2020

Benefits Enrollment Guide

Southern Mutual Church Insurance

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The following descriptions of available benefit elections options, are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

Presented by:

ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Please Register at www.employeenavigator.com .
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer
- states otherwise
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Did you know?

Open Enrollment is the only chance to make changes, unless you experience a “change in status.”

PACKAGE OVERVIEW & CONTACT INFORMATION

Southern Mutual Church Insurance offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.

Effective January 1, 2020:

- Medical benefit plans with **BlueChoice - www.bluechoicesc.com**
- Dental benefit plan with **Delta Dental of SC - www.deltadental.com**
- Vision benefit plan with **EyeMed - www.eyemed.com**
- Basic Life/AD&D, Voluntary Life/AD&D, Short Term Disability, and Long Term Disability plans with **Mutual of Omaha - www.mutualofomaha.com**

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards. In the meantime, you can look up providers for your plans on the internet.

MEDICAL PLANS

For this plan year, you can choose from the following medical options. Refer to the carrier benefits summaries for the exact benefit levels associated with your plan choice.

Carrier Name	BlueChoice with AmFirst			
Name of Plan/ Metallic Level	BlueChoice Advantage Plus 3500		BlueChoice Advantage Plus 3000 HDHP	
Type of Plan	Copay Plan		High Deductible Health Plan	
Office Visits	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Primary	$30	Deductible, then 50%	Deductible, then 0%	Deductible, then 20%
Specialist	$60	Deductible, then 50%	Deductible, then 0%	Deductible, then 20%
Pharmacy				
Deductible	N/A	Out-of-Network Deductible, then 50%	Same as Medical	Deductible, then 20%
Tier 1	$8		Deductible, then 0%	
Tier 2	$25			
Tier 3	$45			
Tier 4	$70			
Tiers 5 & 6	$125/$175			
Common Services				
In-Patient Facility	Deductible, then 50%	Deductible, then 50%	Deductible, then 0%	Deductible, then 20%
Out-Patient Facility	Deductible, then 50%	Deductible, then 50%	Deductible, then 0%	Deductible, then 20%
Urgent Care	$60	Deductible, then 50%	Deductible, then 0%	Deductible, then 20%
Emergency Room	$300 Copay, then 50% Coinsurance		Deductible, then 0%	Deductible, then 20%
Annual Deductible				
Individual	$1,000	$7,000	$3,000	$6,000
Family	$1,000 per person	$14,000	$6,000	$12,000
Coinsurance	50%		0%	20%
Coinsurance Max/Annual Out of Pocket				
Individual	$1,000	$21,700	$3,000	$12,000
Family	$1,000 per person	$43,400	$6,000	$24,000
Maximum Benefits	Unlimited Lifetime Maximum		Unlimited Lifetime Maximum	

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

HEALTH SAVINGS ACCOUNT (HSA)

Option for High Deductible Health Plan (HDHP)

For employees who elect the HDHP, you have the option of opening a Health Savings Account (HSA). The HSA-eligible plan provides a way to save money that becomes available in future years for health care expenses.

- In 2020 individuals can contribute up to $3,550 and families can contribute up to $7,100 to their HSA (these totals represent the total of employee and employer contributions).
- If you are 55 or older, you can make a $1,000 catch-up contribution.
- Contributions to an HSA can be made on a pre-tax or post-tax basis, and funds within the HSA grow without incurring taxes. Funds are withdrawn tax-free for healthcare related needs without having to file receipts, although you should keep your receipts in case you are ever audited.
- Money deposited in the HSA by the employee AND employer immediately become the employee's asset and is portable.

Pre-Tax Plan	What is this account and how does it work?	Maximum Contribution Allowed	Can money in accounts be "rolled over"?
Health Savings Account (HSA)	An HSA account can be funded with pre-tax dollars by you, your employer or both to help pay for eligible medical expenses.	Employee only coverage: $3,550 Family coverage: $7,100 Catch up contribution (55 year of age or older): $1,000	Yes, amounts left in your HSA account can be rolled over year to year and is portable if you leave employment of the company

The benefit plan information shown in this guide is illustrative only. This information is not intended to be exhaustive nor should any discussion or opinions be construed as professional advice.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Who is Eligible and When

All Full-Time Employees working at least 30 hours each week. Please check with your HR representative for specific eligibility requirements.

Benefits You Receive

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses and prescriptions not covered by their insurance plan with pretax dollars. There are limits on salary reduction contributions to a health FSA offered under a cafeteria plan and is applicable to both grandfathered and non-grandfathered health FSAs. This limit will be indexed for cost-of-living adjustments. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA

The Dependent Care FSA lets employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

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DENTAL PLAN

For this plan year, you can choose from the following dental option. Refer to the carrier benefits summary for the exact benefit level associated with your plan.

Carrier Name	Delta Dental of SC
Name of Plan	Delta Dental PPO Premier
Type of Plan	PPO
Class	**In Network**
Preventive	0%
Basic Restorative	Deductible then 20%
Major Services	Deductible then 50%
Orthodontia	50%
Plan Details	
Deductible applies to Preventive	No
Endodontics/Periodontics: Basic or Major	Basic
Orthodontics (Adult/Children)	Children
Waiting Periods Applied	No
Deductible	
Person - Calendar Year	$50
Family - Calendar Year	$150
Plan Maximums	
Calendar Year Max	$1,500
Ortho Lifetime Max	$1,000

Did you know?

One can of soda is the amount of sugar recommended for three days for a child. Sugary Sodas are a major risk factor for tooth decay*

**Source:* American Dental Association (ADA)

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VISION PLAN

For this plan year, you can choose from the following vision option. Refer to the carrier benefit summary for the exact benefit level associated with your plan.

Carrier Name	EyeMed
Name of Plan	Voluntary - Insight Plan H
Exam	**In Network**
Copay	$10 Copay
Frequency	12 Months
Lenses	
Frequency	12 Months
Single	$25 Copay
Bifocal	$25 Copay
Trifocal	$25 Copay
Contacts Elective	$150 Allowance plus 15% off Balance
Contacts Medically Necessary	$0 Copay
Frames	
Frequency	12 Months
Frames	$150 Allowance plus 20% off Balance

Did you know?

Your eyes need a rest even while you're awake. Use the 20-20-20 rule to reduce eyestrain. After working for 20 minutes, look away about 20 feet in front of you for about 20 seconds.*

Source: National Eye Institute
https://nei.nih.gov/health/healthyeyes

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LIFE AND AD&D INSURANCE PLAN

Basic Life

Carrier Name	Mutual of Omaha
Life Benefit	$50,000
AD&D Benefit	Spouse: $5,000 Child Over 14 Days: $2,500
Age Reduction Benefit	Reduces to: 65% at age 65, then 50% at age 70
Conversion Privilege	Yes
Waiver of Premium	Yes

Voluntary Life

Carrier Name	Mutual of Omaha
Employee Life and AD&D Benefit	$10,000 Increments up to 5x Earnings
Dependent Life and AD&D Benefit	**Spouse:** $5,000 Increments up to $20,000 **Child:** $2,000 Increments up to $10,000
Conversion Privilege	Yes
Waiver of Premium	Yes

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DISABILITY INSURANCE

Short Term Disability

Carrier Name	Mutual of Omaha
Benefit	60%
Maximum Weekly Benefit	$1,500
Waiting Period-Accident	30 Days
Waiting Period-Sickness	30 Days
Duration of Benefits	9 Weeks

Long Term Disability

Carrier Name	Mutual of Omaha
Benefit	60%
Maximum Monthly Benefit	$7,500
Elimination Period	90 Days / End of Short Term Disability
Duration of Benefits	SSNRA

Did you know?

Of today's 20 year-olds, just over 1 in 4 will become disabled before they retire.*

**Source:* Council For Disability Awareness. "Disability statistics." July 3, 2013. Web Accessed November 10, 2014.

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EMPLOYEE DEDUCTIONS

Southern Mutual Church Insurance contributes 100% of Employee Only Cost and 50% of Dependent Cost toward the medical plans for each Employee electing Medical Coverage with BlueCoice.

