2018 *Living Well* Resource Guide

Benefits and resources designed to help you live a balanced life

IMPORTANT NOTICE: This document serves as a summary of material modification to your 2018 benefit plans.

This Resource Guide includes links to help you access information quickly. Click on the bar at the top to go to a section. Click on the arrows at the bottom of the page to go to another page. Click a Web address to go to the site.

Personalized benefits and resources.

McLeod understands that not everyone has the same needs, desires or life goals. That's why we created the *Living Well* program, which offers a wide variety of employee benefits, support and developmental programs designed to help you create balance in your work and personal life.

Options that promote your well-being.

Living Well gives you the opportunity to select the benefits and resources that work for you. Take advantage of the unique and comprehensive framework *Living Well* provides to support your well-being.

Learn. Choose. Live well.

Eligibility

Child

The term "child" means your or your spouse's:

- Biological child
- Legally adopted child, including child(ren) placed with you for the purpose of adoption;
- Stepchild
- Child(ren) for whom you or your spouse are legal guardians (with appropriate documentation), or
- Child(ren) for whom you are required to provide insurance coverage under a Qualified Medical Child Support Order (QMCSO).

For you

You are eligible for most benefits if you are budgeted to work 40 hours or more per pay period. You are eligible for full-time employee rates for all benefits if you are budgeted to work 72 hours or more per pay period. However, to comply with the Affordable Care Act, employees budgeted 60+ hours per pay period are eligible to elect medical insurance at full-time employee rates.

For your dependents

Dependents who are eligible for benefits coverage include your:

- Legal spouse or common-law spouse (with completed affidavit) as recognized by South Carolina.
- Child up to age 26, regardless of marital, student, or tax-dependent status.
- Physically or mentally dependent child who is unable to care for themselves, or an unmarried, disabled child of any age who resides with you and who was medically certified as disabled prior to their 26th birthday and who is primarily dependent upon you for support (with appropriate legal documentation).

Verifying eligible dependents

McLeod Health partners with Businessolver to gather dependent verification documents, a process that ensures that only eligible dependents are covered on our insurance plans. If you are adding a dependent to your medical plan and they were not previously covered on your benefits, you will receive further instructions from Businessolver about acceptable documents and how to submit them.

The most common acceptable types of documents include:

Spouse documentation

- Marriage Certificate
- Page 1 of your most recent state or federal tax return listing both you and your spouse

Dependent child(ren) documentation

- Long Form Birth Certificate
- Adoption papers
- Legal Guardianship Document

Documentation must be submitted to Businessolver within 30 days from the date of request in order to prevent a loss of coverage from the enrollment date for your unverified dependents.

The Dependent Verification Process is under the same strict privacy and protection requirements as HIPAA. Your information, and that of your family, will be kept in the strictest of confidence. Once your dependent information has been verified, it will be destroyed. The Dependent Verification Center has implemented technology, security features, and strict policy guidelines to safeguard the privacy of your individually identifiable information from unauthorized access or improper use.

Please contact Businessolver at **844.436.7172** if you need assistance with the dependent verification process or to request a complete list of eligible documents.

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Enrolling for benefits

You are eligible to enroll in or make changes to McLeod's benefit programs if you:

- **Are a new hire or newly eligible for benefits.** You have **31 days** from your eligibility date to enroll in or decline coverage to avoid being placed in default coverage.
- **Are currently enrolled in McLeod's benefit programs.** You can make changes to your benefit elections each fall during the Annual Enrollment period.
- **Have a qualifying work/life event during the year.** You can make appropriate changes to your benefits if you notify Businessolver within 31 days of the event.

Three ways to enroll

You can enroll for McLeod benefits in one of the following ways:

- **Computer:** Go to *Living Well On-line* or www.McLeodLivingWell.com from any computer.
- **Mobile App:** Use the **MyChoice** mobile app. For more information log into Businessolver.
- **Phone:** Call Benefits Enrollment Counselor at **844.436.7172**, Monday – Friday, 8:00 a.m. – 8:00 p.m.

How to access *Living Well On-line*

Benefit Enrollment

Using a McLeod work computer

- Go to the Compass Home Page.
- Click the *Living Well On-line* link in the center panel.
- Click on the *Benefit Enrollment* icon.

Using your personal computer

- Make www.mcleodhealth.org in Internet Explorer (IE) a Trusted Site.
- Set the Site Security Level to Low. While IE is open, select *Tools* > *Internet Options* > *Security* > *Trusted Sites* > *Sites.*
- In the website field box, type in: www.mcleodhealth.org. Make sure the Require Server Verification box is not checked. Click *Close.*
- Set the Security Level to Low. Click *Apply.*
- Go to www.mcleodhealth.org and click on *Living Well* Login located at the bottom of the screen.
- Enter your McLeod network User ID and Password.
- Allow your computer to install Citrix. Once your IE browser has been configured and you enter the URL (above), your workstation will go through an initial install of a Citrix web client. Just follow the prompts. You will see the installation process taking place on your screen. After this initial installation of the Citrix web client, no further action is necessary.
- Once logged in, you will see the *Living Well On-line* icon.
- Enter your McLeod network User ID and Password (again)
- Click on *Benefit Enrollment* icon

If you have difficulty accessing *Living Well On-line*, please contact the Information Systems Help Desk at **843.777.2288**, or the HR Service Center at **843.777.2595**. For priority service, have your employee ID number available.

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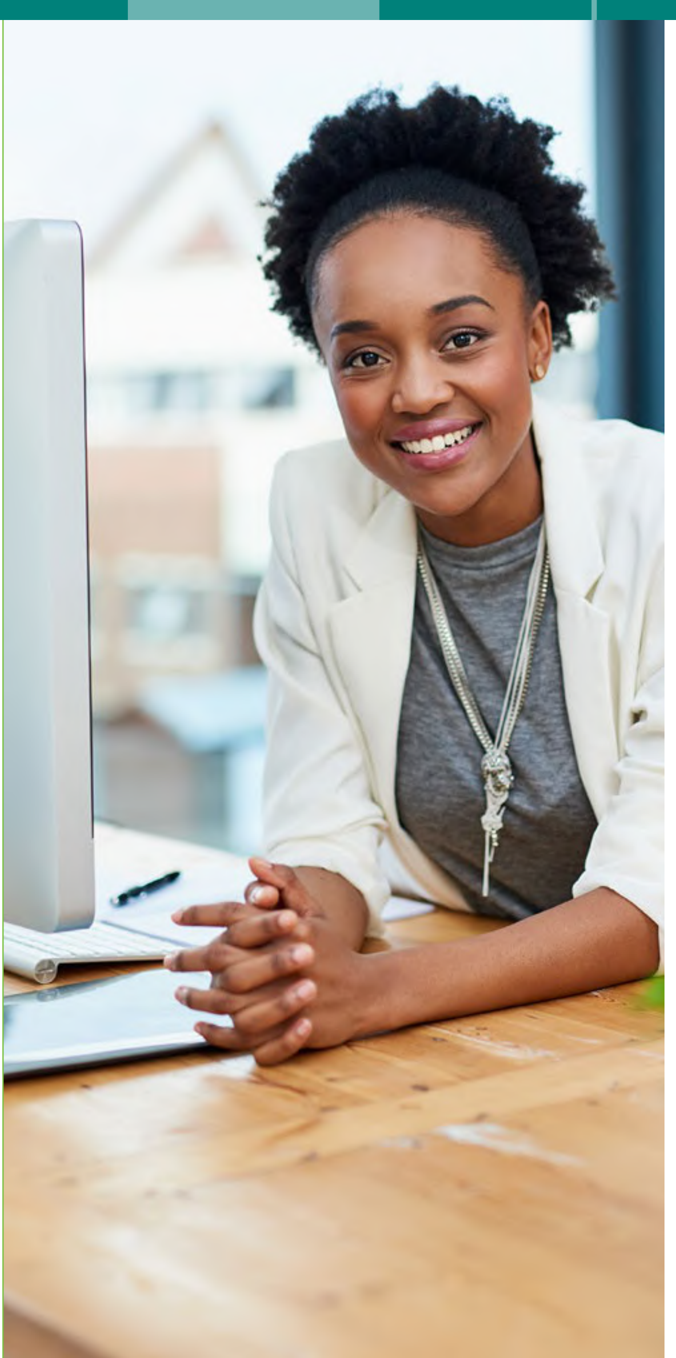

What is *Living Well On-line*?

Living Well On-line is an Employee Self-Service (ESS) System located on the home page of the Compass, our intranet and it helps you keep track of your benefit selections and other personalized information.

Living Well On-line is your go-to source for access to:

- Personal information
- Pay stubs, pay history, and W-2's
- PTO balances
- Employment history
- Job profile information
- Emergency contact information
- Links to vendor sites
- Policies and procedures
- Benefit plan documents
- *Living Well* newsletters
- PTO Sell Request, during eligible dates
- New hire and Annual Enrollment benefit elections
- Verifying employment

If have questions about McLeod's benefits and programs, call the HR Service Center at **843.777.2595**.

Verifying employment

McLeod has made it simple to obtain your own Verification of Employment documentation through *Living Well On-line*. This is where you can access your job profile information on McLeod letterhead, obtain W-2 forms, check stubs, or instructions on how to submit government forms for completion. Our system can be used for verifications of employment and income as needed.

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When your coverage begins

The benefits you elect each fall during the Annual Enrollment period will begin on January 1 of the following year if you are considered actively at work and in a benefits-eligible status on that day.

- **If you are a newly benefits-eligible employee,** your coverage will begin the first of the month following or coinciding with your start date or the date you change to a benefits-eligible status.
- **If you have a qualifying work/life event during the year,** the effective date of benefit changes will depend on the type of qualifying event.

When your coverage ends

Most of your benefit coverages may end and you will be offered coverage through COBRA when:

- Your budgeted hours are changed to less than 20 hours per week.
- Your employment ends for any reason other than gross misconduct.
- You exhaust or are not eligible for a Family Medical Leave.
- You stop paying your share of the premiums.

Your dependent(s) coverage ends and COBRA coverage will be offered the:

- Day your coverage ends.
- Day the dependent is no longer eligible.
- Last day of the month that a dependent child turns 26.

Choosing the coverage you need

When you enroll for benefits, you have the option to choose the level of coverage you need. Dependents may only be covered under the plan you elect for yourself. The coverage levels available for most benefit plans are:

- Employee Only
- Employee + Child(ren)
- Employee + Spouse
- Family
- Decline coverage

ID cards

Depending upon your benefit elections, you will receive separate ID cards from each of the following vendors after you enroll:

- **BCBSSC:** Medical, Prescription Drug Plan and Dental Plan*
- **Physicians Eyecare Plan (PEP):** Vision
- **WageWorks:** Flexible Spending Card
- **HSA Bank**

**If you are enrolled in a medical, prescription drug and dental plan, you will get one combined ID card.*

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When you become benefits-eligible during the year

If you change to a benefits-eligible status during the year, you will become eligible for benefits the first of the month following or coinciding with the status change. To be sure your deductions begin on time and you have coverage when you need it, be sure to enroll within 14 days of a status change. However, you will have 31 days from the date you are eligible to enroll in benefits. All applicable pre- and post-tax payroll deductions for the benefits you elect will begin on the first paycheck of the effective month.

What happens if you don't enroll

If you do not enroll for benefits within 31 days of your eligibility date, you will be defaulted into the coverages below. You will be responsible for paying all benefit premiums from the date that they became effective. These deductions will be taken out of the first paycheck following your elections, or as soon as administratively feasible.

Benefits†	Budgeted (72+ hours per pay period)	Budgeted (40 – 71 hours per pay period)
Medical plan*	Core – Employee Only	Not eligible
Life insurance	1-times base pay (minimum $10,000)	1-times base pay (minimum $10,000)
STD & LTD	Basic – 50%	Not eligible
McLeod Health 401(k) Plan**	3% Contribution	3% Contribution

†All other benefit options will be considered waived.

**The tobacco surcharge will apply unless an affidavit and annual Tobacco Screening Test, resulting in negative results, is completed at Employee Health.*

***All eligible employees will be defaulted into the 3% contribution rate and will increase 1% each year, if no election is made.*

Changing benefits during the year

The Health Insurance Portability and Accountability Act (HIPAA) permits a special enrollment period to change your elected coverage mid-year if you have a qualifying life/work event, provided you notify Businessolver **within 31 days** of the event. Examples of qualified life/work events include:

- Change in your legal marital status—marriage, death of spouse, divorce, legal separation, or annulment.
- Change in your number of dependents including:
  - Birth or adoption of a child
  - The placement of a child with you for adoption
  - Your dependent child satisfying or ceasing to satisfy eligibility requirements for coverage
  - The death of your dependent child or spouse
  - A court order requires you to provide coverage for a child under a Qualified Medical Child Support Order (QMCSO).
- Change in your employment status or that of your spouse or dependent child to include beginning or termination of employment or changing from a non-benefits-eligible position to a benefits-eligible position.
- Note: IRS regulations specify that an employee must actually obtain coverage under the spouse's or dependent's plan for the election change to be consistent. Sufficient proof of coverage will be required.

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Changing benefits during the year (continued)

- Significant change in coverage (e.g., a significant cost increase or reduction in coverage of your spouse's benefits). Only the election for health plan coverage may be changed mid-year due to a change in the cost of coverage.
- When a child is no longer eligible due to age, it is your responsibility to contact Human Resources. Coverage terminates the end of the month following the child's 26th birthday.

