial protection in place when a critical health event occurs. Benefits are paid directly to you, placing you in control at a time when you may feel that your options are limited. See the benefit schedule for additional details. Please see policy certificate for all plan details.

Wellness Benefit: Pays $100 for you and your dependents for a wellness screening.

Cancer Plan Benefits	Premier	Premier Plus
First Occurrence Benefit	$5,000	$10,000
First Occurrence for insured dependent child under age 21	$7,500	$15,000
Reoccurrence Benefit	25% after 2 years, 50% after 5 years, 100% after 10 years	
Waiver of Premium	Yes	
Screening and Diagnostic Benefit		
Cancer Screening Benefit	$100	
Additional Invasive Diagnostic Benefit	$300	
Daily Hospital Confinement Benefit		
Confinements of 30 days or less	$100/day	
Confinements longer than 30 days	$200/Day	
Confinements for insured dependent child under age 21	$200/Day	
Monthly Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Expense Benefit		
Radiation/Chemotherapy/Immunotherapy	$1,000 per month	
Experimental Treatment	$1,000 per month	
Daily Self-Administered Chemotherapy or Immunotherapy Drugs Benefit		
Self-Administered by injection/8 per month	$250 per day	
Self-Administered by pump or implant/4 per month	$250 per day	
Self-Administered Drugs taken orally / 4 per month	$250 per day	
Surgical Expense Benefit		
Surgical Benefit	$1,000	
Anesthesia Benefit	30%	
Skin Cancer	Biopsy $125, Excision $350 with flap $750	
Medical Imaging and Medication Benefit		
Medical Imaging	$1,000 per year	
Anti-Nausea Medication Benefit	$150 per month	
Colony Stimulating Factors	$1,000 per month	

Hairpiece	Lifetime maximum $200
Rental or Purchase of Durable Goods	Pays up to $1,500 per calendar year
Home Health Care Expense Benefit	$100 per day / 60 days per year
Convalescent Care Facility Expense Benefit	$75 per day equal to days of confinement
Mental Health Consultation Benefit	$80 per session 50 sessions Lifetime maximum
Wheelchair Accessible Home Modifications	$2,000 Lifetime
Child Tutorial Benefit	$30 per 1 hour session 50 sessions Lifetime
Child Care Benefit	$60 per day 50 days Lifetime
Pet Boarding Benefit	$50 per day 30 days Lifetime
Specified Disease Benefit	
$1,500 initial hospital confinement, $100 per day first 30 days, $200 after 30 days	

Lump-Sum First-Occurrence Benefit

We will pay 100% of the selected benefit amount upon the first diagnosis of Cancer for a Covered Person while the coverage is in force. Each Covered Person is limited to one Cancer First-Occurrence benefit per lifetime. Applies to Covered "Cancer" only. Not payable for any Cancer diagnosed in first 12 months of coverage if the Cancer is a Pre-Existing Condition.

Pre-Existing Condition Limitation

Benefits will not be paid for any loss that is a Pre-Existing Condition, unless the Covered Person has satisfied the Pre-Existing Condition Limitation Period. A pre-existing condition is a condition, whether diagnosed or not, for which symptoms existed within the Pre-Existing Condition Limitation Period, or for which medical advice or treatment was recommended or received from a physician within the same period. No pre-existing condition limitation will be applied for dependent children who are born or adopted while the named insured is covered and who are continuously covered from the date of birth or adoption. Pre-Existing Limitation Period is [12] months prior to the coverage Effective Date applicable to the Covered Person.

Coverage Levels	Bi-Weekly (24) Premium	
	Premier	Premier Plus
Employee Only	$9.01	$10.52
Employee + Spouse	$16.39	$19.37
Employee + Child(ren)	$10.47	$12.29
Family	$18.09	$21.44

Critical Illness

This coverage pays a lump sum benefit following the diagnosis of a critical illness, such as a heart attack or stroke. Critical illness insurance is a supplemental coverage that can complement your health insurance and help cover out of pocket expenses. Please see policy certificate for all plan details.