Coverage Tier	Employee Monthly Cost	Employee Per Pay Period Cost
Line of Coverage	**BlueChoice Advantage Plus 3500**	
Employee Only	$0.00	$0.00
Employee/Spouse	$376.19	$188.10
Employee/Child(ren)	$281.35	$140.68
Employee/Family	$655.31	$327.65
Line of Coverage	**BlueChoice Advantage Plus HDHP 3000**	
Employee Only	$0.00	$0.00
Employee/Spouse	$322.25	$161.13
Employee/Child(ren)	$241.75	$120.88
Employee/Family	$563.88	$281.94
Line of Coverage	**Delta Dental**	
Employee Only	$0.00	$0.00
Employee/Spouse	$47.56	$23.78
Employee/Child(ren)	$57.71	$28.86
Employee/Family	$115.62	$57.81
Line of Coverage	**EyeMed**	
Employee Only	$8.59	$4.30
Employee/Spouse	$16.33	$8.17
Employee/Child(ren)	$17.19	$8.60
Employee/Family	$25.26	$12.63

The rates shown in this guide are illustrative only. To the extent the rates contained herein differ from those in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the rates in the underlying insurance documents will govern in all cases.

REQUIRED NOTICES

Newborn and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy , including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.

REQUIRED CHIP NOTICE

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

REQUIRED CHIP NOTICE (CONT)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

REQUIRED CHIP NOTICE (CONT)

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS - Medicaid	**WEST VIRGINIA - Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH - Medicaid and CHIP	**WISCONSIN - Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT - Medicaid	**WYOMING - Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

HIPAA Notice

HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants. All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI. If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

More information can be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

Link to OneDigital's privacy policy: https://www.onedigital.com/privacy-policy/

Model Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within the appropriate time period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

For additional information on your employer's privacy policy, please contact your HR department.

CONFIDENTIALITY NOTICE

Digital Insurance LLC dba OneDigital Health and Benefits does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

Additional Benefit Information

Southern Mutual Church Insurance
Blue Choice Health Plan Dual Option
Effective January 1, 2020 - December 31, 2020

The Benefits Shown are In-Network Benefits Out-of-Network Benefits are paid at a lower rate and members can be balance-billed	Blue Choice Copay Plan w/AmFirst	Blue Choice High Deductible Net Benefit Summary
	Covered Insured Pays:	Covered Insured Pays:
Individual Deductible:	Blue Choice $3,500 EE pays $1,000	$3,000
Family Deductible:	Blue Choice $7,000 EE pays $1,000 per person	$6,000
Calendar or Benefit Year Deductible:	Calendar Year	Calendar Year
Aggregate or Embedded Ded/MOOP:	Embedded/Embedded	
Coinsurance Amount:	EE 50% & AmFirst 50%, then Blue Choice 100%	0%
Individual Coinsurance Limit:	EE pays $1,000 using Blue Choice & AmFirst	$0
Family Coinsurance Limit:	EE pays $1,000 per Person using Blue Choice & AmFirst	$0
Individual Total Out-of-Pocket Maximum:	Blue Choice $7,350, EE pays $2,000 & AmFirst pays $5,350	$3,000
Family Total Out-of-Pocket Maximum:	Blue Choice $14,700, EE pays $2,000 per person & AmFirst pays $5,350 per person	$6,000
In & Out Patient Hospital Services:	Deductible + Coinsurance	Subject to Deductible
In & Out Patient Testing:	Deductible + Coinsurance	Subject to Deductible
Primary Care Office Visit Copay:	$30	Subject to Deductible
Specialist Office Visit Copay:	$60	Subject to Deductible
Preventive Care* Office Visit (In-Network Only):**	Covered at 100%	Covered at 100%
Urgent Care:	$60	Subject to Deductible
Emergency Care:	$300, then 50%	Subject to Deductible
Prescription Benefits:	$8/$25/$45/$70/$125/$175	Subject to Deductible
Mail Order Prescription Benefits:	$20/$62.50/$112.50/$175/$312.50/ $437.50	Subject to Deductible
Maximum Lifetime Benefit:	Unlimited	Unlimited

Claim Example 1: Bob has a hospital charge of $2,700. He pays the first $1,000 plus 50% of the $1,700 balance, for a total of $850 more.
Bob's total cost is $1,850. The $850 left is the responsibility of BCHP & AmFirst.

Claim Example 2: Mary has a hospital charge of $30,000. She pays the first $1,000 plus 50% of the next $2,000 because the coinsurance max is $1,000.
Mary's total cost is $2,000. The $28,000 is the responsibility of BCHP & Amfirst.

Tammie J. King, RHU, REBC
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BlueChoice HealthPlan South Carolina
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Schedule of Benefits
BlueChoice Advantage Plus℠
Southern Mutual Insurance

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.		
BENEFITS	**In-Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS**
Deductible per Benefit Period		
Per Member	$3,500	$7,000
Per Family (All family Members can contribute with no one Member contributing more than the individual deductible amount.)	$7,000	$14,000
Maximum Out-of-Pocket per Benefit Period (includes deductible, coinsurance and all copays)		
Per Member	$7,350	$21,700
Per Family	$14,700	$43,400

Services other than Mental Health and Substance Use Disorders

BENEFITS	**In-Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS** (Member must pay balance of Provider's Charge)
Primary Care		
Office services	$30 per visit	Deductible, then 50%
Mandated Preventive Care	$0	Not Covered
Specialty Care		
Office services	$60 per visit	Deductible, then 50%
Hospital services (includes inpatient, outpatient & ambulatory care services)	Deductible, then 50%	Deductible, then 50%
Emergency room care (in order to be covered, Emergency room care must be for an Emergency Medical Condition)	Deductible, then 50%	Deductible, then 50% (plus any amount above the allowable charge up to the billed amount)
Other Routine Care		
GYN Exam – 2 per Benefit Period	$0	Deductible, then 50%
Routine Screening Mammogram	$0	Deductible, then 50%
Routine Screening Colonoscopy	$0	Deductible, then 50%
Maternity Care		
Routine Maternity Physician Services (no additional copay for ongoing routine care)	Deductible, then 50%	Deductible, then 50%

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Schedule of Benefits
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Southern Mutual Insurance

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Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS		Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Inpatient Hospital/Facility Services (Authorization required)			
Admission (including maternity)	Deductible, then 50%		Deductible, then 50%
Skilled Nursing Facility	Deductible, then 50%		Deductible, then 50%
Long-term Acute Care	Deductible, then 50%		Deductible, then 50%
Outpatient/Ambulatory Care Facilities			
All outpatient services (including maternity)	Deductible, then 50%		Deductible, then 50%
Emergency room services (in order to be covered, Emergency room services must be for an Emergency Medical Condition)	$300 per visit, then 50%		$300 per visit, then 50% (plus any amount above the allowable charge up to the billed amount)
Ambulatory Surgical Center	$60 per visit		Deductible, then 50%
Urgent care	$60 per visit		Deductible, then 50%
Prescription Medicine	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)	Covered only at a Participating Pharmacy
Tier 1	$8	$20.00	
Tier 2	$25	$62.50	
Tier 3	$45	$112.50	
Tier 4	$70	$175.00	
No max per Benefit Period	You will have to pay more if you select a non-generic drug instead of its less-expensive Covered generic drug (or Covered over the counter) alternative.		
Tier 5	$125	$312.50	Not Covered
Tier 6	$175	$437.50	
No max per Benefit Period • Specialty medications are not available through the mail order program for a 90-day supply. This only applies to generic or brand drugs in these tiers.	Not Covered: Drugs designated as excluded on the Prescription Drug List.		

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Schedule of Benefits
BlueChoice Advantage Plus℠
Southern Mutual Insurance

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Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Other Services		
Ambulance	Deductible, then 50%	Deductible, then 50%
Behavioral Therapy (ABA) for Autism Spectrum Disorder	Deductible, then 50%	Not Covered
Dental Services due to accidental injury	Deductible, then 50%	Not Covered
Durable Medical Equipment (DME)	Deductible, then 50%	Not Covered
Home Health	Deductible, then 50%	Deductible, then 50%
Hospice	Deductible, then 50%	Deductible, then 50%
Initial Prosthetic Appliances	Deductible, then 50%	Deductible, then 50%
Medical Supplies	Deductible, then 50%	Deductible, then 50%
Occupational Therapy	Deductible, then 50%	Not Covered
Outpatient Private Duty Nursing	Deductible, then 50%	Deductible, then 50%
Physical Therapy	Deductible, then 50%	Not Covered
Speech Therapy	Deductible, then 50%	Not Covered
Chiropractic Services		
Manipulation	$60 per visit	Not Covered
All Other Services	Deductible, then 50%	Not Covered

Covered Transplants will be treated the same as any other medical condition. Services must be provided at a BlueChoice HealthPlan participating facility or a Blues Distinction for Transplant designated facility.