The change you make must be consistent with the life/work event. If such an event occurs, you must make changes **within 31 days** of the qualifying event. You will need to provide proof of the change, such as a marriage certificate, record of birth, spouse's employer information, etc.

Depending on the qualifying event, changes will become effective the first day of the month following the qualifying event. Coverage for newborns (including adopted children) is effective from the date of birth or adoption. Changes due to divorce become effective at the end of the month. Changes due to death become effective from the date of death.

Notify Businessolver at **844.436.7172 within 31 days** of any qualifying event. If you don't, you will not have the opportunity to make changes until the next Annual Enrollment period. All required documents must be returned to Businessolver **within 30 days** of the date you reported the change.

If a dependent no longer qualifies under the plan, (e.g. divorce or death, etc.) and you have not contacted Businessolver in a timely manner, the maximum premium refund you will be eligible to receive is up to three months.

> If you have a qualifying life/work event during the year, notify Businessolver at **844.436.7172** or log into *Living Well On-line* **within 31 days** of the qualifying event.

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Your benefits

Medical plan options

McLeod offers three medical plan options. All include prescription drug and behavioral health coverages.

Core Plan

About the Core Medical Plan

The **Core Plan Option** provides coverage competitive with other plans in the market at affordable rates. The McLeod Core Plan is a traditional preferred provider organization (PPO) insurance plan that covers most types of medical care, including physician office visits, inpatient hospital stays, outpatient services, and psychiatric and substance abuse. The Core Plan lets you receive care from the network provider of your choice. The highest level of coverage is available when you use services provided through the McLeod Network.

Enhanced Plan

About the Enhanced Medical Plan

The **Enhanced Plan Option** provides several coverage enhancements compared to the Core Plan, including lower annual deductibles, coinsurance and out-of-pocket maximums. However, you will pay a higher per-pay-period premium. When choosing a plan, be sure to estimate the anticipated benefits you receive to be sure it is worth the additional premium cost.

High Deductible Health Plan with Health Savings Account

About the High Deductible Health Plan

The **High Deductible Health Plan (HDHP)** is like the Core and Enhanced medical plans because you pay less from your pocket when you choose services from a McLeod provider or a BCBS in-network provider. It provides comprehensive medical and prescription drug coverage plus a way to save for health care expenses today and in the future—tax free—in a **Health Savings Account** (HSA).

The per-pay-period premiums are the same as with the Core Medical Plan, but the deductible and out-of-pocket maximums are highest with the High Deductible Health Plan. The trade-off is that you can save money in the HSA to pay for eligible medical expenses such as your deductible and out-of-pocket expenses.

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What is an HSA?

The Health Savings Account (HSA) is an account that helps you save money for eligible health care expenses—now and in the future. Money contributed to an HSA is completely tax-free when used for eligible health care expenses:

- No tax when the money goes into your account, which lowers taxable income so you pay less taxes today;
- No tax when the money comes out to pay for your eligible health care expenses;
- No tax on the money you earn when you invest your HSA contributions in mutual funds and other assets.

You can use the HSA to pay for eligible health care expenses, like prescription drugs, visits to the doctor, and even dental and vision care.

In addition to the tax advantages of the HSA, McLeod will put $1 into your HSA for every $1 you contribute, up to an annual maximum based on your coverage tier.

Health Savings Account

Full & part-time (budgeted 40+ hours per pay period)

Coverage level	McLeod maximum contribution	Your maximum contribution
Employee only	$250	$3,250
Family*	$500	$6,400

**Family coverage tier includes Employee + Spouse and Employee + Child(ren) coverage tiers.*

Are you eligible for the HSA?

You must enroll in the High Deductible Health Plan to be eligible for the HSA. In addition, you may NOT be eligible if:

- You or your spouse is participating in a Health Care Flexible Spending Account (Health Care FSA)
- You are enrolled in Medicare
- You are claimed as a dependent on another person's tax return
- You are a veteran who has received medical treatment through the Veterans Health Administration within the last three months (excluding all dental care, all vision care, preventive prescription drugs and preventive medical treatments for you or your children, or treatments received related to a disability incurred while in military service)

How to use your HSA

You will receive an HSA Bank debit card connected to your HSA account that you can use like any personal debit or credit card to pay for health care expenses directly. When using your HSA card, select the "pay as credit" option to avoid transaction fees. While you do not need to submit any receipts to HSA Bank, you must save your bills and receipts for tax purposes.

You can also pay out of pocket and request reimbursement from your account online via **My Health Toolkit** using the auto pay or pay claim by claim feature.

Any balance left in your HSA rolls over from year to year, and it's yours to keep.

Contact HSA Bank at 866.471.5946 or **https://myaccounts.hsabank.com** with questions.

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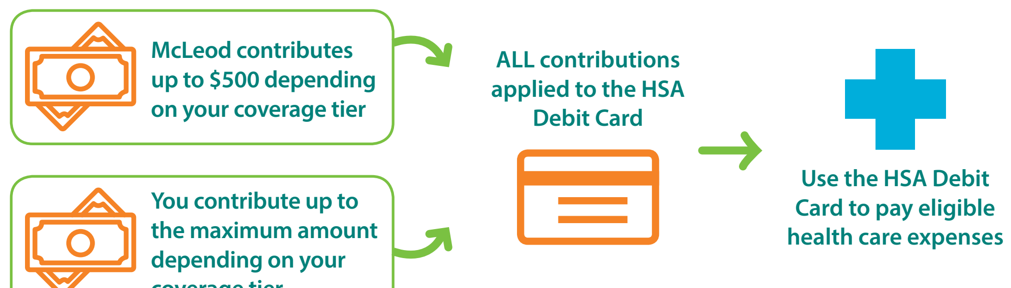
Eligible HSA expenses

You can use your HSA to pay for a variety of eligible health care expenses, including:

- Acupuncture
- Ambulance fees
- Artificial limbs
- Chiropractic care
- Dental visits
- Eyeglasses
- Health insurance premiums for long-term care or post-65 retiree coverage
- Medical equipment (including wheelchairs or modifying your living space for a disability)
- Medical plan deductibles and coinsurance
- Mental health care
- Nursing services
- Prescription drugs
- Prescription vision and hearing expenses
- Rehab (alcoholism)
- Transportation for essential medical care

For more information about eligible expenses, visit **www.irs.gov**.

How the HSA works



HSA saving advantages add up

- Unused funds remain in your account and can grow—with interest—from year to year.
- There are no "use it or lose it" rules for HSAs (like there are for FSAs). So, you can save your HSA funds for future health care needs—such as retiree medical expenses.
- An HSA allows you to save for the future—tax-free.
- The HSA is portable—you can take it with you when you leave or retire.
- The HSA is one way to fund eligible medical expenses before you become Medicare-eligible.
- And, when you take charge of your health and manage how your health care dollars are spent, you can keep more money in your HSA.

For more details about Health Savings Accounts, see Publication 969 at **www.irs.gov**.

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Medical plan options at a glance

Plan provisions	Core Plan		Enhanced Plan		HDHP Plan	
	BCBS Network	McLeod Network	BCBS Network	McLeod Network	BCBS Network	McLeod Network
Annual deductible	Employee $1,100 Family $3,050	Employee $850 Family $2,550	Employee $1,000 Family $2,800	Employee $700 Family $2,100	Employee $2,800 Family $5,600	Employee $2,000 Family $4,000
Annual deductible notes	Medical annual deductible is separate from the pharmacy plan.		Medical annual deductible is separate from the pharmacy plan.		Medical and pharmacy annual deductibles are combined.	
Annual out-of-pocket maximum	Employee $5,500 Family $11,000	Employee $4,600 Family $9,200	Employee $5,300 Family $10,600	Employee $3,600 Family $7,200	Employee $6,550 Family $13,100	Employee $6,550 Family $13,100
Annual out of pocket maximum notes	Medical annual out of pocket maximum is separate from the pharmacy plan.		Medical annual out of pocket maximum is separate from the pharmacy plan.		Medical and pharmacy annual out of pocket maximum are combined.	
McLeod HSA maximum contribution[1]	N/A		N/A		Employee only: Up to $250 Family[2]: Up to $500	
MD office visit – primary care	100% of allowable charges after $35 per visit copay – No deductible	100% of allowable charges after $35 per visit copay – No deductible	100% of allowable charges after $35 per visit copay – No deductible	100% of allowable charges after a $35 per visit copay – No deductible	100% of allowable charges after $35 per visit copay and deductible	
MD office visit – specialist	70% of allowable charges after deductible	100% of allowable charges after $50 per visit copay – No deductible	75% of allowable charges after deductible	100% of allowable charges after $50 per visit copay – No deductible	70% of allowable charges after deductible	80% of allowable charges after deductible
McLeod Telehealth	100% of allowable charges after $35 per visit copay- No deductible		100% of allowable charges after $35 per visit copay- No deductible		100% of allowable charges after $35 per visit copay and deductible	
Urgent care	100% of allowable charges after $100 per visit co pay – No deductible	100% of allowable charges after $50 per visit copay – No deductible	100% of allowable charges after a $100 per visit copay – No deductible	100% of allowable charges after $50 per visit copay – No deductible	70% of allowable charges after deductible	80% of allowable charges after deductible

[1] McLeod matches 100% of employee contributions up to the coverage tier maximum.

[2] Family coverage tier includes Employee + Spouse and Employee + Child(ren) coverage tiers.

McLeod Health

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Plan provisions	Core Plan		Enhanced Plan		HDHP Plan	
	BCBS Network	McLeod Network	BCBS Network	McLeod Network	BCBS Network	McLeod Network
Inpatient Facility (behavioral health, skilled nursing facility & long-term acute care)	65% of allowable charges after a $1,600 per admission copay and deductible	80% of allowable charges after a $300 per admission copay and deductible (limited to 4 admissions per year)	65% of allowable charges after a $1,600 per admission copay and deductible	85% of allowable charges after a $300 per admission copay and deductible (limited to 4 admissions per year)	65% of allowable charges after deductible	80% of allowable charges after deductible
MD treatment or services- inpatient/ outpatient/ home setting (MD and hospital charges might be paid through different networks providers)	65% of allowable charges after deductible	80% of allowable charges after deductible	75% of allowable charges after deductible	85% of allowable charges after deductible	65% of allowable charges after deductible	80% of allowable charges after deductible
Outpatient medical or behavioral health facility	65% of the allowable charges after $300 per visit copay and deductible	80% of the allowable charges after deductible	65% of allowable charges after $300 per visit copay and deductible	85% of allowable charges and deductible	65% of allowable charges after deductible	80% of allowable charges after deductible
Emergency room (copayment will be waived if admitted to the hospital from the ER)	80% of the allowable charges after $350 per visit copay and deductible	80% of the allowable charges after $350 per visit copay and deductible	80% of allowable charges after a $350 per visit copay and deductible	80% of allowable charges after a $350 per visit copay and deductible	80% of allowable charges after deductible	80% of allowable charges after deductible
Impacted tooth (bony impacted or partially impacted), including anesthesia	*Inpatient:* 65% of allowable charges after $1,600 per visit copay and deductible *Outpatient:* 65% of allowable charges after a $50 per visit copay and deductible	*Inpatient:* 80% of allowable charges after $300 per visit copay and deductible *Outpatient:* 80% of allowable charges after deductible	*Inpatient:* 65% of allowable after $1,600 per visit copay and deductible *Outpatient:* 65% of allowable charges after a $50 per visit copay and deductible	*Inpatient:* 85% of allowable charges after a $300 per visit copay and deductible *Outpatient:* 85% of allowable charges after deductible	65% of allowable charges after deductible	80% of allowable charges after deductible

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Plan provisions	Core Plan		Enhanced Plan		HDHP Plan	
	BCBS Network	McLeod Network	BCBS Network	McLeod Network	BCBS Network	McLeod Network
Ambulance & air services	80% of allowable charges after deductible	80% of allowable charges after deductible	80% of allowable charges after deductible	80% of allowable charges after deductible	80% of allowable charges after deductible	80% of allowable charges after deductible
Durable medical equipment (pre-authorization required, if $500 or more)	80% of the allowable charges after deductible	80% of the allowable charges after deductible	80% of allowable charges after deductible	80% of allowable charges after deductible	80% of allowable charges after deductible	80% of allowable charges after deductible
Home Health Care/Hospice Care/Hospice House (pre-authorization required)	70% of the allowable charges after deductible	80% of the allowable charges after deductible	75% of allowable charges after deductible	85% of allowable charges after deductible	65% of allowable charges after deductible	80% of allowable charges after deductible
Physical/ occupational/ speech therapy	65% of the allowable charges after $50 per visit copay and deductible (limited to a combined 30 visits per member per benefit)	80% of the allowable charges after deductible	70% of allowable charges after $50 per visit copay and deductible (limited to a combined 30 visits per member per benefit year)	85% of allowable charges after deductible	65% of allowable charges after deductible (limited to a combined 30 visits per member per benefit)	80% of allowable charges after deductible
Allergy injections	65% of the allowable charges after deductible	80% of the allowable charges after deductible	75% of allowable charges after deductible	85% of allowable charges after deductible	65% of allowable charges after deductible	80% of allowable charges after deductible
Chiropractic services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive colonoscopy, low dose CT, breast cancer at risk services[3]	Not covered	100% of the allowable charges No deductible	Not covered	100% of allowable charges No deductible	Not covered	100% of the allowable charges No deductible
Preventive services under PPACA[3]	70% of allowable charges No deductible	100% of the allowable charges No deductible	70% of allowable charges No deductible	100% of allowable charges No deductible	70% of allowable charges after deductible	100% of the allowable charges No deductible

[3] *For more information refer to* **www.healthcare.gov**.