Critical Illness Benefit: $10,000 or $20,000

Critical Illness Covered Conditions	Premier	Premier Elite
Heart Attack	100%	100%
Stroke	100%	100%
Major Organ Failure	100%	100%
End-Stage Renal Failure	100%	100%
Paralysis	100%	100%
Complete Loss of Sight	100%	100%
Complete Loss of Hearing	100%	100%
Coma	100%	100%
Benign Brain Tumor	100%	100%
Coronary Artery Disease (Bypass Surgery)	25%	25%
Advanced Alzheimer's Disease	25%	25%
Advanced Parkinson's Disease	25%	25%
Type I Diabetes		100%
Sudden Cardiac Arrest		25%
Angioplasty		10%
Infectious Disease		10%
Spouse and Children % of employee coverage	50%	100%

Additional Occurrence & Reoccurrences of the same Critical Illness

There is no wait between initial occurrences and different critical illnesses. Reoccurrences of the same critical illness can be paid six months after the initial critical illness.

Pre-Existing Conditions:

This coverage includes a 12/12 pre-existing condition limitation. The insured is given credit toward their pre-existing condition limitation period based on the length of time and amount of coverage they had with the prior carrier.

Exclusions & limitations

This is not a complete disclosure of plan qualifications and limitations. Benefits and riders may vary by state and may not be available in all states. In addition to any benefit specific exclusion, benefits will not be paid for any loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following, unless coverage is specifically provided for by name in insurance certificate:

- A specified health event for insured or covered spouse or for a specified health event for covered dependent child(ren) occurring prior to the effective date of coverage for a covered person;
- Any condition not specifically listed as a specified health event for insured or covered spouse or for a specified health event for covered dependent child(ren);
- Suicide or attempt at suicide, or intentional self-inflicted injury or sickness;
- Participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician or taken according to the physician's Instructions) or while intoxicated as defined by the law of the jurisdiction in which the cause of the loss occurs;
- Use of alcohol, drugs or narcotics;
- Commission of or attempt to commit an assault or felony;
- Engaging in an illegal activity or occupation; or
- Declared war or any act of declared war.

Premier Plan:

$10,000	Non-Tobacco	Semi Monthly (24)		
Age Band	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
< 30	$1.45	$1.92	$1.65	$2.12
30-39	$2.59	$3.64	$2.79	$3.84
40-49	$4.76	$6.89	$4.97	$7.10
50-59	$9.15	$13.47	$9.35	$13.68
60-64	$13.30	$19.70	$13.50	$19.90
65-69	$16.30	$24.19	$16.50	$24.39
70+	$19.62	$29.18	$19.82	$29.38

$10,000	Tobacco	Semi Monthly (24)		
Age Band	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
< 30	$2.10	$2.89	$2.44	$3.23
30-39	$4.03	$5.79	$4.36	$6.13
40-49	$7.68	$11.27	$8.02	$11.61
50-59	$15.07	$22.36	$15.41	$22.70
60-64	$22.07	$32.85	$22.41	$33.19
65-69	$27.11	$40.42	$27.45	$40.76
70+	$32.72	$48.83	$33.06	$49.17

$20,000	Non-Tobacco	Semi Monthly (24)		
Age Band	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
< 30	$2.39	$3.34	$2.80	$3.74
30-39	$4.68	$6.78	$5.09	$7.18
40-49	$9.03	$13.29	$9.43	$13.69
50-59	$17.80	$26.45	$18.20	$26.85
60-64	$26.10	$38.90	$26.50	$39.30
65-69	$32.09	$47.88	$32.49	$48.29
70+	$38.74	$57.86	$39.15	$58.26

$20,000	Tobacco	Semi Monthly (24)		
Age Band	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
< 30	$3.69	$5.28	$4.37	$5.96
30-39	$7.55	$11.07	$8.23	$11.75
40-49	$14.86	$22.04	$15.54	$22.72
50-59	$29.65	$44.22	$30.32	$44.90
60-64	$43.63	$65.19	$44.31	$65.87
65-69	$53.73	$80.34	$54.40	$81.02
70+	$64.93	$97.15	$65.61	$97.83

*Spouse covered at 50% and child(ren) covered at 50% of the employee

Premier Elite:

$10,000	Non-Tobacco	Semi Monthly (24)		
Age Band	Employee	Employee & Spouse	Employee & Child(ren)	Family
< 30	$2.10	$3.71	$3.52	$5.13
30-39	$3.32	$6.14	$4.74	$7.56
40-49	$5.70	$10.90	$7.12	$12.32
50-59	$10.61	$20.72	$12.03	$22.14
60-64	$15.38	$30.25	$16.80	$31.67
65-69	$19.20	$37.90	$20.62	$39.32
70+	$22.65	$44.80	$24.07	$46.22