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the BlueCross and BlueShield Association.

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Schedule of Benefits
BlueChoice Advantage Plus^{SM}
Southern Mutual Insurance

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

Mental Health & Substance Use Disorders

(Companion Benefit Alternatives, Inc. (CBA) must authorize these services in advance. On behalf of BlueChoice HealthPlan, CBA manages behavioral health and substance abuse benefits for our members and their dependents. CBA is a separate company. Call CBA at 1-800-868-1032)

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Inpatient Hospital Facility Services	Deductible, then 50%	Deductible, then 50%
Inpatient Physician Services	Deductible, then 50%	Deductible, then 50%
Outpatient Facility Institutional Services	Deductible, then 50%	Deductible, then 50%
Outpatient Facility Professional Services	Deductible, then 50%	Deductible, then 50%
Office Professional Services (does not require prior authorization)	$30 per visit	Deductible, then 50%
Urgent Care (does not require prior authorization)	Deductible, then 50%	Deductible, then 50%

Benefits not listed above will be covered the same as "Services other than Mental Health and Substance Use Disorders"

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the BlueCross and BlueShield Association.

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Schedule of Benefits
BlueChoice Advantage Plus℠
Southern Mutual Insurance

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.	
MAXIMUMS	
Occupational Therapy	20 visits per Benefit Period
Outpatient Private Duty Nursing	60 visits per Benefit Period
Physical Therapy	20 visits per Benefit Period
Skilled Nursing Facility	120 days per Benefit Period
Speech Therapy	20 visits per Benefit Period
Benefit Period	Calendar Year

BENEFITS	MEMBER PAYS
Routine Vision Care - Physicians EyeCare Network (PEN) Providers Only (Refer to Provider Directory)	**(Authorization not required)**
One routine eye exam or one exam for contact lenses per Benefit Period	$0
One standard contact lens fitting per Benefit Period	$45
One pair of eyewear from a designated selection every other Benefit Period	$0
Please consult your PEN Provider for information on discounts for which you may be eligible if you elect to receive eyewear/contact lenses outside the standard designated selection.	
(For Members outside of the South Carolina service area, $71 will be allowed toward the routine eye exam and a $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.)	

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the BlueCross and BlueShield Association.

Schedule of Benefits
BlueChoice Advantage Plus℠
Southern Mutual Insurance

The following benefits are covered outside of the BlueChoice Advantage Plus medical benefits.

BENEFITS	MEMBER PAYS
Employee Assistance Program (EAP Services)	
Individual & Family Counseling (visits 1-3)	$0
Life Management Services (3 visits)	$0
Benefits are provided under an agreement between First Sun EAP and the Employer. First Sun EAP is a separate company that does not offer BlueChoice HealthPlan products. These services are offered by First Sun EAP, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these services. For services, please call First Sun EAP at 1-800-968-8143. First Sun EAP staff are available 24 hours a day, 7 days a week.	

- Personal Health Assessment

Schedule of Benefits
BlueChoice Advantage Plus HDHP℠
Southern Mutual Insurance

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Deductible per Benefit Period		
Individual Coverage	$3,000	$6,000
Family Coverage	$6,000	$12,000
Maximum Out-of-Pocket per Benefit Period (includes deductible, coinsurance and all copays) (Embedded MOOP: All family members can contribute with no one member contributing more than the Individual amount.)		
Individual Coverage	$3,000	$12,000
Family Coverage	$6,000	$24,000

Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Physician Care		
Office services	Deductible, then 0%	Deductible, then 20%
Mandated Preventive Care	$0	Not Covered
Other Routine Services	(Not subject to deductible or copayment)	
GYN Exam (2 per Benefit Period) Routine Screening Mammogram Routine Screening Colonoscopy	$0	Deductible, then 20%
Hospital/Facility Services	**(Authorization required)**	**(Authorization required)**
Inpatient Admission (including maternity)	Deductible, then 0%	Deductible, then 20%
Skilled Nursing Facility	Deductible, then 0%	Deductible, then 20%
Long-term Acute Care Facility	Deductible, then 0%	Deductible, then 20%

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Schedule of Benefits
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Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Outpatient/Ambulatory Care Facilities		
All services (including maternity)	Deductible, then 0%	Deductible, then 20%
Emergency room services (in order to be covered, Emergency room services must be for an Emergency Medical Condition)	Deductible, then 0%	Deductible, then 0% (plus, any amount above the allowable charge up to the billed amount.)
Ambulatory Surgical Center	Deductible, then 0%	Deductible, then 20%
Urgent care	Deductible, then 0%	Deductible, then 20%
Prescription Medicine Certain Prescription Medicine may require prior authorization or have dosage limits	Deductible, then 0%	Not Covered
Specialty Pharmaceuticals	Deductible, then 0%	Not Covered
Other Services		
Ambulance	Deductible, then 0%	Deductible, then 20%
Behavioral Therapy (ABA) for Autism Spectrum Disorder	Deductible, then 0%	Not Covered
Dental Services due to accidental injury	Deductible, then 0%	Deductible, then 20%
Durable Medical Equipment (DME)	Deductible, then 0%	Deductible, then 20%
Home Health	Deductible, then 0%	Deductible, then 20%
Hospice	Deductible, then 0%	Deductible, then 20%
Initial Prosthetic Appliances	Deductible, then 0%	Deductible, then 20%
Medical Supplies	Deductible, then 0%	Deductible, then 20%
Occupational Therapy	Deductible, then 0%	Deductible, then 20%
Outpatient Private Duty Nursing	Deductible, then 0%	Deductible, then 20%
Physical Therapy	Deductible, then 0%	Deductible, then 20%
Speech Therapy	Deductible, then 0%	Deductible, then 20%
Chiropractic Services		
Manipulation	Deductible, then 0%	Not Covered
All Other Services	Deductible, then 0%	Not Covered
Covered Transplants will be treated the same as any other medical condition. Services must be provided at a BlueChoice HealthPlan participating facility or a Blues Distinction for Transplant designated facility.		

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the BlueCross and BlueShield Association.

Schedule of Benefits
BlueChoice Advantage Plus HDHP^{SM}
Southern Mutual Insurance

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Mental Health & Substance Use Disorders

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BENEFITS	**In-Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS** (Member must pay balance of Provider's Charge)
Inpatient Hospital Facility Services	Deductible, then 0%	Deductible, then 20%
Inpatient Physician Services	Deductible, then 0%	Deductible, then 20%
Outpatient Facility Institutional Services	Deductible, then 0%	Deductible, then 20%
Outpatient Facility Professional Services	Deductible, then 0%	Deductible, then 20%
Office Professional Services (does not require prior authorization)	Deductible, then 0%	Deductible, then 20%
Urgent Care (does not require prior authorization)	Deductible, then 0%	Deductible, then 20%

Benefits not listed above will be covered the same as "Services other than Mental Health and Substance Use Disorders"

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MAXIMUMS	
Occupational Therapy	20 visits per Benefit Period
Outpatient Private Duty Nursing	60 visits per Benefit Period
Physical Therapy	20 visits per Benefit Period
Skilled Nursing Facility	120 days per Benefit Period
Speech Therapy	20 visits per Benefit Period
Benefit Period	Calendar Year

The following benefits are covered outside of the BlueChoice Advantage Plus medical benefits.