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Choice of network providers

If you choose a McLeod Medical Plan, you will have a choice of two provider networks:

- **McLeod Provider Network.** When you use a McLeod provider for your health care needs, you receive excellent quality care at the lowest cost to you. The McLeod Network Provider list is located on *Living Well On-line*.
- **Blue Cross Blue Shield Provider Network.**

All benefit-year deductibles and copayments must be met before any covered and allowable expenses can be paid. Coinsurance amounts (items stated as a %) indicate what McLeod pays after annual deductibles and copays are met. Allowable charges are paid at 100% after the out-of-pocket maximum is met. There are no lifetime limits under the plan. However, all services are subject to the provisions of the Summary Plan Descriptions.

For additional information, contact the HR Service Center at **843.777.2595**.

Keeping you well with preventive care

Preventive care coverage is included in McLeod's medical plan options. To reinforce our focus on wellness, and in accordance with the Health Care Reform Act, preventive care services provided to eligible employees and their eligible dependents at a McLeod Network Facility and by a McLeod Network Provider are covered at 100% with no copays or deductibles. There is no cost to you if the primary reason for the visit is to receive preventive services.

Eligible preventive services provided at and by other BCBS Network Providers will be covered at 70% with no deductible.

Visit **www.healthcare.gov** for a complete listing of these preventive care services.

Benefit of breast-feeding support

Expecting employees or their spouse, who are covered under a McLeod Medical Plan, can receive one breast pump per birth from the McLeod Resource Center at no cost, provided the date of birth was within the previous 12 months. Employees should contact their medical doctor or pediatrician and obtain an order or documentation that verifies the date of birth or expected date of birth.

For additional information, contact the McLeod Resource Center at **843.777.2890**.

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Surcharges

Spousal surcharge

If you choose to cover your legal spouse under our medical plans and your spouse has coverage available through his or her own employer, you will pay a spousal surcharge of **$60 per pay period** (24 paychecks annually). This surcharge is in addition to the Employee + Spouse or Family contribution rate and applies even if your spouse does not take his or her employer's coverage.

The surcharge does not apply to the following:

- The unemployed
- Those whose employer does not offer coverage
- Anyone who has or is eligible for Medicare, unless they are eligible for coverage through their employer
- A spouse who works for McLeod Health

You will be required to list your spouse's employer and contact information and to certify that the information you are providing is true and accurate to the best of your knowledge. Falsification or significant omissions will be grounds for denial or retroactive termination of benefit coverage, recoupment of benefits improperly paid and it may result in termination of employment.

If your spouse's benefit eligibility changes at any time during the year, you must contact the HR Service Center at **843.777.2595** and the surcharge will be added or removed as appropriate.

If both you and your spouse are employees of McLeod Health: McLeod does not permit "double coverage," that is, you may not elect coverage as both an employee and a spouse. Only you or your spouse can elect coverage for your eligible dependent child(ren). Also, dependent children may not elect coverage as an employee if covered as a dependent by a parent who is employed by McLeod.

Tobacco-use surcharge

Employees and their spouses covered under a McLeod Medical Plan who have used tobacco products within the previous six months will pay a **tobacco-use surcharge of $20 for employees and $30 for spouses per pay period** (24 paychecks annually).

- **If you're a new hire:** You must complete a *Tobacco Screening Test* as part of our new hire health assessment process performed by Employee Health. When you enroll in a health plan, you will be required to complete a *Tobacco-Use Affidavit*. If you elect to cover your spouse under a health plan, you will be required to complete a *Spousal Tobacco-Use Affidavit*.
- **If you become benefits-eligible during the year:** You must complete a *Tobacco Screening Test* **within 31 days** of your qualifying life/work event. When you enroll in a health plan, you will be required to complete a *Tobacco-Use Affidavit*. If you elect to cover your spouse under a health plan, you will be required to complete a *Spousal Tobacco-Use Affidavit*.

Want to avoid the surcharge? You might qualify for a tobacco cessation program. Contact *McLeod Healthier You* at **843.777.5191** to find a support program that is right for you.

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McLeod Healthier You – save $45 per month!

McLeod Healthier You is designed to provide you with guidance in managing your chronic disease and navigating the healthcare system through the use of RN Care Managers. Care Managers meet regularly with participants, educating them on chronic disease management, setting goals, and reinforcing care plans established by primary care physicians and/or specialists. Care Managers also serve to ease transitions if participants require higher levels of care, such as an emergency or inpatient hospital admission.

Over the years, we have found that participants who experience the greatest success through *McLeod Healthier You* are those who actively engage in a Primary Care Home and work with our team to manage risks related to their current medical conditions.

***McLeod Healthier You* offers you a premium discount of $45 per month if you and your spouse (if applicable) indicate that you have fulfilled the following four steps.**

1 Complete the Health Risk Assessment (HRA) and Biometric Screening.

- Complete the HRA on the participant portal at https://portal.ourhealthylives.org or at a screening event (listed below).
- Complete your Biometrics screening at a screening event.

Note: Alternatively, you can submit results from your provider's office to *McLeod Healthier You*.

2 Engage in a Primary Care Home.

- Indicate that you have had at least one visit with your primary care provider (PCP) in the last 12 months.

  Note: For help finding an office or completing this requirement, contact *McLeod Healthier You*.

3 Participate in age/gender appropriate screenings.

- Complete at least five age/gender appropriate screenings or recommendations.

  Note: Based on your age and gender, your PCP may recommend testing even when you feel fine. These screening tests help your provider determine the best preventative or treatment measures for you.

4 Schedule a Care Management session with a McLeod Healthier You Care Manager.

- If you are at **Low Risk** for chronic disease, schedule one session to review your biometric screening results and plan for continued success.
- If you are at **Moderate or High Risk** for chronic disease, schedule at least four sessions to assist in managing your current health conditions, setting goals and navigating the healthcare system.

We hope that you will partner with the *McLeod Healthier You* program this year. Keeping our employees healthy helps us fulfill the mission, vision and values of McLeod Health. Our employees, one of our most valuable assets, represent a key factor in why McLeod Health is the Choice for Medical Excellence in our region.

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Prescription drug coverage

When you choose one of the McLeod medical plan options, you automatically receive prescription drug coverage.

Benefits through the Core and Enhanced Medical Plans offer pharmacy coverage with the convenience of copays without having to meet an annual deductible. With the HDHP plan, your medical and pharmacy annual deductibles and out-of-pocket maximums are combined.

Out-of-network providers are not covered.

Pharmacy benefits at a glance

Plan Provisions	Core Plan			Enhanced Plan			HDHP Plan		
	BCBS Network	McLeod Network		BCBS Network	McLeod Network		BCBS Network	McLeod Network	
Annual pharmacy deductible	$100 deductible per member	No deductible		$100 deductible per member	No deducible		Medical and pharmacy annual deductibles are combined.		
Annual pharmacy out-of-pocket maximum	Employee $1,000 Family $2,000	Employee $1,000 Family $2,000		Employee $1,000 Family $2,000	Employee $1,000 Family $2,000		Medical and pharmacy annual out of pocket maximum are combined.		
Maximum days supplied	30 days	30 days	90 days	30 days	30 days	90 days	30 Days	30 days	90 days
Generic	$15 after pharmacy deductible	$5	$10	$15 after pharmacy deductible	$5	$10	$15 after deductible	$5 after deductible	$10 after deductible
Preferred brand	$50 after pharmacy deductible	$35	$70	$50 after pharmacy deductible	$35	$70	70% after deductible; $80 max	80% after deductible; $60 max	80% after deductible; $120 max
Non-preferred brand	$80 after pharmacy deductible	$60	$120	$80 after pharmacy deductible	$60	$120	50% after deductible; $150 max	60% after deductible; $100 max	60% after deductible; $200 max
Specialty	Not Covered	80%; $250 max	80%; $500 max	Not Covered	80%; $250 max	80%; $500 max	Not covered	80% after deductible; $250 max	80% after deductible; $500 max

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McLeod Choice Pharmacy

The McLeod Choice Pharmacy has two convenient locations at the Florence and Loris campuses. We also offer delivery to our other campuses in Darlington, Dillon, Seacoast, Clarendon, and Cheraw. Our knowledgeable pharmacists and staff provide free patient consultations, answer questions, address concerns and provide important facts about your medications.

The McLeod Choice Pharmacies accept most major insurance providers including Medicare Part D, and employees have a variety of payment options including payroll deduction. McLeod Choice Pharmacy in Florence offers a large selection of over-the-counter products. The hours of our locations vary, check with your local pharmacy site for current hours. Saturday and evening hours are available at the McLeod Choice Pharmacy Florence location.

Prescription home delivery service

The McLeod Choice Pharmacy in Florence offers home delivery of most maintenance medications at no additional cost. This benefit works best for "maintenance medications" that you need to take over an extended period of time. It is preferred to have prescriptions written for a 90-day supply. However, if the prescription is written for a 30-day supply, the pharmacy can call your prescriber and ask for a larger quantity as long as your medication does not have quantity restrictions. Over-the-counter (OTC) items can be delivered in combination with your prescriptions. Usually, prescriptions are delivered to your home address within four business days.

For home delivery, call the McLeod Choice Pharmacy at **843.777.2166** or Toll Free **888.810.2267** (option 3) or visit **www.mcleodchoicepharmacy.org**.

Contraceptive coverage

In accordance with the Affordable Care Act, McLeod covers certain generic contraceptives at no charge (copay or deductibles) for employees and dependents covered under a McLeod Medical Plan through the McLeod Choice Pharmacy.

Cost-savings through Step Therapy

The Step Therapy Program is designed to encourage cost-savings by promoting generic drug use and providing consumer education. When you fill your prescription, you will automatically receive the generic equivalent of the medication, if it is available.

If your history shows that the generic drug was previously dispensed and your physician has completed and received approval through the Medication Prior Authorization process, the brand or higher cost medication can be dispensed.

Not all medications are included in the Step Therapy Program. For specific information on your prescription benefit, please contact the McLeod Choice Pharmacy at **843.777.2166**, or Caremark Customer Service at **888.963.7290**.

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Behavioral Health benefits

If you are enrolled in a McLeod Medical Plan, you are eligible for Behavioral Health benefits. You will pay the lowest cost for care when you receive a referral through the McLeod Employee Assistance Program (EAP). You can go directly to a BCBS Network Provider without a referral, but you will pay a higher copay, deductible, and out-of-pocket maximum.

Behavioral Health benefits at a glance

Plan Provisions	McLeod EAP Network (referral required)	BCBS Network (without a referral)
Annual deductible	No deductible	Must meet deductible and out-of-pocket maximum as outlined in the medical plan you elected.
Annual out-of-pocket maximum	Employee: $100 Family: $200	Must meet deductible and out-of-pocket maximum as outlined in the medical plan you elected.
Licensed therapist (Masters)	100% of allowable charges after a $10 per visit copay No deductible	100% of allowable charges after a $35 per visit copay No deductible
Psychologist (Ph.D.)	100% of allowable charges after a $15 per visit copay No deductible	100% of allowable charges after a $50 per visit copay No deductible
Psychiatrist (MD)	100% of allowable charges after a $20 per visit copay No deductible	100% of allowable charges after a $60 per visit copay No deductible
Facility, physician inpatient and outpatient services, and BCBS provider office visits are paid through the Core, Enhanced or High Deductible Health Plan.		

Note: For the HDHP, co-pays apply after the deductible has been met.

Employee Assistance Program

The McLeod Employee Assistance Program (EAP) offers up to five free confidential counseling visits to all McLeod employees and their immediate family members. Licensed EAP counselors can help with a variety of issues, from financial stress, parenting concerns, and career or stress-related issues, to difficulties with family relationships, depression or anxiety, alcohol and drug problems, domestic violence, grief, and work-related issues.

You will receive free short-term counseling and support services, and if necessary, be referred for additional assistance and support to an appropriate behavioral health care provider in the community.

For more information or to schedule a confidential appointment through the McLeod EAP Program, call **843.317.4949**. In the Coastal Area, call **843.655.9438**.

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Dental plan options

McLeod offers two dental plan options that cover routine cleanings and basic restorative care:

- Basic Plan
- High Plan

When you enroll in the dental plan, you will be covered for a full range of dental services in four basic categories: preventive, basic procedures, major procedures, and orthodontic procedures. There are two levels of dental coverage offered in the dental plan: Basic and High. Most providers in the region accept the BCBS dental insurance.

Dental benefits at a glance

Type	Basic Plan	High Plan
Deductible	Individual $50 Family $100	Individual $50 Family $100
Maximums		
Calendar year	$1,000	$1,500 ($750 major)
Orthodontia*	Not covered	$1,500
Coverage		
Type A: Preventative and diagnostic	100%	100%
Type B: Basic restorative	80%	80%
Type C: Major restorative (includes implants)	Not covered	50%
Type D: Orthodontia*	Not covered	50%

** Orthodontia care covers dependent children under the age of 19.*

For more information or to find a network provider, go to **www.southcarolinablues.com**. Then, go to *Helpful Links > Dental Resource Center.*

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Vision plan

McLeod offers a vision plan to help meet your basic vision needs. When you enroll in the Vision Plan through Physicians Eyecare Plan (PEP), you will receive coverage for eye exams and receive allowances for eyeglasses and contacts. PEP has a large provider network of ophthalmologists and optometrists within South Carolina.