$10,000	Tobacco	Semi Monthly (24)		
Age Band	Employee	Employee & Spouse	Employee & Child(ren)	Family
< 30	$3.20	$5.90	$5.60	$8.29
30-39	$5.25	$10.00	$7.65	$12.39
40-49	$9.26	$18.02	$11.66	$20.42
50-59	$17.54	$34.57	$19.93	$36.97
60-64	$25.57	$50.63	$27.96	$53.02
65-69	$32.01	$63.51	$34.40	$65.91
70+	$37.82	$75.13	$40.21	$77.53

$20,000	Non-Tobacco	Semi Monthly (24)		
Age Band	Employee	Employee & Spouse	Employee & Child(ren)	Family
< 30	$3.71	$6.91	$6.55	$9.75
30-39	$6.14	$11.78	$8.98	$14.62
40-49	$10.90	$21.30	$13.74	$24.14
50-59	$20.72	$40.94	$23.56	$43.78
60-64	$30.25	$60.00	$33.09	$62.84
65-69	$37.90	$75.30	$40.74	$78.14
70+	$44.80	$89.09	$47.64	$91.93

$20,000	Tobacco	Semi Monthly (24)		
Age Band	Employee	Employee & Spouse	Employee & Child(ren)	Family
< 30	$5.90	$11.30	$10.69	$16.09
30-39	$10.00	$19.50	$14.79	$24.29
40-49	$18.02	$35.54	$22.81	$40.33
50-59	$34.57	$68.64	$39.36	$73.43
60-64	$50.63	$100.76	$55.42	$105.54
65-69	$63.51	$126.53	$68.30	$131.31
70+	$75.13	$149.77	$79.92	$154.55

*Spouse covered at 100% and child(ren) covered at 100% of the employee

Accident and Cancer Wellness Benefit

Accident Health Screening Benefit: Benefit paid for eligible health screening tests - $100 (2 tests per insured per year).

Cancer Wellness Benefit: Pays $100 for you and your dependents for a wellness screening.

Submitting your claim: Submit your claim the way you like. Mail, phone, email or fax your claim to:

Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

Phone: 1-800-845-7519
Email: claims@bbadmin.com
Fax: 512-275-9359

Employee Assistance Program

Employee Benefit Summary
EAP/Work-Life Program

The Employee Assistance Program is a voluntary short-term counseling and referral service designed to help with personal, job or family related concerns. Employees and eligible Family Members (spouse and dependents in household) can access short-term problem resolution sessions that aim to identify, resolve and gain control over personal problems that may be interfering with work and daily life.

Services are confidential and free!

Some common concerns the EAP can help with:

- Stress, Anxiety, Depression
- Life Transitions
- Grief & Loss
- Divorce / Separation
- Conflict Resolution
- Substance Abuse
- Work-Life Counseling

DEDICATED TOLL FREE HELP LINE

- 24 hours a day
- 7 days a week
- 365 days a year

DIAGNOSTIC ASSESSMENT AND PROBLEM RESOLUTION SESSIONS

- If referral services are required, they will be coordinated with existing health insurance benefits should long-term treatment be recommended *(deductibles and co-pay may apply)*

LEGAL CONSULTATIONS

- Employees / Family Members are eligible to receive one initial 30 minute telephonic consultation on separate legal matters at no cost (Employment Law excluded)
- If the attorney is retained beyond the initial consultation, a 25% discount will be applied

ADDITIONAL COUNSELING BENEFITS

- Employees / Family Members are eligible to receive one telephonic diagnostic assessment & up to 5 face-to-face short-term problem resolution sessions (as clinically appropriate.)

FINANCIAL CONSULTATIONS

- Employees / Family Members are eligible to receive one initial telephonic consultation on separate financial issues at no cost
- Consultation is generally limited to between 30-60 minutes
- 25% discount for services beyond initial consultation

ONLINE WORK-LIFE EAP RESOURCES

www.my-life-resource.com

Username: **hmsa**
Password: **myresource**

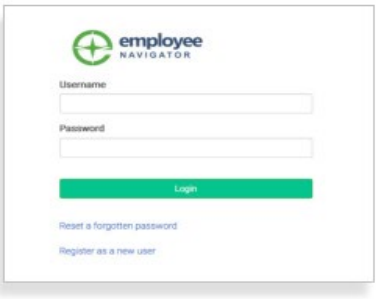
ONLINE RESOURCES AVAILABLE *(but not limited to):*

- Additional Legal and Financial Tools
- Online Seminars
- Childcare Service Locators
- Eldercare Resources
- Health and Wellness Resources
- 1,000+ Articles