BENEFITS	MEMBER PAYS
Routine Vision Care - Physicians EyeCare Network (PEN) Providers Only (Refer to Provider Directory)	**(Authorization not required)**
One routine eye exam or one exam for contact lenses per Benefit Period	$0
One standard contact lens fitting per Benefit Period	$45
One pair of eyewear from a designated selection every other Benefit Period	$0
Please consult your PEN Provider for information on discounts for which you may be eligible if you elect to receive eyewear/contact lenses outside the standard designated selection.	
(For Members outside of the South Carolina service area, $71 will be allowed toward the routine eye exam and a $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.)	

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Schedule of Benefits
BlueChoice Advantage Plus HDHP℠
Southern Mutual Insurance

BENEFITS	MEMBER PAYS
Employee Assistance Program (EAP Services)	
Individual & Family Counseling (visits 1-3)	$0
Life Management Services (3 visits)	$0
Benefits are provided under an agreement between First Sun EAP and the Employer. First Sun EAP is a separate company that does not offer BlueChoice HealthPlan products. These services are offered by First Sun EAP, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these services. For services, please call First Sun EAP at 1-800-968-8143. First Sun EAP staff are available 24 hours a day, 7 days a week.	

- Personal Health Assessment

INFINISOURCE
BENEFIT SERVICES

Infinisource Benefit Services HSA

A Better Way to Pay for Health Care - Today and Tomorrow

As health care costs continue to soar, finding ways to offer affordable health benefits to your employees is a persistent challenge. Now you can leave employees with more spending money per paycheck while they save money on out-of-pocket health care expenses with a Health Savings Account (HSA) solution from Infinisource Benefit Services.

An HSA is a tax-advantaged savings account that is used in combination with a High Deductible Health Plan (HDHP) and gives your employees a simple way to manage health care costs. They can use the HSA funds to cover qualified medical expenses.

How HSAs Work:

With the Infinisource Benefit Services HSA, any earnings on your contributions are tax-advantaged. The HSA account is funded by pre-tax contributions by the employee. This gives employees a great tax benefit while you, their employer, pay less in FICA and FUTA payroll taxes. When an employee incurs a qualified medical expense, they can pay using the Infinisource Benefit Services debit card, online bill pay or other methods.

If the employee doesn't have enough money in their HSA to cover a medical expense, they can make a partial payment and pay the difference using another method. There is no "use it or lose it" condition. Any unused funds remain in the account and continue to accrue interest until used.

More information on HSA plans can be found on the U.S. Department of Treasury website at www.treas.gov. *(Hint: search on HSA)*

Infinisource Benefit Services HSA helps you:

- ✓ Add depth and flexibility to your employee health benefits and retirement plans
- ✓ Reduce FICA and FUTA payroll taxes
- ✓ Save on health insurance premiums by offering HSAs along with high-deductible health plans
- ✓ Get access to secure and easy-to-use online, self-service portals available 24/7/365
- ✓ Promote healthier lifestyle choices through increased involvement and use of 100% covered preventative care
- ✓ Go Green with paperless online claims, direct deposit reimbursement and electronic statements

Infinisource Benefit Services HSA helps your employees:

- ✓ Offset rising health care costs with tax-free funds
- ✓ Plan for future health expenses with tax-free investment accounts - no "use it or lose it" annual requirement
- ✓ Easily monitor health spending with convenient debit cards and secure online account access
- ✓ Plan for retirement - after age 65, participants can use HSA funds for non-qualifying expenses

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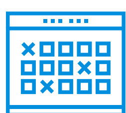
Features and Functionality

By offering Infinisource Benefit Services HSAs to your employees, you can fight rising health insurance costs, offer greater depth and flexibility in your benefits packages, and promote healthy lifestyles with these powerful features:

Features

Infinisource HSAs are administered on the same platform as Infinisource FSAs, HRAs, Transit or Parking plans, creating a single online portal or mobile phone app experience for the user.



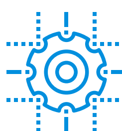
Automated scheduling of lump sum, first of the month, or payroll cycle contributions allows for easy mid-year enrollments

Monthly reports generate automatically, with e-mail alerts directing recipients to secure portals for viewing, creating a virtually paper-free administration process

Employees can access funds through online distribution requests, or by using a convenient benefits debit card

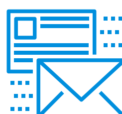
An integrated debit card provides seamless, flexible fund access and compliance

Employees may receive manual distributions by direct deposit or check

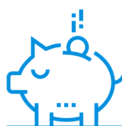


Employees can view account details, request distributions, update addresses, change payroll deduction elections, view statements, change beneficiaries, or allocate funds into an array of mutual funds using convenient online portals

Easy online enrollment creates an HSA account with direct deposit and investment options

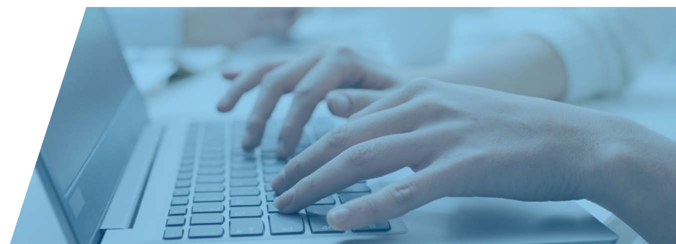


Automated communication and e-mail alerts ensure consistent messaging



FDIC-insured cash and interest bearing account

At Infinisource, delivering easy-to-use solutions backed by the highest levels of service is our top priority. We offer a cloud-computing solution designed to provide you and your employees with the functionality, reliability, and integration you need.



Interested in learning more about Infinisource Benefit Services HSA administration? Call us today at 800-300-3838 to find out how we can help.

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INFINISOURCE BENEFIT SERVICES help

Limited FSA Administration

Infinisource has been selected by your employer to provide a Limited Flexible Spending Account, an employer-sponsored benefit plan that allows employees to have money deducted from their pay on a pre-tax basis. Funds are then used for reimbursement for qualified medical expenses for you, your spouse and dependents.

Here are some benefits:

- Increase your spendable income by paying fewer taxes
- Health care elections are available from day one of the plan year
- Typical tax savings of 30%-it's like buying your health care at a 30% off sale
- Eligible expenses include:
  - Dental expenses (e.g., cleanings, fillings, braces)
  - Vision expenses (e.g., exams, eye glasses, contact lenses)
  - Post deductible expenses and preventive care expenses

Your contribution amount is limited by federal regulations. Review your Summary Plan Description for your plan limits and your employer's provisions for unused amounts you have at year-end.

Save all FSA related expenses documentation such as itemized receipts and your insurance carrier's explanation of benefits. These items should be submitted with your reimbursement request.

You can use your smartphone to check your health benefit account balances anywhere, anytime so you'll always know how much money you have available to spend on qualified medical expenses. By going mobile, you can submit claims, send receipts and even receive alerts via text message.

You can also review your account balance and reimbursements at www.infinisource.com.

If you have questions or need help, call us at 866-370-3040 or email fbamail@infinisource.com. Our Customer Service Team is available from 8 a.m.-8 p.m., Monday through Thursday and Friday 8 a.m.-6 p.m., Eastern Time.

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Limited FSA worksheet

Estimated unreimbursed health care expenses

Medical	**Annual amount**
Post Deductible and Preventative	______
SUBTOTAL	______
Dental	
Deductible	______
Coinsurance payment	
Cleaning Dentures Fillings/crowns/bridges Fluoride treatments Orthodontia (based on expenses incurred for upcoming plan year)	______
X-rays	______
SUBTOTAL	______
Vision	______
Deductible	______
Coinsurance payment Contact lenses and solutions Examinations	______
Frames	______
Laser eye surgery	______
Lenses	______
SUBTOTAL	______
TOTAL	______

Unreimbursed health care expenses cannot exceed your plan's maximum.

NOTE: any coordination of benefits with another group plan may reduce your out-of-pocket expenses.

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INFINISOURCE
BENEFIT SERVICES

Savings Snapshot

You can increase the money you take home each pay period by using a Flexible Benefits Plan. Here is an example of the tax savings an employee earning $2,200 a month can experience using this great benefit.