Vision benefits at a glance

Benefit (recurrence)	In-network	Out-of-network*
Copayments		
Eye exam (every 12 months)	$15 copay	$55 reimbursement less exam copay
Materials (every 12 months)	$25 copay	N/A
Allowances		
Prescription eyeglass (lenses and frames) OR contact lenses (every 12 months)	$200 allowance, discounts apply after allowance	65% of material allowance used less materials copay
Contact lens fitting fee	$49 or 15% off usual & customary fitting for non-standard contact lens	N/A
Refractive surgery (Including Lasik)	10% – 15% discount	N/A

**Please submit a claim form (available at Living Well On-line) along with your itemized receipts to: Physicians Eyecare Plan, 48 Courtenay Dr., Charleston, SC 29403.*

Find an in-network provider, check your eligibility, print a replacement ID card, download an out-of-network claim form and find answers to frequently asked questions through *Living Well On-line* or **www.physicianseyecareplan.com**.

Important information

- New members will be mailed a PEP membership card.
- You are responsible for payment to the providers for any amount exceeding the material allowance, including but not limited to any copays and contact lens fitting fees.
- Medical and surgical treatments of the eyes are not covered benefits.
- Material allowance does not cover non-prescription lenses, non-prescription or cosmetic contact lenses, or non-prescription sunglasses.
- Certain providers do not offer discounts on some services or provide eye exam services. Ask your provider which services are provided through PEP.
- Spherical daily wear, extended wear and disposable contact lens are considered standard contact lens; any other contact lens types are considered non-standard.

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Flexible spending accounts

Flexible spending accounts (FSAs) allow you to set aside tax-free dollars from your pay to cover eligible health and dependent care expenses up to plan limits.

Health Care Flexible Spending Account

The Health Care FSA allows you to pay for certain out-of-pocket medical, dental, vision, and prescription expenses with tax-free dollars. The amount you save through this account is deducted from your paycheck before taxes are calculated and withheld. You can submit receipts to receive reimbursement or use your WageWorks debit card and have the pre-tax dollars taken from your account at the time of the purchase.

Health Care FSA	You can contribute **$4 – $110.42 per pay period** up to $2,650 maximum per year

Other features of the Health Care FSA include:

- When you use the WageWorks debit card, no documentation is needed for an office visit, prescription, or facility copay of $50 or less.
- Most over-the-counter items are not eligible expenses without prescription from your physician.
- Leftover funds greater than $500 will be forfeited at the end of the year.
- You can submit claims for reimbursement until **March 30** of the next plan year for eligible expenses incurred through the end of the previous plan year.

If you enroll in the High Deductible Health Plan, which features a Health Savings Account, you are not eligible to enroll in a Health Care Flexible Spending Account.

Dependent Care Flexible Spending Account

The Dependent Care FSA is designed to let you pay for certain childcare or adult day or home care expenses with tax-free dollars. You must first elect to have a specified amount of pre-tax money deducted from each paycheck and put into your Dependent Care FSA. You will then pay your dependent care provider, fill out a reimbursement claim form, and submit the form along with other required documents for reimbursement to WageWorks.

Dependent Care FSA	You can contribute **$4 – $208.33** per pay period up to $5,000 maximum per year

Leftover funds In the Dependent Care FSA will be forfeited at the end of the year.

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Manage your Health Care FSA and/or Dependent Care FSA:

- Online at **www.wageworks.com**, or
- Using the WageWorks smart phone app. With the app you can transmit receipts, view account information, and look up eligible expenses.

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For more information on eligible expenses for the FSAs, visit *Living Well On-line*, located in the center panel of the Compass, or **www.wageworks.com**.

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Life insurance

McLeod offers you basic and optional life and accident insurance benefits that can provide income to your family in the event of your death or accidental injury or the death of a covered dependent.

- Basic and Supplemental Life Insurance
- Dependent Life Insurance
- Accidental Death & Dismemberment Insurance

Life insurance benefits at a glance

Benefit	Coverage
Basic Life	1 x base pay ($10,000 minimum)
Supplemental Life	1 x base pay, up to a total of 3 x base pay*
Dependent Life	$10,000 spouse and each covered child
Accidental Death & Dismemberment	$10,000 $20,000 $30,000 $40,000 $50,000 $100,000 $200,000 $300,000 Limit: Up to 10 x base pay to maximum of $300,000

**Maximum benefit: $1 million, basic and supplemental coverages combined*

Basic group term life insurance

If you are budgeted to work 40 hours or more per pay period, you will receive free guaranteed issued basic life insurance equal to one-times your annual base salary. When you reach age 65, your Basic Life Insurance amount will reduce according to a schedule. Certain employees who are eligible for two-times Basic Life Insurance and have remained in a benefits-eligible position have been grandfathered into this employer paid coverage level.

Keep in mind the "value" of any employer provided life insurance coverage that is greater than $50,000 (based on IRS regulations), will result in taxable income to you. This is known as imputed income. The amount of imputed income will be shown on your pay stub, and any appropriate taxes will be withheld.

Conversion privileges

If you have a change in status or are no longer eligible for life insurance coverage, you may be able to convert your life insurance to a private policy. Contact the HR Service Center immediately at **843.777.2595** to request conversion information. Within 31 days of your life insurance coverage ending or reducing, you must notify CIGNA in writing and pay the first premium payment. The individual policy will be issued without evidence of insurability (EOI) and will contain life insurance benefits only.

For more information, contact Cigna at **1-800-238-2125**.

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Supplemental group term life insurance

McLeod Health offers you the opportunity to purchase additional term life insurance at group rates. If you are newly eligible, you can elect the maximum life coverage of up to 4-times base pay (including basic) without Evidence of Insurability (EOI). After the initial newly eligible enrollment period, you may increase one level of life coverage each plan year without EOI. You have the ability to purchase at guaranteed issue 1-, 2-, or 3-times your annual compensation up to $1,000,000 when combined with the Basic Life Guaranteed Issued Amount.

If you elect a higher increase in coverage during a subsequent plan year or for qualified life events, EOI is required for an increase of two levels or more, of life insurance coverage. EOI must be approved before the additional coverage will become effective.

Your life insurance amounts will automatically increase or decrease when there is an increase or decrease in your base salary.

Accelerated death benefit

If while insured under this policy you provide satisfactory proof of a Terminal Condition, you may request a portion of your life insurance benefit. Terminal Condition means a condition that is expected to result in your death within a 12-month period or in which there is no reasonable prospect of recovery.

Contact the HR Service Center at **843.777.2595** or review the Summary Plan Description and Policy on *Living Well On-line*.

Dependent life insurance

While no amount of income can compensate for the death of a family member, it is important that the survivors be able to meet family financial responsibilities. To help you prepare for those financial concerns, McLeod offers a dependent life benefit of $10,000 for your spouse and each covered child.

Dependent Term Life Insurance is available to employees who are budgeted 40 or more hours per pay period. Premiums are deducted from your paycheck on an after-tax basis, resulting in a non-taxable death benefit payable to you, if a covered dependent dies.

Accidental death & dismemberment insurance

Statistics show that accidental bodily injuries are the fourth greatest cause of death of working employees in the United States. McLeod Health offers Accidental Death & Dismemberment (AD&D) insurance that provides benefits for you if you have a loss within 365 days of the accident. McLeod offers coverage options ranging from $10,000 to $300,000 to a maximum of 10 times your base annual salary. AD&D Insurance is available to employees who are budgeted 40 or more hours per pay period.

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Paid Time Off

Paid Time Off (PTO) is a special bank of time for you to use for vacation, holidays, personal days, or other absences due to your own illness or that of a family member.

Before taking PTO, you must get pre-approval from your supervisor in accordance with your department's time-off processes. Attendance policies and department call-in procedures apply.

How you earn PTO

You will receive PTO based on your years of continuous benefits-eligible service and budgeted status (.8 and greater). You will accrue a prorated amount of PTO each pay period for every hour you work, up to your annual maximum accrual. The maximum PTO accrual allowed is one and a half times your annual accrual rate. For example: If you accrue at a rate of 160 hours, your accrual maximum will be 240 hours per year.

PTO at a glance

Years of Benefit-Eligible Service	Per Hour	Budgeted FTE	Budgeted Hours Per Pay Period	Maximum Hours Eligible to Accrue Per Pay Period	Maximum Hours Eligible to Accrue Per Year
Up to 5 Years	0.076923	1.0 and Over	80	6.153840	240
		0.90	72	5.538456	216
		0.80	64	4.923072	192
6 to 10 Years	0.096153	1.0 and Over	80	7.692240	300
		0.90	72	6.923016	270
		0.80	64	6.153792	240
> 10 Years	0.115384	1.0 and Over	80	9.230720	360
		0.90	72	8.307648	324
		0.80	64	7.384576	288

**Paid Time Off (PTO) Accrual is based on Regular Hours Worked and PTO Hours Paid during eligible pay periods. It does not accrue while on a Leave of Absence or above the maximum amounts listed above.*

When your years of benefit-eligible service increase to the next level, your PTO accrual will automatically change to the new rate. Your PTO balance and the number of hours you use and accrue each pay period can be viewed on *Living Well On-line*.

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PTO if you terminate employment

If you leave McLeod and meet specific guidelines, you may be paid for any unused, accrued PTO. You will not be eligible to receive payment for accrued PTO, and accrued PTO will be lost, if you:

- Leave McLeod before completing one year of continuous benefits-eligible service at the time of separation
- Fail to work a required notice, or
- Are dismissed involuntarily for any reason.

PTO Sell Program

McLeod recognizes that not everyone has the same time off needs. To help prevent 'maxing out' on PTO, a PTO Sell opportunity may be available. In November and/or May, if you meet the eligibility criteria, you will be able to sell your PTO time. The criteria will require that you:

- Retain at least 100 available hours in your PTO bank after your sell request
- Sell PTO time in eight-hour increments, up to 48 hours.

Due to IRS tax rules, McLeod applies an early withdrawal penalty of 10%, called a "haircut provision," on all monies voluntarily cashed out. This is a voluntary PTO Sell Program. You can choose to keep your time in your PTO bank and continue to use it to meet your time-off needs.

PTO Sell Requests will be available during the sell windows through *Living Well On-line*.

Grandfathered Sick Pay (GSP)

If you were employed with McLeod Health before January 1, 2000, and you have a balance in your Sick Pay bank, that amount remains available to use ("grandfathered") for long-term illnesses. GSP was designed to offer income protection for illnesses lasting more than three consecutive calendar days. Since GSP was intended to be the first line of disability protection, you will be required to utilize all accrued time in this bank before you will be paid short-term disability benefits. When your employment ends or you change to an ineligible status, any unused GSP time is forfeited. Please refer to the PTO policy for further information on when GSP can be used.

Income Protection Program

The Income Protection Program provides you with a "safety net" of protection by coordinating your benefits through the Paid Time Off (PTO), Grandfathered Sick Pay (GSP), and Short-Term Disability (STD) and Long-Term Disability (LTD) plans.

Income Protection Program at a glance

Plan that covers absence	Days of disability
PTO	First 24 hours
PTO or GSP	Day 4 through day 14
STD (50% basic or 60% buy-up with supplement from PTO)	Day 15 (or date that GSP is depleted), up to 180 calendar days or until recovery
LTD (50% basic or 60% buy-up)	181+ calendar days, until age 65, plan limits, or recovery

Eligible employees can view their GSP and PTO balance by logging into *Living Well On-line*.

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Disability coverage

McLeod Health offers two levels of disability protection: short-term and long-term disability coverage. McLeod believes disability protection is so important that we pay 100% of the cost of basic coverage if you are budgeted to work at least 72 hours per pay period.

Full-time employees budgeted to work 72 or more hours per pay period automatically receive at no cost basic short- and long-term disability benefits of 50% of covered salary.

Employees classified as part-time or full-time (budgeted to work 40 or more hours per pay period) are eligible to enroll in the optional STD and LTD Buy-Up Plans, which pays a benefit of up to 60% of covered salary.

Effect on benefits

Employees whose leaves are protected under Family Medical Leave Act (FMLA) and/or who are receiving GSP will remain benefit eligible during the period of FMLA approved leave and/or GSP availability. As long as the employee is benefit eligible, health insurance benefits will be maintained at the same level and under the same conditions as if the employee continued to work. It is the employee's responsibility to contact the HR Service Center to obtain information on the effect on benefits while on FMLA Leave, including arrangements for payment of the employee's portion of the required premiums.

Most financial planners recommend having a "rainy day fund" of at least three to six months of income for emergencies or period of disability!

If you need to take a leave of absence

For information on application and approval of any and all continuous and/or intermittent leaves of absence, FMLA, and/or short-term disability benefits, you should inform your manager, Human Resources, and CIGNA.

Follow your department's call-in procedure on or before your first day or partial day out of work. Tell your director when and for how long you plan to be absent, arrive late, or leave early for a qualifying Family and Medical Leave, Leave of Absence, or Intermittent Leave.