1-800-847-7240

Employee Navigator

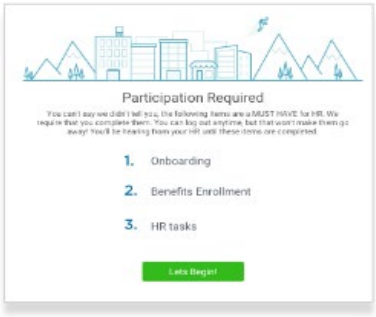
How to Enroll in Benefits



Step 1: Log In

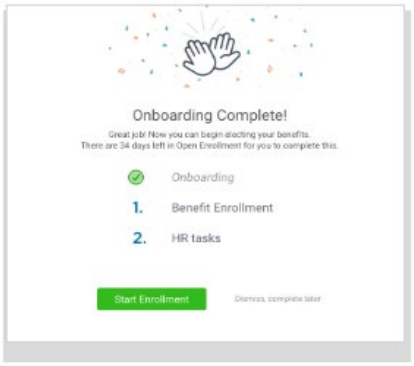
Go to www.employeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

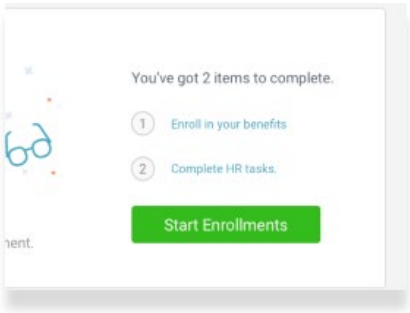


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP

if you hit "**Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**



Step 4: Start Enrollments

After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

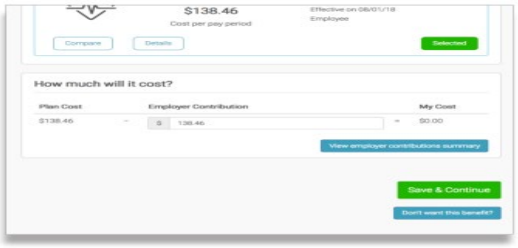
TIP

Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.



Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Review & Confirm Elections

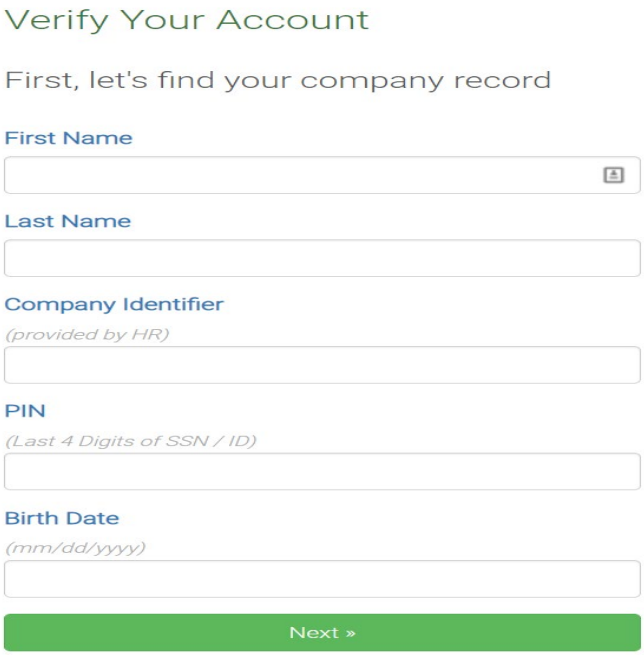
Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

Scan the QR code below with your smart phone to access your online benefit enrollment system, Employee Navigator.

You will be asked to create a Username and password in order to complete your account registration (See screenshot below). **Your Company Identifier is SOUTHPORT.**



Newborn and Mothers Health Protection Act of 1996

Under the Newborn and Mothers Health Protection Act of 1996, Group Health Plans that provide benefits for childbirth must annually notify all participants of this act. Mothers and their newborn children are permitted to remain in the hospital for 48 hours after a normal delivery or 96 hours following a cesarean section. However, an attending provider may discharge a mother or her newborn earlier than 48 hours, or 96 hours in the case of a cesarean section, if he or she makes this decision in consultation with the mother.