	Without 125 Plan	With 125 Plan
Monthly income before taxes	**$2,200.00**	**$2,200.00**
Pre-tax salary deductions		
Health FSA contribution	$.00	$60.00
Employee contribution to health plan	$.00	$50.00
Total	**$.00**	**$110.00**
Payroll taxes		
FICA (7.65%)	$168.30	$140.00
Federal income tax (12.16%)	$267.52	$222.53
State income tax (4%)	$88.00	$73.20
Total	**$523.82**	**$435.73**
After tax expenses		
Health care expenses	$60.00	$.00
Employee contribution to health plan	$50.00	$.00
Total	**$110.00**	**$.00**
Spendable income	**$1,566.18**	**$1,654.27**

Employee's spendable income **increases**

$22.03 each week

$88.09 each month

$1,057.08 each year

Frequently Asked Questions

General Information

Why should I participate in the Limited Flexible Benefits Plan?
There are some great advantages to using a Limited Flexible Benefits Plan!

- Reduced taxes - the money contributed to a Limited FSA is not subject to taxes (federal income and FICA taxes and most state and local income taxes).
- Increase your take-home pay – less taxes, more money in your pocket
- The Benny Card – pay for expenses at point of purchase

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Another advantage to participating in the Plan is the opportunity it offers for you to budget for health care expenses by withholding a small amount from each paycheck. With proper planning, you won't be faced with having to come up with large amounts of money at one time. This is especially advantageous if you are scheduling a surgery, anticipating maternity expenses or if you do not have other coverage for dental and vision expenses. Even those with coverage for medical, dental and vision usually have deductibles, co-pays and other out-of-pocket expenses to cover.

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You may set aside pre-tax dollars to cover eligible medical expenses that are not covered by any other type of insurance. The account helps you budget for planned expenses such as deductibles, co-payments and prescriptions. You may refer to the Limited FSA Worksheet for a list of some eligible and ineligible expenses.

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If I terminate employment or retire, can I receive the remaining balance in my Limited FSA?
No. However, you can continue to submit claims incurred prior to your termination date before the end of the run-out period (defined in your Summary Plan Description).

Example: Your plan has a 90-day run-out period following termination. Your termination date is September 13. Your physician sees you on September 12, but you do not receive the Explanation of Benefits from your insurance carrier until October 31. You can still submit this expense as it was incurred prior to your termination date, and prior to the end of the 90-day run-out period following your date of termination. Any expense incurred after September 13 is not eligible.

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- Change in dependent's eligibility
- Change in employment status of employee, spouse or dependents

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Each time you submit claims to your health insurance carrier, you will receive an Explanation of Benefits (EOB) detailing what the health plan will pay and what you must pay. For expenses that are partially covered under another insurance plan, you must attach a copy of both EOBs.

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The documentation requirements are also listed on the FSA Request for Reimbursement Form to assist you in properly filing your claim. Following these guidelines will ensure you receive your reimbursement without unnecessary delays.

How long after the end of the Plan year do I have to submit claims?
Claims must be submitted prior to the end of the run-out period for the Plan. The run-out period is defined in your Summary Plan Description.

Will I receive reimbursement for claims that are greater than the current balance of my Limited FSA?
Yes, the annual amount is available to you from the beginning of the Plan year.

How do I know that you received my claim and whether or not it was paid?
Generally, within two business days of submitting a claim, you can view your account to check on the status of the claim at www.infinisource.com. Simply choose Flexible Spending Account /Health Reimbursement under employee/participant and follow the on-screen instructions.

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Claims are generally processed within two business days of receipt. Reimbursements are then processed and released according to the disbursement schedule and funding option of the employer. Generally, disbursement schedules are daily. This means that reimbursements are processed each day and include any claims that were processed the previous day. The release of your reimbursement depends upon the funding option chosen by the employer.

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How do I know why my claim was denied?
You will receive a letter indicating the reason for the denial along with instructions for submitting the requested documentation.

Why may the amount of my reimbursement differ from the amount of my request?
There are reasons that you may see a different reimbursement amount. For example:

1. If the request was for more than the balance of your account.

Annual election	$1,000.00
Total amount disbursed to date	$700.00
Available balance	$300.00
Total amount of request	$500.00

You will only be reimbursed $300.00, as this is your available balance.

2. If the request was for a dependent care claim, you may only be reimbursed for the total amount that you have contributed.

Annual election	$5,000.00
Total amount contributed	$3,000.00
Total amount of request	$4,250.00

You will only be reimbursed $3,000.00, as this is the amount that you have contributed to the account. The entire request of $4,250.00, will be processed and the remaining $1,250.00 will be disbursed as contributions are made.

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INFINISOURCE
BENEFIT SERVICES

KNOW YOUR ELIGIBLE AND INELIGIBLE EXPENSES
Maximize the Value of Your Reimbursement Account

Your Health Care Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) dollarscan be used for a variety of out-of-pocket health care expenses. The following list is based on eligible and ineligible expenses used by federal employees.

ELIGIBLE EXPENSES

Baby/Child to age 13
- Lactation consultant
- Lead-based paint removal*
- Special formula*
- Tuition: special school/teacher for disability or learning disability*
- Well baby/well child care

Dental
- Dental x-rays
- Dentures and bridges
- Exams and teeth cleaning
- Extractions and fillings
- Oral surgery
- Orthodontia
- Periodontal services

Eyes
- Eye exams
- Eyeglasses and contact lenses
- Laser eye surgeries
- Prescription sunglasses
- Radial keratotomy

Hearing
- Hearing Aids and batteries
- Hearing exams

Lab Exams/Tests
- Blood tests and metabolism tests
- Body scans
- Cardiograms
- Laboratory fees
- X-rays

Medications
- Insulin
- Prescription drugs

Medical Equipment/Supplies
- Air purification equipment*
- Arches and other orthotic inserts
- Contraceptive devices
- Crutches, walkers, wheel chairs
- Exercise equipment*
- Hospital beds*
- Mattresses*
- Medic alert bracelet or necklace
- Nebulizers
- Orthopedic shoes*
- Oxygen
- Post-mastectomy clothing
- Prosthetics
- Syringes
- Wigs*

Obstetrics
- Doulas*
- Lamaze class
- OB/GYN exams
- OB/GYN prepaid maternity fees (reimbursable after date of birth)
- Pre- and post-natal treatments

Practitioners
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

Therapy
- Alcohol and drug addiction counseling (must be treating a medical condition)
- Exercise programs*
- Hypnosis*
- Massage*
- Occupational therapy
- Physical therapy
- Smoking cessation programs*
- Speech therapy
- Weight loss programs*

Medical Procedures/Services
- Acupuncture
- Alcohol and drug/substance abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility enhancement and treatment
- Hair loss treatment*
- Hospital services
- Immunization
- In vitro fertilization
- Personal trainers*
- Physical examination (not employment-related)
- Reconstructive surgery (due to a congenital defect, accident or medical treatment.)
- Service animals
- Sterilization/sterilization reversal
- Transplants (including organ donor)
- Transportation*

This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a note of medical necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact Infinisource.

INELIGIBLE EXPENSES

Note: This list is not meant to be all-inclusive

- Contact lens or eyeglass insurance
- Cosmetic surgery/ procedures
- Electrolysis
- Marriage or career counseling
- Swimming lessons
- Sunscreen (SPF less than 15 needs RX)

PLEASE NOTE:

Please note: The IRS will not allow OTC medicines or drugs to be purchased with the FSA funds unless accompanied by a prescription.

ELIGIBLE OVER-THE-COUNTER ITEMS

Note: Product categories are listed in bold face; common examples of products are listed in regular face.

The following is a high-level list of over-the-counter (OTC) items that clearly are not medicine or drugs and are eligible for purchase with Health Care FSA or HRA dollars. You can use your benefits card for these items

Antiseptics, wound cleaners
Alcohol, peroxide, Epsom salt

Baby electrolytes
Pedialyte, Enfalyte

Denture adhesives, repair and cleansers
PoliGrip, Benzodent, Efferdent

Diabetes testing and aids
Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes, glucose products

Diagnostic products
Thermometers, blood pressure monitors, cholesterol testing

Elastics/athletic treatments
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

Eye care
Contact lens care

Family planning
Pregnancy and ovulation kits

First aid dressings and supplies
Band Aid, 3M Nexcare, non-sport tapes

Hearing aid/medical batteries

Incontinence products
Attends, Depend, GoodNites for juvenile incontinence

Sunscreen (SPF 15 and over)

INFINISOURCE
BENEFIT SERVICES

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What are some examples of OTC drugs that are eligible for reimbursement from my Health FSA?
Antiseptics, diabetes testing aids, bandages and contact lens care. For a more inclusive list, please see the OTC expenses list available at www.infinisource.com.