Contact CIGNA within your first day or partial day out of work at **888.842.4462** or fill out a claim form online at **www.myCigna.com**.

Provide details and inform CIGNA about your illness, injury, or pregnancy including symptoms and/or diagnosis, doctor, hospital, or physician visits, including dates and contact information.

In order to approve or deny your leave request, CIGNA will review the details of your leave request and may request information from McLeod, your physician, or hospital. CIGNA will send you a letter that explains the decision to either approve or deny your request, along with your necessary next steps. If you have questions, contact the HR Service Center at **843.777.2595**.

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Short-Term Disability

Short-Term Disability (STD) provides income protection for illnesses or injuries that last longer than 14 consecutive calendar days. If you are out of work for more than 14 consecutive calendar days, you may be eligible to receive STD benefits. Be sure you notify your supervisor in accordance with your department and HR attendance and leave policies.

Newly benefits-eligible employees will have a 12-month waiting period in a benefits-eligible position to become eligible for STD. This coverage will begin on the first day of the next month following the initial waiting period.

Employees who have grandfathered sick pay (GSP) must deplete this balance, prior to qualifying for STD benefit payments.

Approved STD benefit payments continue for up to 24 weeks.

Other income sources such as Workers' Compensation or Social Security could result in an offset in STD benefits.

Long-Term Disability

Long-Term Disability (LTD) is another extremely important component of our income protection plan that provides income security for a disabling injury or illness that lasts more than 180 consecutive calendar days. This benefit is designed to protect your financial security if you become totally and permanently disabled.

You may be eligible for LTD, if you anticipate being out for more than 180 calendar days due to an injury or illness. If you have been approved for STD benefits, your STD application will serve as your LTD application. A claims representative will contact you if additional information is needed to process your claim. If you are not eligible for STD prior to the LTD benefit, you will need to complete a Long-Term Disability Claim Form.

To be approved for LTD benefits, you may need to provide additional information or current medical certification. To receive LTD benefits, you need to furnish any information requested by the claims representative in a timely manner. You may also want to check with the Social Security Administration to see if you qualify for Social Security Disability benefits. Other income sources such as Workers' Compensation or Social Security could result in an offset in LTD benefits.

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Please refer to the chart below for additional information about the LTD benefit plans.

LTD benefits	LTD 50% Basic Plan	LTD 60% Buy-Up Plan
Maximum EARNINGS on which benefit is based	$144,000	$200,000
Maximum monthly benefit	$6,000	$10,000
Excludes	Other Income benefits and earnings	
Minimum monthly benefit	$100 or 10% of the Gross Monthly Benefit, whichever is greater.	
Own occupation duration	24 Months	
Age at disability	**Maximum benefit period**	
Less than age 60	To age 65 (but not less than 5 years)	
Age 60	60 months	
Age 61	48 months	
Age 62	42 months	
Age 63	36 months	
Age 64	30 months	
Age 65	24 months	
Age 66	21 months	
Age 67	18 months	
Age 68	15 months	
Age 69 and over	12 months	

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Retirement savings

McLeod understands that preparing for a comfortable retirement is a shared responsibility. That's why we offer a 401(k) Plan, which can help you save for the future and ensure your financial security. This plan offers you, if eligible, ways to save using before- and after-tax dollars from your pay. McLeod helps your savings grow by matching your contributions.

For more information about the McLeod 401(k) Plan or to schedule a personal planning meeting, contact a Lincoln Retirement Consultant at **843.777.5767**, toll-free at **800.234.3500** or through Lincoln's website at **www.LFG.com**. Lincoln Retirement Consultants are available on-site to meet with you face-to-face.

McLeod Health 401(k) Plan at a glance

Who is eligible	All active employees are eligible to contribute following 30 days of employment.
Plan administrator	Lincoln Retirement
Your contributions	**Before-Tax** – Money you contribute is before taxes, so it cost you less today to save. **After-Tax (Roth) Contributions** – Money you contribute is after taxes, saving you taxes when you withdraw money from your retirement account. **Catch-Up Contributions** – Individuals who are 50 or older may elect to make additional "catch up" contributions to their account.
McLeod matching contributions	McLeod contributes $1 for every dollar on the first 1% and $.50 on the next 2% to 6% that you contribute, if eligible.
Changing contributions	You can increase, decrease or suspend contributions at any time.
Tax-deferred growth	Any earnings on your accounts grow on a tax-free basis until they are distributed to you.
Vesting	You become 100% vested in the McLeod Health matching contribution after you have been employed for two years and worked 1,000 hours in each year.
Automatic deferrals	You are automatically set up to defer 3% but you can increase or decrease this amount. These contributions are automatically deducted from your paycheck and added to your account.
Auto escalation (up to 10%)	If you do not make an active election, your contribution will increase 1% each year, after the first full year.
Investment options	A broad range of investment options are available to help you build, diversify and maintain your savings over time based on your needs and savings goals.

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Other programs that add balance

McLeod offers you a variety of programs to help you achieve a healthy life balance.

ID theft protection

Zander Identity Theft Solutions is a comprehensive service that provides employees the most comprehensive and affordable tools to help prevent becoming a victim of identity theft.

Some of the plan features include:

- Complete and unlimited restoration transfers the recovery work directly to a Certified Identity Theft Specialist who is available to you 24/7/365.
- Reimbursement protection up to $1 million in stolen funds from your bank account and out of pocket costs.
- Monitoring Alerts provide instant notification when your personal information is detected and at risk of identity theft. Alerts are sent to your email, smart phone, computer or tablet.
- Dependent eligibility – Eligible family members include spouse/partner and children up to the age of 18.

Program benefits Include:

- Personal Information monitoring
- Change of address monitoring
- Social Security number monitoring
- Unlimited recovery services
- 24/7/365 customer and recovery services
- Wallet protection
- $1 million in reimbursement protection

Dependents 18-26 whom you claim as a dependent on your taxes will receive the following benefits:

- Unlimited recovery services
- 24/7/365 customer and recovery services
- Wallet protection
- $1 million in reimbursement protection

If you have questions regarding the ID Theft protection program, or need information on reporting a theft event, call member services at **877.795.8472** or online at **www.zanderidtheft.com**.

Direct deposit

Direct deposit is a convenient and safe way to receive your paycheck. You are required to use direct deposit for receipt of your paycheck. Some of the advantages of direct deposit are:

- Direct deposit saves you a trip to the bank.
- Direct deposit ensures your funds are in the bank on payday—even if you are not at work that day.

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Merchant discount program

Local businesses, working in partnership with McLeod, make available a large number of discounts and other offerings to our employees. To receive discounts at participating merchants, simply request the discount and show your ID badge.

A complete listing of the merchants participating in our program is available through *Living Well On-line*. View discounts and access Mobile App installation instructions at **www.mcleodhealthmerchantdiscounts.com**.

Employee Emergency Fund

Unexpected emergencies can cause a financial hardship for you and your family. The McLeod Employee Emergency Fund was set up by McLeod employees to assist other employees who have experienced an emergency that could not have been anticipated (such as a house fire or lengthy illness) and has resulted in their inability to meet basic expenses, including rent or mortgage, utilities, food, or transportation. The fund is not designed to help with financial problems unrelated to an emergency nor for non-necessities.

Prior to seeking assistance, employees must have been employed for at least six months in a budgeted 40 hours or more per pay period position. Employees may receive assistance only once within a 12-month period and may receive no more than five awards in a lifetime. The maximum assistance per application is $1,000.

The fund receives money from generous contributions of fellow McLeod employees as well as through the haircut provisions of the PTO Sell Program. Each request is reviewed by a committee comprised of volunteers representing all of McLeod campuses. Without knowing the identity of the applicant, they consider the entire circumstances and decide what action to take.

Applications can be obtained by clicking on the Employee Assistance Program icon through *Living Well On-line* or by calling McLeod EAP at 843.317.4949 in the Pee Dee Area or 843.655.9438 in the Coastal Area.

Child Development Center

The McLeod Child Development Center provides quality care for your child(ren). Fully licensed and accredited, this center offers childcare services Monday through Friday. Children six weeks to 12 years of age can attend this private, not-for-profit child development center. Enrollment is on a first-come, first-served basis. Fees are based on a child's age, and you can simplify payment through payroll deduction.

You can get more information on these services by calling the McLeod Child Development Center at **843.777.7221**.

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Health and fitness centers

The McLeod Health and Fitness Center, the Center for Health and Fitness at McLeod Loris and McLeod Health and Fitness Clarendon are wellness leaders that set the standard of excellence for health and fitness in the region.

These Health and Fitness Centers are committed to the support and development of the whole person. It does not matter what size, shape or age you are, the staff will help you meet your health and wellness goals. Our personal trainers can develop a workout program customized just for you.

To inquire about memberships and services offered, call:

- McLeod Health and Fitness Center in Florence: **843.777.3000**
- Center for Health and Fitness at McLeod Loris: **843.716.7111**
- McLeod Health and Fitness Clarendon: **803.435.5200**

The McLeod Activity Center for Kids

The McLeod Activity Center for Kids (MACK), located inside the McLeod Health and Fitness Center, in Florence, is an innovative, energetic facility designed just for kids. The MACK features a large area with mats and workout space, a Wii for various fitness games, a learning center, game room, arts and crafts room, outdoor playground, and a separate infant and toddler playroom—all designed for children age six weeks to 11 years.

The MACK also features theme camps and programs of many types. Call **843.777.3030** for more information.

Critical illness and accident protection

Offered by Voya Employee Benefits Compass Critical Illness Insurance

Critical illness insurance pays a lump-sum benefit if you are diagnosed with a covered disease or condition[1]. You can use this money however you like, for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs or any of your regular household expenses. Compass Critical Illness Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Offered by Voya Employee Benefits Compass Accident Insurance

Accident insurance pays you benefits for specific injuries and events resulting from a covered accident[1]. You can use this money however you like, for example: deductibles, child care, housecleaning, groceries or utilities. Compass Accident Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

[1] See the product brochure, certificate of coverage and any applicable riders for a list of covered accidents, along with complete provisions, exclusions and limitations. Insurance products issued by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Home and Administrative Office: 20 Washington Avenue South, Minneapolis, MN 55401. Policy provisions and product availability may vary by state.

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Wellness Benefit

If you enroll in critical illness or accident insurance coverage, available through Voya Employee Benefits, you have access to the Wellness Benefit. The Wellness Benefit provides an annual benefit if you complete a health screening test, whether or not there were any out-of-pocket costs. This benefit is designed to encourage you to maintain a healthy lifestyle. The tests can help screen for a wide range of potential illnesses and diseases.

To find out more about critical illness, accident insurance or the Wellness Benefit go to *Living Well On-line*.

Work-life benefits

Balancing your work and personal life is just as important to your well-being as proper exercise and nutrition. McLeod offers you the resources you need to achieve that balance. Additional benefits include:

- Jury duty pay
- Bereavement pay
- Military leave
- Educational leave
- Adoption benefit
- McLeod Advantage Payroll Deduction Program
- Lunch and learns
- On-site cafeteria discount
- Free parking
- Healthy choice vending machines
- Accessible ATM
- McLeod news articles
- And many more

Please know your benefits by reviewing the HR policies through *Living Well On-line*. Take the time to explore the Compass for important updates and to discover events happening each week at McLeod.

Educational opportunities and recognition

McLeod University

McLeod University is our in-house educational entity that provides classes through Organizational Learning. McLeod values and recognizes that learning is a life-long process and that employees are the most important resource of the organization. McLeod Health is committed to investing in its employees by providing comprehensive learning opportunities that enhance the knowledge, skills, critical thinking and services provided by employees to our customers.

McLeod University classes are free to employees and volunteers. We offer a variety of classes, such as *Communication*, *How to Make Yourself Indispensable, Trust* and many more. Our instructor-led classes are held as requested throughout the year. For your added convenience, e-courses are available via Greenlight.

To find out more about your educational requirements or to register for any McLeod University training, log into Greenlight through *Living Well On-line*.

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Scholarship program

McLeod is committed to helping you advance yourself personally and professionally. We offer a variety of programs to help encourage and support continued growth and development. A description of the scholarship application process can be found on-line under the Student Opportunities tab at **jobs.mcleodhealth.org**.

For more information, please contact the Scholarship Advisor at **843.777.2595**.

Service awards

McLeod appreciates your dedicated long-term service. Annually employees, based on years of experience, are honored at a service awards reception or banquet throughout our campuses. Activities may vary between campuses.

You may be eligible to receive credit for your past service with McLeod if you:

- Work at a McLeod entity at the time you qualify for the recognition
- Completed at least one year of service prior to terminating employment, and
- Have completed at least one year of service since being rehired by McLeod.

If you meet the above requirements, complete an *Employee Past Service Credit Request Form*, and return it to the HR Service Center by the annual deadline.

Convenience programs

Juggling a hectic work-life schedule can be challenging. That is why McLeod provides you with many types of programs to help make things a little easier. Whether it is helping you with errands, or finding a work schedule that fits your needs, McLeod is there to support you. Take advantage of the many convenience programs listed below.

Mother-friendly workplace

McLeod Health recognizes the challenges a new or expecting mother faces with her new baby. That is why we have created a "mother-friendly" workplace for both expecting and new mothers. This program offers assistance to new mothers returning to work who want to continue to breastfeed. Rooms and equipment are available to pump your breast milk in a clean, private and quiet environment. It is available days, evenings, nights, and weekends, until Mom and baby are ready to wean. McLeod provides a pump and an opportunity to join a working mother's support group.