Under the Newborn and Mothers Health Protection Act provisions, the time limits affecting the stay begin at the time of delivery, if the delivery occurs in a hospital. If a delivery occurs outside the hospital, the stay begins when the mother or newborn is admitted in connection with the childbirth. Whether the admission is in connection with childbirth is a medical decision to be made by the attending provider. A health plan may not require that a health care provider obtain authorization from the plan for all or part of the hospital stay required under the Newborn and Mothers Health Protection Act provisions. But, the rules do provide that plans may require pre-certification for the entire length of the hospital stay. Under the Newborn and Mothers Health Protection Act, an attending provider is defined as an individual who is licensed under applicable state law to provide maternity or pediatric care to a mother or newborn child. Therefore, attending providers could include physicians, nurse midwives, and physician's assistants. Attending providers do not include health plans, hospitals, and managed care organizations.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance 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 another employer stops contributing toward your or your dependents' other coverage). Should you choose to do this, you must request enrollment within 31 days* after your or your dependents' other coverage ends (or after the other employer stops contributing toward the coverage). 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. Should you choose to do this, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 was passed into law on October 21,1998 amending the Employee Retirement Income Security Act of 1974 (ERISA). The law requires plans which provide mastectomy coverage to provide notice to individuals of their rights to benefits for breast reconstruction following a mastectomy.

Your Plan currently provides coverage for a mastectomy and reconstructive breast surgery following a mastectomy. Benefits for medical and surgical treatment for reconstruction in connection with a mastectomy are further clarified as follows according to the requirements of the Women's Health and Cancer Rights Act of 1998:

1) reconstruction of the breast on which the mastectomy has been performed;
2) surgery and reconstruction of the other breast to produce symmetrical appearance; and
3) coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient.

These benefits will be paid at the same benefit level as other benefits payable under the Plan.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

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

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

COBRA Continuation Coverage

A federal law known as The Consolidated Omnibus Reconciliation Act (COBRA) requires that most employers sponsoring group healthcare plans offer employees and their families the opportunity for a temporary extension of healthcare coverage (called continuation coverage) at group rates in certain instances where coverage under the terms of the plan would otherwise end. This notice is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

If you are an employee of City of Southport and are covered by its group healthcare plan, you have a right to choose this continuation coverage if you lose your group healthcare coverage under the terms of the plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you are the spouse of an employee and are covered by the group healthcare plan, you have the right to choose this continuation coverage if you lose your group healthcare coverage under the terms of the healthcare plan for any of the following reasons:

- The death of your spouse.
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment.
- Divorce or legal separation from your spouse.
- Your spouse becomes entitled to Medicare.

In the case of dependent children of an employee covered by the group healthcare plan, they have the right to continuation coverage if group healthcare coverage under the terms of the healthcare plan is lost for any of the following reasons:

- The death of a parent.
- A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment.
- Parent's divorce or legal separation.
- A parent becomes entitled to Medicare.
- The dependent ceases to be a dependent child under the terms of the health plan.

Individuals described above who are entitled to COBRA continuation coverage are called qualified beneficiaries. If a child is born to a covered employee or if a child is, before age 18, adopted by or placed for adoption with a covered employee during the period of COBRA continuation coverage, the newborn or adopted child is a qualified beneficiary. These new dependents can be added to COBRA coverage upon timely notification to the Plan Administrator in accordance with the terms of the group healthcare plan. Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing dependent status under the terms of the healthcare plan. This information must be provided within 60 days of the later of the event or the date on which coverage would end under the terms of the Plan because of the event. If the information is not

provided within 60 days, rights to continuation coverage under COBRA will end. The employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours or Medicare entitlement.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the later of the date you are notified of your rights or the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group healthcare coverage will end. COBRA continuation coverage is not available to any covered individual if coverage is lost due to termination of employment for gross misconduct. If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. Any changes made to the healthcare plan for similarly situated employees or family members will also apply to the individual who chooses COBRA continuation coverage. The terms of the coverage are governed by the plan documentation, which is available upon request from the Plan Administrator in the event you have misplaced your documentation. The law requires that you be given the opportunity to maintain continuation coverage for up to three years unless you lost group healthcare coverage because of your termination of employment (except for gross misconduct) or reduction of hours. If such termination or reduction of hours is the reason for your loss of coverage, the required continuation coverage period is up to 18 months. This 18-month period may be extended to 36 months if other events (such as death, divorce or the employee's Medicare entitlement) occur during the 18-month period. If the covered employee becomes entitled to Medicare less than 18 months before a qualifying event that is termination of employment or reduction of hours, then qualified beneficiaries other than the covered employee may receive continuation coverage for up to 36 months measured from the covered employee's Medicare entitlement.