If I terminate employment or retire, can I receive the remaining balance in my Health FSA?
No. However, you can continue to submit claims incurred prior to your termination date before the end of the run-out period (defined in your Summary Plan Description).

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- Change in legal marital status (marriage, death of spouse, divorce, legal separation, annulment)
- Change in number of tax dependents (birth, death of dependent, adoption or placement for adoption)
- Change in dependent's eligibility
- Change in employment status of employee, spouse or dependents
- Other changes that may permit an election change under the Dependent Care FSA are:
    - Change of dependent care provider
    - Change of rate charged by unrelated dependent care provider
    - Child attaining age 13

Election changes must be consistent with the event. If you experience a Change in Status, please review your Summary Plan Description, as it will provide you with important information on the deadline for reporting this event.

If I elected too much in my Health FSA but not enough in my Dependent Care FSA, can I move money from one account to the other?
No, Health and Dependent Care FSA elections are separate. You cannot move contributions from one account to another. Also, it is very important to note that the elections you make are for the entire year. Your elections cannot be changed unless you experience an IRS Change in Status as noted above.

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What supporting documentation must I file with each Dependent Care claim?
Complete the Dependent Care section of the Request for Reimbursement Form and have your day care provider sign and date. The receipt must include the following information:

- Name and address of provider
- From/through dates of service
- Amount of charge

How long after the end of the Plan year do I have to submit claims?
Claims must be submitted prior to the end of the run-out period for the Plan. The run-out period is defined in your Summary Plan Description.

Will I receive reimbursement for claims that are greater than the current balance of my Health FSA?
Yes, the annual amount is available to you from the beginning of the Plan year.

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Will I receive reimbursement that is greater than the current balance of my Dependent Care FSA?
No, you will only receive reimbursement for the amount that has been contributed at the time you submit your claim.

Can I submit claims for dependent care expenses that are greater than the current balance of my Dependent Care FSA?
Yes, however, you will only receive reimbursement for the amount that you have contributed to your Dependent Care FSA. For example, if you contribute $150 each month to your Dependent Care FSA, then you will only receive $150 in reimbursement each month. The excess amount of expenses will be pended and automatically paid to you as contributions are posted to your account.

What happens if a claim exceeds the amount currently available in my Dependent Care FSA?
The claim will be processed and approved. The amount that is currently available will be disbursed and the remaining portion will be pended until you make another contribution.

How do I know that you received my claim and whether or not it was paid?
Generally, within two business days of submitting a claim, you can view your account to check on the status of the claim at www.infinisource.com. Simply choose Flexible Spending Account /Health Reimbursement under employee/participant and follow the on-screen instructions.

When can I expect to receive my reimbursement?
Claims are generally processed within two business days of receipt. Reimbursements are then processed and released according to the disbursement schedule and funding option of the employer. Generally, disbursement schedules are daily. This means that reimbursements are processed each day and include any claims that were processed the previous day. The release of your reimbursement depends upon the funding option chosen by the employer.

How do I know what my account balance is?
You can use one of the following methods to check your account balance:

- You can view your account at www.infinisource.com. Simply choose Flexible Spending Account/ Health Reimbursement under Employee/Participants and follow the on-screen instructions.
- You can view your balance on the mobile app.
- Your account balance will be displayed on the reimbursement check or direct deposit notification each time you submit a claim.
- You will receive a Balance Statement quarterly during the Plan year. This statement provides a summary of your remaining balance in the Health FSA and/or the Dependent Care FSA as well as claims paid to date.

How do I know why my claim was denied?
You will receive a letter indicating the reason for the denial along with instructions for submitting the requested documentation.

Why may the amount of my reimbursement differ from the amount of my request?
There are reasons that you may see a different reimbursement amount. For example:

1. If the request was for more than the balance of your account.

Annual election	$1,000.00
Total amount disbursed to date	$700.00
Available balance	$300.00
Total amount of request	$500.00

You will only be reimbursed $300.00, as this is your available balance.

15 E. Washington St. • PO Box 488 • Coldwater, MI 49036-0488 • 866-370-3040 • Fax: 800-379-5670 • E-mail: fbamail@infinisource.com
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INFINISOURCE
BENEFIT SERVICES

DEPENDENT CARE FSA FAQ's

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. It's a great option for employees who have dependent children under the age of 13 who attend day care, after-school care or summer day camp, and/or provide care for a person of any age who is claimed as a dependent on the federal income tax return and who is mentally or physically incapable of caring for himself or herself.

Who is a qualified dependent under the Dependent Care FSA?

- Dependent under the age of 13
- Dependent or spouse of employee who is mentally or physically disabled and whom the employee claims as a dependent on their federal income tax return

Can an adult be a qualified dependent?

Yes, an adult may qualify as a dependent provided that the employee is providing more than half of that individual's support for the year and the dependent lives with the employee.

Do I have to use a day care facility?

No. You can be reimbursed for expenses of an individual providing care for your dependent in your home as long as the expenses are incurred for you and your spouse (if married), to work, look for work or attend school full time.

Does my day care provider have to be licensed?

No. However, you are required to submit their Tax Identification Number or Social Security Number when filing your federal income tax return.

My child attends camp during the summer. Is this eligible?

Generally, no. However, if the camp is a day camp and your dependent attends to allow you and your spouse (if married) to work, look for work or attend school full time, then yes, this would be an eligible expense. Overnight camps are specifically excluded.

Does my day care provider have to be 18?

No, but the individual must claim the money as income on their tax return.

copyright 2016

When can I be reimbursed for dependent day care expenses?

Expenses are eligible for reimbursement when they have been incurred, not when you are billed or when you pay for the services.

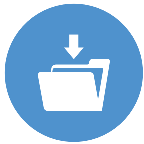
Example: Your day care provider requires you to pay for the month of September on September 1. You can be reimbursed as the services are incurred, not when you paid for the services. You can submit claims after each week, every week or on October 1.

What support documentation must I file with each Dependent Care claim?

Complete the Dependent Care section of the Request for Reimbursement Form and have your day care provider sign and date. The receipt must include the following information:

- Name and address of provider
- From/through dates of service
- Amount of charge

Can I submit claims for dependent care expenses that are greater than the current balance of my Dependent Care FSA?



Yes. However, you will only receive reimbursement for the amount that you have contributed to your Dependent Care FSA. For example, if you contribute $150 each month to your Dependent Care FSA, then you will only receive $150 in reimbursement each month. The excess amount of expenses will be pended and automatically paid to you as contributions are posted to your account.

What happens if a claim exceeds the amount currently available in my Dependent Care FSA?

The claim will be processed and approved. The amount that is currently available will be disbursed and the remaining portion will be pended until you make another contribution.