For more information, call **843.777.8465**.

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Gift shops

How about a convenient way to shop for yourself and others? Come browse at the gift shop for an assortment of reasonably priced gifts, fashion items, flowers, cards, reading materials, toiletry items, and other conveniences.

If you are benefits-eligible, you also have the convenient option of paying for gift shop purchases by payroll deduction.

The McLeod Spa

We offer several convenient locations to help you relax and rejuvenate yourself. McLeod employees receive a discount with their McLeod ID on Tuesdays at the McLeod Spa at the McLeod Health and Fitness Center and McLeod Concourse. At the McLeod Health & Fitness Clarendon facility, McLeod employees receive a 10% discount every day.

Location	Discount	Contact
McLeod Spa at the McLeod Health and Fitness Center	15% off all services and products on Tuesdays	843.777.3200
McLeod Concourse		843.777.3203
McLeod Health & Fitness Clarendon	10% off all services and products daily	803.435.5200

Scout M. Out – McLeod Health employee referral program

McLeod Health is always looking for great people to join the team. As a valued McLeod employee, you understand what it takes to be successful here—and you probably know people who would make an excellent addition to our McLeod family. Our best resource for employees is from our own people.

To help in our recruiting efforts, McLeod offers employees an incentive to find good people and refer more healthcare professionals. For every candidate you send to Talent Management who is hired and remains in good standing at McLeod for at least six months, you will receive a bonus based on your budgeted hours. This offer applies to designated areas of need. The list of currently approved disciplines may change at any time, with or without notice. There is no limit on how many referrals you can make. You can refer anyone electronically through *Living Well On-line*, where you can find a full list of current, approved needs.

Receiving the employee referral bonus

If the candidate referred is hired by McLeod, the referring employee is eligible to receive a bonus based on their budgeted hours. Those budgeted 72 hours or more per pay period receive **up to $1,500** and those budgeted 40 to 71 hours per pay period are eligible for **up to $750**. The bonus will be paid after six months of the referred individual's employment at McLeod as long as both employees are in good standing and still employed at McLeod.

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Workers' Compensation

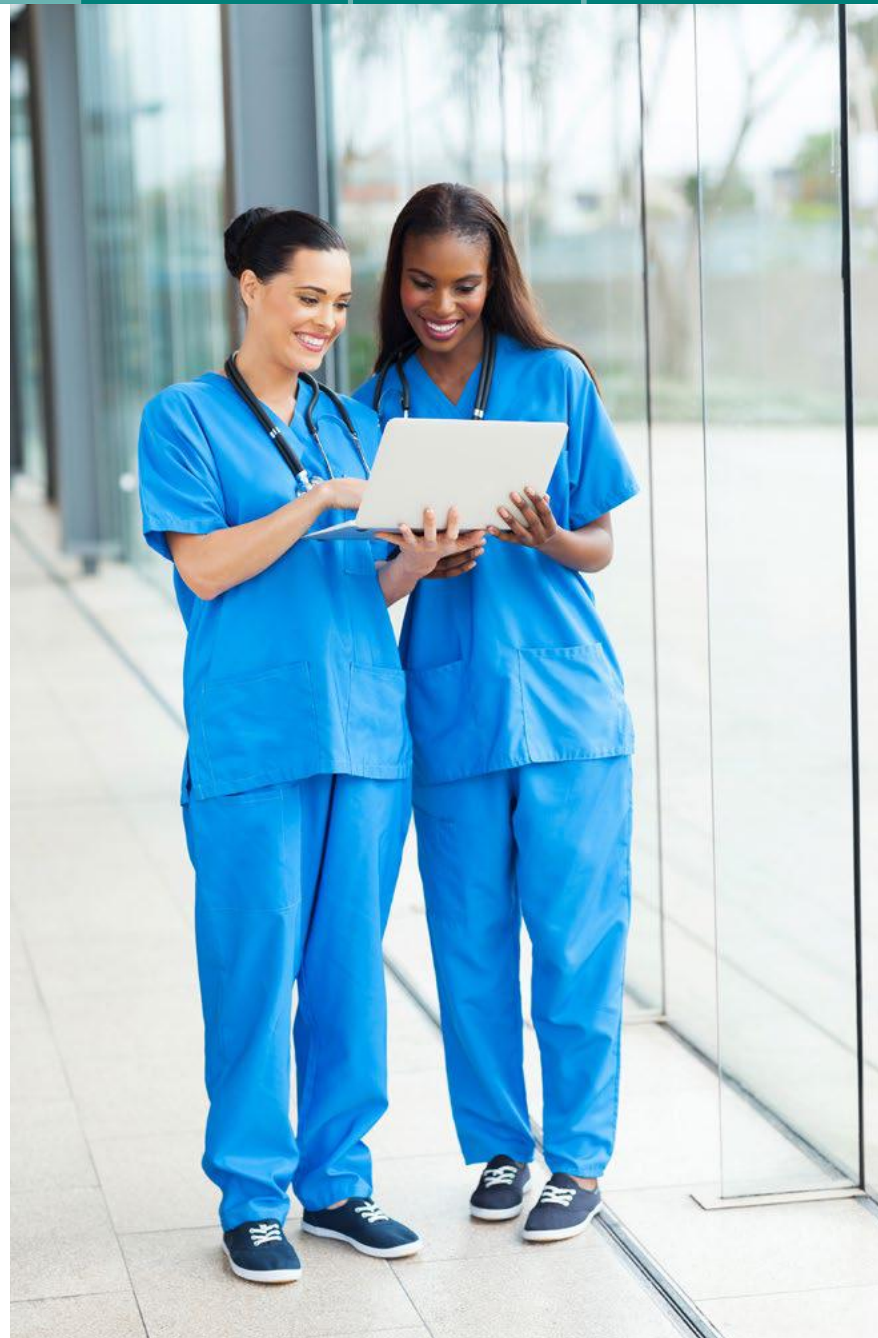
If you are injured on the job, you must report this to your supervisor immediately. McLeod requires a First Report of Employee Injury form, "First Report" to be completed immediately. This form serves as the initiator of all Workers' Compensation claims, and its completion is critical for all work-related injuries.

In order to be covered by Workers' Compensation, medical treatment must be authorized by Employee Health/Occupational Health Services or the Workers' Compensation insurance carrier.

If you have questions, please refer to the Workers' Compensation policy found under the HR policies and procedures, contact your supervisor, or call Employee Health at **843.777.5146**.

Notice: This Resource Guide provides a summary of material modifications to your benefits plan and highlights of the McLeod Health employee benefits program effective January 1, 2018. Nothing in these materials in any way creates an expressed or implied contract of employment between McLeod Health and its employees. While McLeod intends to continue its benefits programs, McLeod Health reserves the right to change, suspend, or end any of these plans at any time.

If you want to read the legal documents governing the McLeod Health Benefit Plans, they are available in the HR Service Center during regular business hours or *Living Well On-line*. If there is a discrepancy between this summary and the plan documents, the plan documents govern.



2018 pay periods

Pay Period Beginning	Pay Period Ending	Actual Pay Date
12/24/2017	1/6/2018	1/11/2018
1/7/2018	1/20/2018	1/25/2018
1/21/2018	2/3/2018	2/8/2018
2/4/2018	2/17/2018	2/22/2018
2/18/2018	3/3/2018	3/8/2018
3/4/2018	3/17/2018	3/22/2018
3/18/2018	3/31/2018	4/5/2018
4/1/2018	4/14/2018	4/19/2018
4/15/2018	4/28/2018	5/3/2018
4/29/2018	5/12/2018	5/17/2018
5/13/2018	5/26/2018	5/31/2018*
5/27/2018	6/9/2018	6/14/2018
6/10/2018	6/23/2018	6/28/2018
6/24/2018	7/7/2018	7/12/2018

Pay Period Beginning	Pay Period Ending	Actual Pay Date
7/8/2018	7/21/2018	7/26/2018
7/22/2018	8/4/2018	8/9/2018
8/5/2018	8/18/2018	8/23/2018
8/19/2018	9/1/2018	9/6/2018
9/2/2018	9/15/2018	9/20/2018
9/16/2018	9/29/2018	10/4/2018
9/30/2018	10/13/2018	10/18/2018
10/14/2018	10/27/2018	11/1/2018
10/28/2018	11/10/2018	11/15/2018
11/11/2018	11/24/2018	11/29/2018*
11/25/2018	12/8/2018	12/13/2018
12/9/2018	12/22/2018	12/27/2018
12/23/2018	1/5/2019	1/10/2019
1/6/2019	1/19/2019	1/24/2019

**Note: When there are three pay periods in a single month, no insurance withholdings will be taken out of the third payment period.*

Contact information

Enrollment/changes during the year	Benefits Call Center	844.436.7172
Medical coverage	BlueCross BlueShield of South Carolina PO Box 100300 Columbia, SC 29202	800.760.9290 – Customer Service 800.810.2583 – PPO Network Providers 800.334.7287 – Precertification 843.317.4949 – Mental Health & Substance Abuse Precertification 866.471.5946 – HSA Bank www.SouthCarolinaBlues.com
Prescription drug coverage	Caremark	888.963.7290 – Customer Service www.SouthCarolinaBlues.com
Dental coverage	BlueCross BlueShield of South Carolina PO Box 100300 Columbia, SC 29202	800.222.7156 – Customer Service www.SouthCarolinaBlues.com
Vision coverage	Physicians Eyecare Plan 48 Courtenay Drive Charleston, SC 29403 9 a.m. – 5 p.m. (Monday through Friday)	800.368.9609 – Member Services 843.579.0508 843.577.5895 – Fax www.physicianseyecareplan.com
Health & Dependent Care Flexible Spending Accounts	WageWorks Claims Administrator PO Box 14053 Lexington, KY 40512	877.WageWorks (924.3967) 866.353.8058 – TTY www.wageworks.com Smartphone App: EZ Receipts
Short-Term Disability, Long-Term Disability and Leave of Absence	CIGNA PO Box 22328 Pittsburgh, PA 15222	888.842.4462 www.myCigna.com
Basic Life, Supplemental Life and Dependent Life	CIGNA PO Box 22328 Pittsburgh, PA 15222	Contact HR Service Center for Claims and Conversion Forms – 843.777.2595

Critical Illness & Accident Insurance	Voya Employee Benefits Claims: PO Box 1548 Minneapolis, MN 55440	877.236.7564 – Questions 888.238.4840 – Claims **https://claimscenter.voya.com**
Identity theft protection	Zander Identity Theft Solutions Available 24 hours	877.795.8472 **www.zanderinsurance.com**
Proof of employment	The Work Number McLeod Employer Code: 12873	800.367.2884 800.424.0253 TTY **www.theworknumber.com**
Retirement plan	Lincoln Retirement Services Company, LLC PO Box 7876 Fort Wayne, IN 46801-7876 8 a.m. – 8 p.m. (Monday through Friday)	800.234.3500 – Retirement Consultant 843.777.5767 – Local Consultant **www.lfg.com**
Workers' Compensation / Employee Health	McLeod Employee Health	843.777.5146
Employee Assistance Program		843.317.4949 – Pee Dee 843.655.9438 – Coastal 877.317.4949
McLeod Choice Pharmacy		843.777.2166 – Florence 843.716.7178 – Loris Seacoast
Breastfeeding support	McLeod Resource Center	843.777.2890
Information Systems Help Desk		843.777.2288
Payroll Services		843.777.2593
McLeod Healthier You		843.777.5191 888.808.7466
HR Service Center		843.777.2595

All sites can be accessed through *Living Well On-line*.

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Important notices

For your protection, federal laws govern employee benefit plans. The following section highlights legal information that you need to know. Please refer to the individual plan documents, certificates of insurance, summary of benefits and coverages, and/or summary plan descriptions for specific information. Please contact the HR Service Center if you have questions concerning any of the McLeod Health benefit plans.

Important notice from McLeod about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with McLeod 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. McLeod has determined that the prescription drug coverage offered by the McLeod Medical Plans are, 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-month Special Enrollment Period (SEP) to join a Medicare drug plan.

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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 McLeod coverage will not be affected. If you join a Medicare drug plan and drop your current medical coverage with McLeod, be aware that you or your dependents will not be able to get this coverage back until the next Open Enrollment period. Note that your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan and keep your coverage under a McLeod plan.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with McLeod and do not 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Summary of options for Medicare eligible employees and/or dependents

Medical and prescription drug coverage are offered as a package under a McLeod Medical Plan (you cannot elect medical coverage without prescription drug coverage).

- Continue medical and prescription drug coverage under a McLeod benefit plan and do not elect Medicare D coverage. **Impact:** Your claims continue to be paid by McLeod.
- Continue medical and prescription drug coverage under a McLeod benefit plan and elect Medicare D coverage. **Impact:** As an active employee (or dependent of an active employee), McLeod continues to pay primary on your claims (pays before Medicare D).
- Drop medical coverage through McLeod and elect Medicare Part D coverage. **Impact:** Medicare is your primary coverage. You will not be able to rejoin a McLeod benefit plan unless you experience a qualifying life/work event change or until the next Open Enrollment period.

For more information about this notice or your current prescription drug coverage

Contact the HR Service Center at **843.777.2595**. NOTE: You will 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 McLeod changes. You also may request a copy of this notice at any time.