The 18-month continuation coverage period applicable to termination (except for gross misconduct) or to reduction of hours may be extended to up to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration and before the end of the 18-month continuation period. If the above requirements are satisfied, the continuation coverage for all qualified beneficiaries may be continued for up to an additional 11 months beyond the end of the initial 18-month period. A higher monthly premium (150 percent of the applicable premium used to determine regular COBRA rates) will be required. The Plan Administrator also must be notified within 30 days after the date of any final determination of the Social Security Administration that the disability no longer exists, if such a determination is made before the end of the 29-month continuation coverage period.

Continuation coverage will be cut short for any of the following reasons:

- The employer no longer provides group healthcare coverage to any of its employees.
- The premium for your continuation coverage is not made on time.
- You become covered under another group healthcare plan that does not contain any exclusion or limitation with respect to any pre-existing condition you have.
- You become entitled to Medicare.
- In the case of the 29-month continuation coverage period for the disabled, the cessation of disability.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all or part of the premium, plus a 2 percent administration fee, for your continuation coverage. As explained above, higher rates apply to the 11-month extension due to disability. There is a grace period of 30 days for payment of the regularly scheduled premium. In addition, upon the expiration of the 18-month or 36-month continuation coverage periods, you will be allowed to enroll in an individual conversion plan if conversion is provided under the terms of the healthcare plan.

Notice for group health plans that provide prescription drug coverage to Medicare Part D eligible individuals

Medicare Part D Creditable Coverage Notice

Important Notice from City of Southport 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 offered by the group health plan through City of Southport and about your portions 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. City of Southport has determined that the prescription drug coverage offered by the medical plan through City of Southport 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (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 coverage through City of Southport will not be affected. You can keep this coverage if you elect Part D, and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

The prescription drug plan option available in conjunction with the medical program is outlined below:

Prescription Drug Type:	Prescription Drug Program HDHP HSA Plan	Prescription Drug Program Buy Up Plan
Tier 1	Deductible then 20% per 30 day supply	$5 per 30 day supply
Tier 2	Deductible then 20% per 30 day supply	$30 per 30 day supply
Tier 3	Deductible then 20% per 30 day supply	$50 per 30 day supply
Tier 4	Deductible then 20% per 30 day supply	$75 per 30 day supply

If you decide to join a Medicare drug plan and drop your current group health coverage through City of Southport, be aware that you and your dependents will be able to get this coverage back, subject to the terms and requirements of such group medical 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 group health coverage through City of Southport 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 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 City of Southport 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.

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, 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: July 1, 2023
Name of Entity/Sender: City of Southport
Contact- Position/Office: Patti Fortuna
Address: 1029 N Howe Street, Southport, NC 28461
Phone Number: (910) 457-7910

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year (adjusted to 9.56% for 2018), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Teresa Parker-Mosley.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer name City of Southport		**2. Employer Identification Number (EIN)** 56-6001338
3. Employer address 1029 N. Howe Street		**4. Employer phone number** (910) 457-7910
5. City Southport	**6. State** NC	**7. ZIP code** 28461
8. Who can we contact about employee health coverage at this job? Patti Fortuna		
9. Phone number (if different from above)	**10. Email address** pfortuna@cityofsouthport.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] Some employees. Eligible employees are: All full time employees working 30 or more hours per week.
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are: Legal spouse & children to age 26.

[x] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.

Allowed Amount This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance Your share of the costs of a covered health care service, calculated as a percentage (for example 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Complications of Pregnancy Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency caesarean section generally aren't complications of pregnancy.

Copayment A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are the copayments, deductibles, and coinsurance. Family cost sharing is the share of the cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000 your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible.)

Diagnostic Test Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME) Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care/Emergency Services Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services Health care services that your plan doesn't pay for or cover.

Formulary A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance A complaint that you communicate to your health insurer or plan.

Habilitation Services Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Copayment A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing base on income; and choose a plan and enroll in coverage.

Maximum Out-of-pocket Limit Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverages.

Minimum Value Standard A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider) A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider".

Orthotics and Prosthetics Leg, arm, back and neck braces, artificial legs, arms and eyes, and external breast prostheses after mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance Your share (for example 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment A fixed amount (for example, $30) you pay for covered health care services from providers who do *not* contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider) A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit

never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy", or "health insurance".

Preauthorization A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes call prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium The amount that must be paid for your health insurance or plan. You and/or your employer usually pay in monthly, quarterly, or yearly.

Premium Tax Credits Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service) Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider And individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by law.

Reconstructive Surgery Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Specialty Drug A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable) The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Plans Arranged By:

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