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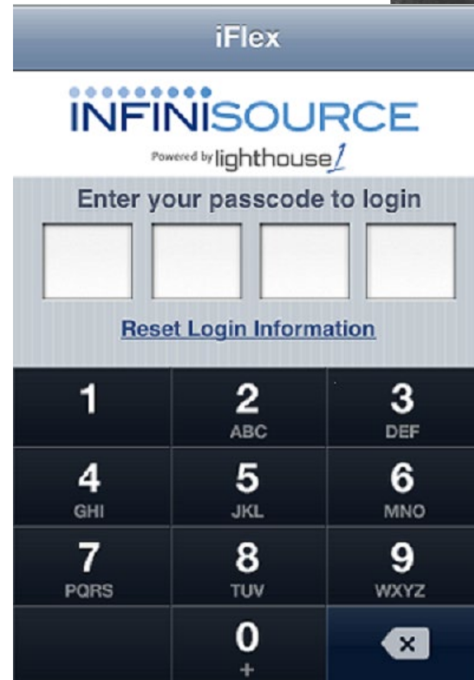
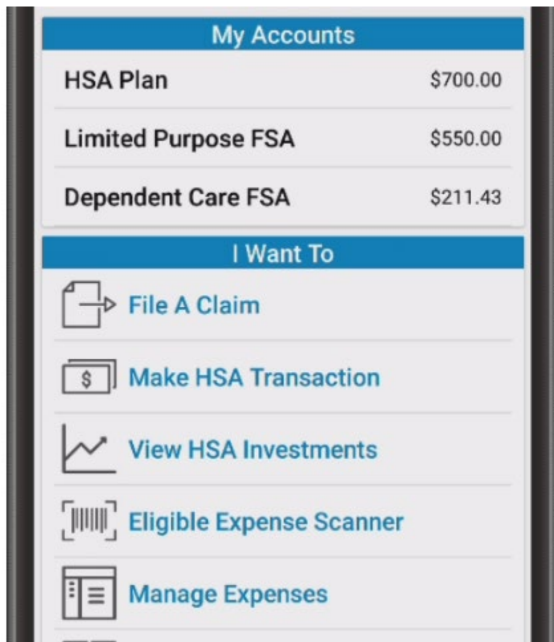
Downloading the iFlex App

1. Install the Infinisource iFlex App on your iPhone or Android.
2. You will be required to enter you username and password once installed. The username and password will be the same as the one created to log into your account at www.infinisource.com.
3. You will be asked to create a four digit passcode. This will be used each time you access the App from your iPhone or Android.





- Submit claims for medical and dependent care FSA, HRA, VEBA, transportation, tuition and premium reimbursement plans
- Snap a photo of a receipt and submit with a new or existing claim, or store in your camera roll for claim filing
- Make an HSA distribution or contribution and view HSA investment details
- Use the Eligible Expense Scanner to scan items to determine if they're qualified medical expenses before you get to the checkout lane
- Access your account funds to pay yourself or someone else such as doctor
- Add and store information on new payees
- Enter and view expense information and receipts
- Report a debit card as lost or stolen

Check Balances

Wondering whether you can pay for an elective procedure or a mounting bill? Do a quick account check to see your current balance. No need to wait for an answer – its right at your fingertips.

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Scan Expenses

How can you easily determine which products can be paid for using your account funds? With Infinisource, you can simply scan a product bar code to help determine eligibility as a qualified medical expense. That's peace of mind with a touch of a button.

Make Payments Quickly

Record a health expense and capture the receipt the moment the transaction happens. Easily add payees and pay bills from any account. And, if you pay out-of-pocket, file a claim with a receipt or request a distribution from your HSA -- right from your phone.

Get started with iFlex Mobile App in minutes.

Download the iFlex Mobile app for your chosen device from the Apple App Store or Google Play and log in using the password you use to access the Infinisource consumer portal.

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INFINISOURCE BENEFIT SERVICES help

How to File a Claim

Infinisource provides all Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA) participants with an online portal that provides anytime access to view and manage account information. One of the many features available online is the capability to file a claim and upload any documentation to accompany the claim.

To file a claim and upload documentation, follow these steps:

Navigate to the Infinisource login page.

For security purposes, it is important for you to login to setup your Username and Password. Infinisource provides you with a 30-day timeframe to access your account to assist with the security of your account. If you access your account after the 30-day timeframe, you will need to contact Infinisource to receive a temporary password.

Login

Existing User?

Login to your account

Username | Forgot Username?

Password | Forgot Password?

Login

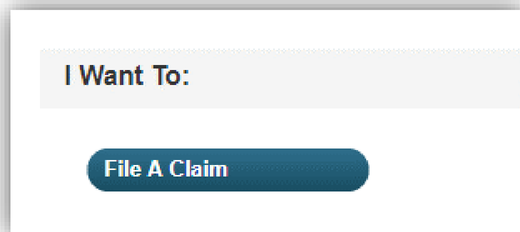
Enter your Username and Password. First time users will login using lower case first initial, last name and last four digits of your Social Security Number as both Username and Password.

Note: If you are using Internet Explorer 11 and have difficulty with processing a claim online, turn off your compatibility mode. Please follow these instructions if you are unaware of how to make that change to your browser.

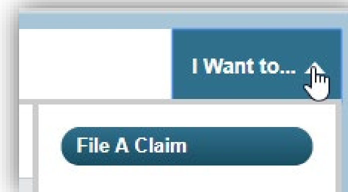
Internet Explorer 11

1. Navigate in Internet Explorer to the site you are trying to access.
2. Press the **Alt** key to display the menu bar.
3. Click the **Tools** menu and choose **Compatibility View Settings**.
4. In the *Add this website* field, you will see the domain (the last part of the website address).
5. Click **Add**.
   Result: the domain appears in the list of websites you've added to compatibility view.

On the Home page, click **File a Claim**.



Or from any of the other tabs, click on the “I Want to…” drop down on the right of the menu items



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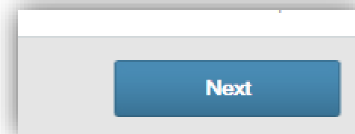
How to File a Claim

In the **Pay From** drop-down menu, choose the account type.

Select a payee from the **Pay To** drop-down menu.

If the payee is not listed, select **Someone Else**.

Click **Next** once you have chosen the *Pay From* and *Pay To*.



When you select *Someone Else,* the next screen will be for you to set up a new payee in the system.

Complete all required fields and click **Next**.

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INFINISOURCE BENEFIT SERVICES help

How to File a Claim

Accounts / File A Claim

Receipt / Documentation

Receipt(s) Upload Valid Documentation

Summary

Pay From Medical

Pay To Me

Upload your receipt.

Upload Receipt(s)

Browse... Remove

Receipts must be in a JPG, GIF, PNG or PDF format and cannot exceed 2 MB

Add Another Receipt

Cancel Submit

When uploading a receipt it must be in .doc, PDF, bmp or gif format and must not exceed 2 MB.

Home Accounts Profile Statements & Notifications Tools & Support Dashboard I Want to...

Available Balance

HSA 15

Cash Account $5,879.92

Investment Account $0.00

Vision Dental FSA 15 $2,476.50

Vision HRA 15 $1,665.14

Plan Filing Rules

01/01/2015 - 12/31/2015

Vision Dental FSA 15

Vision HRA 15

Accounts / File A Claim

Receipt / Documentation

Receipt(s) Upload Valid Documentation

EOB_02-04-2011.pdf Remove Receipt

View Receipt(s)

Summary

Pay From Medical

Pay To Me

* Required

Cancel Previous Next

Enter your claim information on the form that appears (fields with an asterisk "*" are required fields).

- Start Date of Service
- End Date of Service
- Amount
- Provider
- Category
- Type
- Recipient

Accounts / File A Claim

Claim Details

Start Date of Service * 6/5/2015

End Date of Service 6/5/2015

Amount * $ 30.00

Provider * Dr. Jones

Category * Select a category...

Type *

Description

Select a category...
Capital Expenses
Dental
Drugs & Medicine
Hearing Impairment
Medical Expenses
Mental Health, Chemical Dependency & Special Education
Miscellaneous

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How to File a Claim

If the recipient is not listed, click on **Add Dependent.**

Fill out the dependent information, click on **Submit**. Required fields are marked with an asterisk "*".

Once all of the required fields are completed, click **Next.**

The next page is a Transaction Summary of your claim. Review the information to make sure everything is accurate. You can either remove or update if necessary.

You can either click on **Submit,** you can **Save for Later** or **Add Another** claim.

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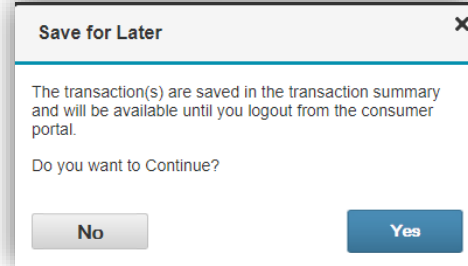
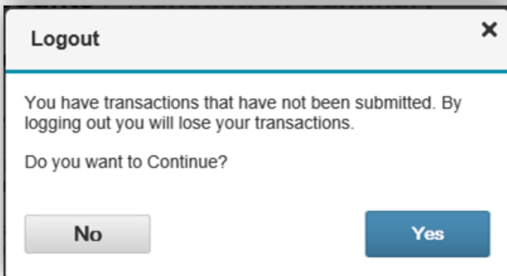
How to File a Claim

If you save for later, you will see the claim as saved on your Home page.