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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 will 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 go to **www.medicare.gov**. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help or call **800.MEDICARE** (800.633.4227). TTY users should call **877.486.2048**.

If you have limited 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 **800.772.1213** (TTY 800.325.0778).

Notice of rescission of coverage

McLeod cannot rescind coverage with respect to an individual once the individual is covered under a plan or policy unless the individual performs an act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. McLeod must provide at least 30 days advance written notice to each participant who would be affected before coverage can be rescinded, regardless of whether the coverage is self-funded or fully-insured.

The regulations define a rescission as a cancellation or discontinuance of coverage that has a retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. A cancellation is not a rescission if: (1) the cancellation has only a prospective effect, or (2) the cancellation is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

McLeod is permitted to rescind coverage if you commit fraud or if you intentionally misrepresent material facts.

The McLeod Plan Notice of Privacy Practices

This notice is effective as of 10-16-2017.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our promise

We understand that health information about you is personal. It is the policy of the McLeod Plan to protect the privacy and integrity of your protected health information (PHI). This is required by law and by ethics. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

Required responsibilities

We are required to:

- Make sure that health information that identifies you is kept private;
- To give you this Notice of our legal duties and privacy practices with respect to health information that we collect and maintain about you;
- To follow the terms of this Notice that are currently in effect.

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Your privacy rights

- **Right to review and ask for a copy** – You have the right to inspect and ask, in writing, to see and get a paper or electronic copy of the PHI the McLeod Plan has about you. The McLeod Plan has the right to say we cannot do as you ask. If you are denied the right to see or copy your medical information, you may ask us to think about it. We may ask a licensed health care professional to review the denial and we will follow their decision. We have up to 30 days to make your information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to an electronic copy** – You have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity if your PHI is maintained in an electronic format. We will make every effort to provide access to your information in the form or format you request. We will provide a readable hard copy of the information if we cannot produce it in the requested form or format. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
- **Right to get notice of a breach** – You have the right to be notified, in writing, if we discover a breach of your unsecured PHI and determine through a risk assessment that notification is required. We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Right to amend** – If you feel your PHI is not complete, you may ask us, in writing, to add to the information. You must provide a reason why the information is to be added. The McLeod Plan has the right to say we cannot do as you ask. We will tell you if we cannot do what you ask.
- **Right to an accounting of disclosures** – You have the right to ask, in writing, for a list of who was made known of your PHI we made in the last six years prior to the date you request the accounting. This list will not include those who were part of your treatment, those who helped to get payment, those who do McLeod Plan management, those who you allowed us to share your information, and anything before April 14, 2003.
- **Right to ask restrictions on disclosures** – You have the right to ask, in writing, to not use or to limit the PHI we make known about you for treatment, payment or hospital management or to someone involved in your care or the payment for your care, like a family member or friend. The McLeod Plan has the right to say we cannot do as you ask. However, if we do agree, we may need to use the information for emergency treatment or to obey the law.
- **Right to ask restriction to a health plan** – You have the right to ask us to not send your PHI to a health plan for payment or health care operations purposes if the information has to do with a health care item or service for which you have paid us in full and out of pocket. We will honor this request.
- **Right to ask confidential communications** – You have the right to ask, in writing, that we get in touch with you about your PHI in a certain way such as only at work or by mail. We will do as you ask, within reason, however you must provide us with information about how payment, if any, will be handled. We will not ask why you are asking us to do this.
- **Right to a paper copy of this notice** – You have the right to receive a paper copy of this Notice at any time even though you may have agreed to receive it by computer. You may obtain a copy from the Corporate Human Resources Department.

The McLeod Human Resources Department has the request forms to fill out and can tell you if there will be a cost.

Uses and disclosures of your protected health information

- **Treatment** – We may use and disclose your PHI to health care providers to help them treat you. For example, our care managers may disclose PHI to a home health care agency to make sure you get the services you need after discharge from the hospital.
- **Payment** – We may use and make known your PHI for payment purposes such as paying doctors and hospitals for covered services. Payment purposes also include activities such as; determining eligibility for benefits; reviewing services for medical necessity; performing utilization review; obtaining premiums; coordinating benefits, subrogation, and collection activities.
- **Health care operations** – We may use and make known your PHI for the management of the McLeod Plan such as reviewing our claims experience and to make determination with respect to the benefit options that we offer to employees. We do not use or disclose your PHI that is genetic information for underwriting purposes.

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- **Health and wellness information** – We may use your PHI to contact you with information about appointment reminders; treatment alternatives; therapies; health care providers; settings of care; or other health related benefits, services and products that may be of interest to you.
- **Business associates** – There are some services provided in our organization through contracts with business associates. An example is a claims processing administrator. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Plan sponsor** – We may disclose your PHI to the plan sponsor, McLeod, for purposes related to benefits and claims administration. The plan sponsor may use this information to plan for its expected expenses under the plan.
- **Public health and safety; health oversight** – We may disclose your PHI to a public health authority, such as DHEC, for public health activities such as responding to public health investigations, to lessen or prevent a serious threat to you or others' health or safety and to health oversight agencies for certain activities such as audits, disciplinary actions and licensure activity.
- **Legal processes, law enforcement and specialized government activities** – We may disclose your PHI in the course of legal proceedings, in response to a subpoena, discovery requests or other lawful process. We may disclose your PHI to law enforcement officials in order to respond to a warrant or subpoena or for specialized governmental activities such as national security. We will disclose your PHI when required to do so by federal, state or local law.
- **Research, deaths and organ donations** – We may disclose your PHI to researchers provided they have established measures to protect your privacy. We may disclose your PHI to coroners, medical examiners and in connection with organ donations.
- **Workers' Compensation** – We may disclose your PHI for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Family, friends and personal representatives** – We may disclose PHI to a family member, relative or a friend that you identify as follows:

  a. when you are present and agree prior to the use or disclosure, or

  b. when you are incapacitated or in an emergency, or in the exercise of our professional judgment we determine that the disclosure is in your best interest. We will only disclose the PHI that is relevant to the person's involvement in your health care or payment related to your health care. Unless prohibited by law we may disclose you PHI to your personal representative. Personal representatives may be someone named in a durable power of attorney or a parent or guardian of an un-emancipated minor.
- **Communications** – We will communicate information containing PHI to the address or telephone number we have on record for the subscriber of your health benefits plan. We may mail information containing your PHI to the subscriber. For example; communication regarding member requests for reimbursement may be addressed to the subscriber.

Note: South Carolina and Federal Law provide protection for certain types of health information, including information about prescription drugs, neonatal testing, alcohol or drug abuse, mental health and sexually-transmitted diseases, including AIDS/HIV, and may limit whether and how we may make known information about you to others.

Other uses of medical information

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to the McLeod Plan will be made only with your written authorization that is not part of any consent we may have obtained from you. This is your right. We will always obtain your authorization for certain uses and disclosures of psychotherapy notes, for marketing purposes and for disclosures that can be the sale of your protected health information. You may cancel that authorization, in writing, at any time. You understand that we are unable to take back any information we have already made known, we must continue to obey the laws where certain information must be made known, and we are to keep our records of the care that we provided to you.

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Changes to this notice

We have the right to change this Notice as it relates to all PHI that we create and/or maintain. We will post the most current Notice on the McLeod Plan web site and will use one of our periodic mailings to inform subscribers about the updated Notice. We will provide a new version of our notice to you within 60 days of a material change.

Complaints

If you think there has been a problem with your privacy rights, you may file a complaint with the Corporate Compliance Officer at **843.777.8097**, or the Compliance Hot Line at **888.679.3531**, or the Secretary of the Department of Health and Human Services. You will not get in trouble for filing a complaint nor will treatment be withheld from you.

If you have any questions about this Notice, please contact the Corporate Compliance Officer at **843.777.8097**.

Family and Medical Leave Act (FMLA)

Eligible and approved employees are granted up to 12 weeks of unpaid job-protected leave within a 12-month period for certain family and medical reasons. You are eligible if you have worked for McLeod for at least one year and have worked 1,250 hours in the prior 12 months. FMLA runs concurrently with any other paid or unpaid leave.

Patient protection and pre-existing conditions

McLeod does not require the designation of a primary care provider. You do not need prior authorization from McLeod or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or making referrals. For a list of participating health care professionals who participate in the McLeod Provider Network to include those who specialize in obstetrics or gynecology go to *Living Well On-line* or contact the HR Service Center at **843.777.2595**. You can also visit **www.SouthCarolinaBlues.com** to review the list of approved providers through the BCBS Provider Network.

McLeod does not exclude or limit a benefit based on a condition that a participant has prior to enrolling in a McLeod plan.

Women's Health & Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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, copays, and coinsurance applicable to other medical and surgical benefits provided under a McLeod plan. If you would like more information on WHCRA benefits, go to *Living Well On-line* for the Summary Plan Description or call the HR Service Center at **843.777.2595**.

Newborns' & Mother's Health Protection Act (Newborn's Act)

McLeod does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48

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hours following a normal delivery or less than 96 hours following a Cesarean delivery. However, the mother's or newborn's attending physician or care provider may, after consulting with the mother, discharge the mother or her newborn earlier than 48 hours (or 96, as applicable). McLeod does not require a provider to obtain authorization for prescribing a length of stay that is 48 hours (or 96 hours following a Cesarean delivery). Certain notice requirements of the pregnancy or the childbirth may apply.

The Mental Health Parity and Addiction Equity Act

McLeod offers services for mental health and substance use disorders (MH/SUD) that is no more restrictive than the coverage for medical/surgical conditions. To include:

- Copays, coinsurance, deductibles, and out-of-pocket maximums, limitations on service utilization, use of care management tools, coverage for out-of-network providers, and criteria for medical necessity determinations.

McLeod typically makes decisions to cover or deny coverage for specific mental health and substance use disorder services based on whether that service is "medically necessary" for the patient. Upon request, McLeod will:

- Share the criteria used to make these medical necessity determinations with any current or potential employee, dependent, or contracting provider
- Explain the reason for any denial of reimbursement or payment for services for mental health and substance use disorder benefits to the employee or dependent

For additional information on mental health benefits, please contact the McLeod Employee Assistance Program at **843.317.4949** or toll free **877.317.4949** in the Pee Dee or **843.655.9438** in the Coastal Area or BCBS at **800.760.9290** or **800.810.2583**.

Genetic Information Nondiscrimination Act (GINA)

McLeod does not use a person's genetic information in making employment decisions such as hiring, firing, job assignments, or any other terms of employment. GINA provides additional underwriting protections, prohibits requesting, requiring, or purchasing genetic testing, and restricts the collection of genetic information.

There are, however, a few exceptions to this rule, such as when McLeod obtains genetic information inadvertently or pursuant to the FMLA; receives voluntary health or genetic services that an employer offers; or acquires genetic information from sources that are "commercially and publicly available," like newspapers, books, and public websites.

McLeod keeps any genetic information we do acquire confidentially, subject to certain very narrow exceptions.

GINA prohibits McLeod from collecting genetic information (including family medical history) prior to or in connection with benefit enrollment; or at any time for underwriting purposes.

McLeod may use a Health Risk Assessment (HRA) that requests family medical history, if it is requested to be completed after and unrelated to benefit enrollment and if there is no premium reduction or any other reward for completing the HRA. McLeod may offer a premium discount or other reward for completion of an HRA that does not request family medical history or other genetic information, such as information about any genetic tests the individual has undergone. Under GINA McLeod may also reward:

- Participation in an annual physical examination with a physician (or other health care professional) who is providing health care services to the individual, even if the physician may ask for family medical history as part of the examination;
- More favorable cost-sharing for preventive services, including genetic screening; and
- Participation in certain disease management or prevention programs. The incentives to participate in such programs must also be available to individuals who qualify for the program but have not volunteered family medical history information through an HRA.

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A person who believes than McLeod has violated GINA may file a charge of discrimination with the EEOC within 180 days of the alleged violation, or within 300 days if a state or local agency enforces a law that prohibits employment discrimination on the basis of the acquisition or use of genetic information.

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 are eligible for health coverage from McLeod, 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance 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 **888.KIDS NOW** or go to **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.

McLeod permits you to enroll in a health plan if you are not already enrolled and if you or your dependents are eligible for premium assistance under Medicaid or CHIP. This is called a "special enrollment" opportunity; however, **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in a plan, you can contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA** (3272).

If you live in one of the following States, you may be eligible for assistance paying premiums. The following list of States is current as of August 10, 2017. You should contact your State for further information on eligibility.

SOUTH CAROLINA – Medicaid	**http://www.scdhhs.gov** 888.549.0820
NORTH CAROLINA – Medicaid	**http://www.ncdhhs.gov/dma** 919.855.4100

To see if any other States have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor	Employee Benefits Security Administration **www.dol.gov/ebsa** 866.444.EBSA (3272)
U.S. Department of Health and Human Services	Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 877.267.2323, Menu Option 4, Ext. 61565

Summary of benefits and coverage

The Summary of Benefits and Coverage for the Core and Enhanced Plans and the High Deductible Health Plan located on the McLeod Health Internet Site. Please visit at **www.mcleodhealth.org** or contact the HR Service Center at **843.777.2595** for additional details.

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Your ERISA benefits rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). In addition, ERISA provides that you, as a plan participant are entitled to:

- Receive information about your plan and benefits.
- Examine, without charge, at the office of the plan administrator and at other specified locations such as work sites all plan documents governing the plan, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
- Obtain, upon written request, copies of documents governing the operation of the plan, including insurance contracts. The plan administrator may make a reasonable charge for the copies.
- Receive a summary or the plan's annual financial report.

Claims filing and appeal procedures

1. You or your covered dependent (member) has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. **An appeal must meet the following requirements.**
   a. Be in WRITING; and,
   b. Be sent (via US mail) to: BlueCross Blue Shield of South Carolina (BCBS), Claims Service Center, Post Office Box 100300, Columbia, SC 29202
   c. Must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
   d. Must include your name, the covered dependents name (if applicable), date of services received, address, identification number and any other information, documentation or materials that support the appeal.
2. A member may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.
3. If the appealed claim involves an exercise of medical judgment, McLeod will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.
4. **The final decision on the appeal will be made within the time periods specified below:**
   - **Pre-service claim** – BCBS will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.
   - **Urgent care claim** – A member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally to the HR Service Center at **843.777.2595**, and an HR Service Center representative will communicate with you by telephone or facsimile. The Plan Administrator or their designee will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
   - **Post-service claim** – BCBS will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.
   - **Concurrent care claim** – The Plan Administrator or designee will decide the appeal of Concurrent Care Claims within the time frame set forth above depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

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5. **Notice of final internal appeals determination:**
   - State specific reason(s) for the Adverse Benefit Determination;
   - Reference specific provision(s) of the Plan of Benefits on which the benefit determination is based;State that a member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits.
     - Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination;
     - If the reason for the Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
     - Include a statement regarding your right to request an external review; and
     - Include a statement regarding your right to bring an action under section 502(a) of ERISA.
6. McLeod retains BCBS assistance in making the determination on appeal. Regardless of its assistance, BCBS is only acting in an advisory capacity and is not acting in a fiduciary capacity. McLeod at all times retains the right to make the final determination.

External review procedures

After a member has completed the appeal process, they may be entitled to an additional external review of their claim at no cost. An external review may be used to reconsider a member's claim if BCBS has denied, either in whole or in part. In order to qualify for external review, the claim must have been denied, reduced, or terminated.

After a member has completed the appeal process, (and an Adverse Benefit Determination has been made) a member will be notified in writing of the right to request an external review. A member should file a request for external review within four (4) months of receiving the notice of BCBS's decision. In order to receive an external review, a member will be required to authorize the release of medical records (if needed in the review for the purpose of reaching a decision on the claim).

Within six (6) business days of the date of receipt of a member's request for an external review, BCBS will respond by either:

- Assigning the request for an external review to an independent review organization and forwarding the member's records to such organization; or,
- Notifying the member in writing that the request does not meet the requirements for an external review and the reasons for BCBS's decision.

The external review organization will take action on a member's request for an external review within forty-five (45) days after it receives the request for external review from BCBS.

Expedited external reviews are available if a member's Physician certifies that they have a serious medical condition. A serious medical condition, used in this provision, means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place a member's health in serious jeopardy. A member may be held financially responsible for the treatment, a member may request an expedited review of BCBS's decision if BCBS's denial of Benefits involves Emergency Medical Care and the member has not been discharged from the treating hospital.

Continuation coverage rights under COBRA

McLeod is required to offer covered employees and family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan would otherwise end due to certain qualifying events. This notice is intended to inform all plan participants, in a summary fashion, of your potential future options and obligations under the continuation coverage provisions of federal law. Should an actual qualifying event occur in the future, McLeod will send you additional information and the appropriate election notice at that time.

What is COBRA continuation coverage? Consolidated Omnibus Budget Reconciliation Act (COBRA) is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. A child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary. Under the Plan, qualified beneficiaries who elect COBRA must pay for the coverage.

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If you are an employee, you will be entitled to elect COBRA if you lose your group coverage under the Plan because any of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct (on your part).

If you are the spouse or dependent child of a McLeod employee, you will be entitled to elect COBRA if you lose your group coverage under the Plan because any of the following qualifying events happens:

- They die;
- Their hours of employment are reduced;
- Their employment ends for any reason other than their gross misconduct;
- They become entitled to Medicare benefits (under Part A, Part B, or both); or
- You (in case of child, parents) become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA coverage available? The Plan will offer COBRA to qualified beneficiaries only after the qualifying event has been reported to Businessolver. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event.

You must give notice of some qualifying events – For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the HR Service Center at **843.777.2595 within sixty (60) days after the qualifying event occurs**.

How is COBRA coverage provided? Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA. Covered employees may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children.

COBRA is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which their employment terminates, COBRA for their spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA generally lasts up to a total of 18 months. There are two ways in which this 18-month period of COBRA can be extended.

Disability extension of 18-month period

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the HR Service Center in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA, for a total maximum of 29 months. The disability must have started before the 60th day of COBRA and must last at least until the end of the 18-month period of coverage. If a qualified beneficiary is determined by the SSA to no longer be disabled, you must notify the HR Service Center at **843.777.2595** of that fact within thirty (30) days after the SSA's determination.

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Second qualifying event extension of 18-month period

If your family experiences another qualifying event while receiving 18 months of COBRA, the spouse and dependent children in your family can get up to 18 additional months of COBRA, for a maximum of 36 months, if notice of the second qualifying event is properly given to the HR Service Center. This extension may be available to the spouse and any dependent children receiving coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must notify the HR Service Center at **843.777.2595** within sixty (60) days after the second qualifying event occurs if you want to extend your continuation coverage.

Other coverage options besides COBRA

Instead of enrolling in COBRA, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA.

You should compare your other coverage options with COBRA and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it is important that you choose carefully between COBRA and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA.

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost coverage from **Medicaid or the Children's Health Insurance Program (CHIP)**. You can access the Marketplace for your state at **www.HealthCare.gov**.

Coverage through the Health Insurance Marketplace may cost less than COBRA. Being offered COBRA will not limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

If you sign up for COBRA, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If you terminate your COBRA early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

If you sign up for Marketplace coverage instead of COBRA, you cannot switch to COBRA under any circumstances.

If you have questions – This notice does not describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. Questions concerning your Plan or your COBRA rights should be addressed to the HR Service Center at **843.777.2595**. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits

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Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa** or call their toll-free number at **866.444.3272**. For more information about health insurance options available through the Health Insurance Marketplace, and to locate someone in your area who you can talk to about the different options, visit **www.HealthCare.gov**.

Keep your plan informed of address changes – In order to protect your family's rights, you should keep the HR Service Center informed of any changes in the addresses of family members. You should also keep a copy of any notices you send in your records.

Plan contact information – HR Service Center, 555 East Cheves Street, PO Box 100551, Florence, SC 29501-0551 (29506-2617 for the street address) **843.777.2595**

Duration of COBRA continuation coverage – Under the COBRA rules there are situations in which a group health plan may stop making COBRA available earlier than usually permitted. One of those situations is where the qualified beneficiary obtains coverage under another group health plan.

New Health Insurance Marketplace coverage options and your health coverage through McLeod

When key parts of the health care law took effect in 2014, there is now 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 McLeod.

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. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1st.

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 McLeod does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

Does McLeod Health's coverage affect eligibility for premium savings through the marketplace? Yes. If you are in a full-time benefits eligible position and have an offer of health coverage from McLeod, **you may not be eligible for a tax credit** through the Marketplace and may wish to enroll in a McLeod plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if:

- McLeod does not offer coverage to you at all.
- The cost of a plan from McLeod that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year.
- The coverage McLeod provides does not meet the "minimum value" standard set by the Affordable Care Act.

McLeod contributes almost 80% of the actual cost of employee only coverage for employees in a benefits eligible full-time position and therefore meets the "minimum value standard", which requires that McLeod share in the cost of coverage and that it be no less than 60% of costs. McLeod strives, and it is our intention, to make the cost of coverage to you affordable, based on your wages.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by McLeod, you will lose the share of the insurance cost paid by McLeod and potentially your ability to purchase insurance through McLeod. **REMEMBER that you must make any elections or changes during the McLeod Open Enrollment period each year or within 31 days of becoming eligible for benefits or from having a qualifying event occur.** Please review the Resource Guide or contact the HR Service Center at **843.777.2595** for qualifying event rules. If you purchase through the Marketplace, you will also lose the tax savings that you have by purchasing insurance through McLeod on a before-tax basis.

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How can i get more information? For more information about coverage offered by McLeod, please review the Summary Plan Descriptions or contact the HR Service Center at **843.777.2595**. More information can be obtained by visiting the *Benefits Section* of *Living Well On-line*.

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.

Information about health coverage offered by McLeod Health

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.

3. Employer Name – McLeod Health
4. Employer Identification Number (EIN) – 51-0473500
5. Employer address – 555 East Cheves Street / PO Box 100551, Florence, SC 29502-0551
6. Employer phone number – **843.777.2595**
7. City – Florence
8. State – SC
9. ZIP code – 29502
10. Who can we contact about employee health coverage at this job? Human Resources Service Center
11. Phone number (if different from above) – same as above
12. Email address – **livingwell@mcleodhealth.org**
    - Here is some basic information about health coverage offered by McLeod Health:
    - As your employer, we offer a health plan to: All employee's who are in a benefits eligible position and budgeted to work 40 hours or more per pay period
    - Eligible dependents are:
      - Your legal spouse or common-law spouse as recognized by South Carolina.
      - Your child up to age 26, regardless of marital, student, or tax-dependent status. The term "child" means your or your spouse's (1) biological child; (2) legally adopted child, including children placed with you for the purpose of adoption; (3) stepchild; (4) children who you or your spouse are legal guardians; or (5) a child for whom you are required to provide insurance coverage under a Qualified Medical Child Support Order (QMCSO).
      - Your incapacitated dependent (mentally or physically handicapped) whom is dependent on you for at least 51% of their support

The coverage for full time benefits eligible employees meets the minimum value standard, and is intended to be affordable, however, that is dependent on your household income.

*** Even though McLeod intends for 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.

13. Are you currently eligible for coverage offered by McLeod Health or will you be eligible in the next 3 months? If you are uncertain, contact the HR Service Center at **843.777.2595**.
14. Does McLeod Health offer a health plan that meets the minimum value standard? Yes
15. The Core Plan which meets the minimum value standard – Employee Only coverage in 2018 is $74.91 twice per month.
16. Effective January 1, 2018, the McLeod Health Core Medical Plan meets the minimum value standard. The premium for the Employee-Only coverage tier under this plan will be $74.91 twice per month in 2018.

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For more information about coverage offered by McLeod, please review the Summary Plan Descriptions or contact the HR Service Center at **843.777.2595**. More information can be obtained by visiting *Living Well On-line*.

Wellness programs

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under any wellness programs, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under any wellness program, call Employee Health at **843.777.5146** and we will work with you to develop another way to qualify for the reward.

Notice regarding wellness program

McLeod Healthier You is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the *McLeod Healthier You* program you will be asked to complete a voluntary health risk assessment (an "HRA") that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You also will be asked to complete a biometric screening, which will include a blood test for blood sugar and cholesterol, as well as, additional screenings/ recommendations. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the *McLeod Healthier You* program receive an incentive of a health insurance premium discount of $45 per month if they complete the HRA, biometric screening and other requirements during the assigned times. Although you are not required to participate, only employees who do so will receive the health insurance premium discount.

The *McLeod Healthier You* program offers additional incentives to employees who choose to participate, including subsidies to reduce your cost for fitness programs such as gym memberships and weight management programs. Prescription assistance also may be available for employees who participate in *McLeod Healthier You* chronic disease care management programs for medical conditions such as diabetes, hypertension, hyperlipidemia, obesity, heart failure, asthma and chronic obstructive pulmonary disease (COPD). If you are unable to participate in any health-related activities available through the *McLeod Healthier You* program, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the *McLeod Healthier You* Coordinator at **888.808.7466** or **healthieryou@mcleodhealth.org**.

The maximum allowable incentives received by an employee for participating in the *McLeod Healthier You* program cannot exceed 30 percent of the total cost of employee-only coverage. This is in line with the rules set by the Equal Employment Opportunity Commission (EEOC).

The information collected will be used to help you understand your current health and potential health risks and may be used to offer you services through the *McLeod Healthier You* wellness program, such as chronic disease care management. You also are encouraged to share your results or concerns with your own doctor.

Protections from disclosure of medical information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the *McLeod Healthier You* program and McLeod Health may use aggregate information it collects to design a program based on identified health risks in the workplace, the *McLeod Healthier You* program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation or standard needed to participate in the program, or as expressly permitted by law. Medical information you provide in connection with the *McLeod Healthier You* program that personally identifies you will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the *McLeod Healthier You* program. You will not be asked or required to waive the confidentiality of your health information as a condition of participating in or receiving an incentive under the *McLeod Healthier You* program. Anyone who receives your information for purposes of providing you services as part of the *McLeod Healthier You* program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the *McLeod Healthier You* Medical Director, Coordinator and Care Managers as necessary in order to provide you with services under the *McLeod Healthier You* program. If you choose to designate a primary care office at the time of your HRA and biometric screening, the *McLeod Healthier You* program also will share your health information with that primary care office.

In addition, all medical information obtained through the *McLeod Healthier You* program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the *McLeod Healthier You* program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the *McLeod Healthier You* program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact *McLeod Healthier You* at **888.808.7466** or **healthieryou@mcleodhealth.org**.