If you log out prior to submitting your saved claim, you will receive the following prompt.

Note: If you see Receipts Needed link in the Message Center section of your Home Page, click on it. A listing of the claims requiring receipts will appear.

Remember, you can now **go mobile** by using your smart phone to access:

- FSA Account balances
- Submit claims for reimbursement
- Send receipts using a mobile device's camera
- Configure alerts via text message

Easily check information now using an iPhone, iPod Touch, iPad or Android-powered device.

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DELTA DENTAL

Dental Benefits

SOUTHERN MUTUAL CHURCH INSURANCE CO	Delta Dental PPO℠ Network	Delta Dental Premier® Network	Out-of-Network
	Based on applicable PPO Maximum Plan Allowance - No balance billing	Based on applicable Premier Maximum Plan Allowance - Balance billing is possible	Based on applicable Maximum Plan Allowance for Out-of-Network dentist - Balance billing is possible
Preventive Services • Bitewings, one set per benefit period • Oral Examinations, twice in any benefit period • Prophylaxis (cleanings), twice in any benefit period • Topical fluoride treatments for dependent children for dependent children under age 16, once in any benefit period	100%	100%	100%
Basic Services • Emergency palliative treatment • Endodontics • Fillings • Full mouth x-rays, once in any 36 month period • Non-Surgical Periodontics • Periapical x-rays, as required • Periodontal maintenance, twice in any benefit period (subject to your prophylaxis frequency limitation) • Sealants for dependent children under age 16, once in 5 years • Simple extractions • Space maintainers for dependent children under age 16, once in 5 years • Surgical Periodontics	80%	80%	80%
Major Services • Bridge repairs & recement • Bridges, once in 7 years • Crown repairs & recement • Crowns, Inlays, Onlays, once in 7 years • Denture repairs & adjustments • Dentures, once in 7 years • General Anesthesia • Implants, as well as bone grafts, are a covered benefit. Limited to once in 7 years. • Oral surgery • Stainless steel crowns • Surgical extraction of impacted teeth • Surgical extractions	50%	50%	50%
Orthodontia • Orthodontia for dependent children under age 19 (lifetime maximum)	50% up to $1,000 No deductible	50% up to $1,000 No deductible	50% up to $1,000 No deductible
Calendar Year Deductible (Applied to Basic and Major services)	$50 individual 3X family	$50 individual 3X family	$50 individual 3X family
Annual Maximum (Applied to Preventive, Basic and Major services)	$1,500	$1,500	$1,500
Dependent Age Limit: 26			

This is intended to be a summary only. If a discrepancy occurs the Summary Plan Document will govern. Please refer to your Summary Plan Description (SPD) for a more complete listing of services including plan limitations and exclusions. Orthodontic treatment in progress may be covered. Benefits provided by the prior carrier will be subtracted from the lifetime maximum available from Delta Dental.

DELTA DENTAL®

Choose Your Network

	Delta Dental PPO℠ Network	Delta Dental Premier® Network
Dentists Nationwide	56%	79%
Potential Savings	25%	5%

Network Options	Dentist's Charge	Average Discount	Your Share
Delta Dental PPO℠ Network	$1000	5%	$375
Delta Dental Premier® Network	$1000	5%	$475
Non-Network	$1000	None	$525
Without Dental Insurance	$1000	None	$1000

Cost Savings Example (Crown, if covered at 50%)

Please note – this example is for illustrative purposes only. Dentist charges, discounts and your share will be impacted by your benefits and the dentist you choose. Please check your summary plan description for detailed information on benefit coverage and limitations.

Find Your Provider

Mobile App

Download the Delta Dental mobile app (Apple and Android devices), and select "Find a Dentist."

Web

To find a dentist who participates in the Delta Dental PPO℠ network or Delta Dental Premier℠ network, visit www.DeltaDentalSC.com and click on "Find a Provider."

Customer Service

Our customer care team can assist via phone at 800-335-8266 or via email at service@deltadentalsc.com.

Delta Dental of South Carolina

DeltaDentalSC.com | @DeltaDentalSC | Facebook.com/DeltaDentalSC

Delta Dental of Missouri does business in South Carolina as Delta Dental of South Carolina.

DDSC-190225-1355

IN NETWORK BENEFITS

- Comprehensive eye exam every 12 months with a $10 copay.
- $150 material allowance every 12 months towards glasses and/or contact lens* with a one-time $25 copay.
- After your material allowance has been used, receive a 15% discount on glasses contact lens at most
- providers**.
- Discounts of 10%-15% on refractive surgery including LASIK at participating providers.
- Standard contact lens fitting fee of no more than $55 or 10% discount off the usual and customary fitting for non-standard contact lens*** at most providers*.
- No claims or paperwork to file.

**Material allowance does not cover non-prescription lenses, non-prescription or cosmetic contact lenses, or non-prescription sun-glasses.*

OUT OF NETWORK BENEFITS

- If you choose to use an out-of-network provider, you will be reimbursed the following amounts:
  - Exam including contact lens fitting: $40 reimbursement
  - Materials: $105 reimbursement

IMPORTANT INFORMATION:

- You will be mailed a membership card.
- To find an in-network provider near you, go to www.eyemed.com or call 1.866.939.3633
- Please visit www.eyemed.com for participating refractive surgery providers and discounts.
- To make an appointment, call an in-network provider and let them know that you are an EyeMed member
- You are responsible for payment to the in-network provider of any amount exceeding the material allowance, any copays and any contact lens fitting fees.
- This is a routine vision program. Medical and surgical treatments of the eyes are not covered benefits.

VISION INSURANCE COSTS:

TYPE OF COVERAGE	Employee Pays Total Cost Semi-Monthly Payroll Deductions
EMPLOYEE	**$4.30**
EMPLOYEE & SPOUSE	**$8.17**
EMPLOYEE & CHILD(REN)	**$8.60**
EMPLOYEE & FAMILY	**$12.63**

GROUP TERM LIFE CERTIFICATE SUMMARY

This summary describes the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. The capitalization of a term not normally capitalized according to standard punctuation rules indicates a word or phrase that is a defined term in the Certificate. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on November 9, 2015.

POLICY INFORMATION

Policyholder: Southern Mutual Church Insurance Company
Policy Effective Date: December 1, 2015
Policy Anniversary: December 1
Policy Number: GLUG-AY4G
Group Number: G000AY4G
Class(es): All Other Eligible Employees

ELIGIBILITY

You (the Employee) must be performing the normal duties of Your regular job for the Policyholder on a regular and continuous basis 30 or more hours each week to be eligible for insurance.

Your eligible Dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility) to be eligible for insurance.

WHEN INSURANCE BEGINS

An eligible Employee will become insured on the day the Employee becomes eligible, subject to certain conditions (as described in the Exceptions to When Insurance Begins provision in the Certificate).

An eligible Dependent will become insured on the latest of the day the Employee becomes insured, the Employee acquires the eligible Dependent, or the Employee submits a Written Request to enroll the Dependent for insurance (if required), subject to certain conditions (as described in the Exceptions to When Insurance Begins provision in the Certificate).

Additional eligibility conditions apply as described in the Certificate.

BENEFIT AMOUNT(S)

Insurance for You (The Employee)

Your amount of life insurance is $50,000.

Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

If You have questions regarding the amount of Your insurance, You may contact the Policyholder.

Insurance for Your Dependent(s)

Your Spouse's amount of life insurance is $5,000.

The amount of life insurance for Your eligible Dependent child(ren) is based on the age of the Dependent, as follows:

Age of Dependent Child	Amount of Life Insurance
Six months and older	$2,500
14 days to less than six months	$2,500
Less than 14 days	$0

If You have questions regarding the amount of insurance for Your Dependent(s), You may contact the Policyholder.

Benefit Reduction(s)

As You grow older, the amount of life and AD&D insurance for You will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce to:
65	65%
70	50%

FEATURE(S)

Living Benefits

In the event You incur a Terminal Condition while insured under the Policy, You, Your Spouse or Your legal representative may submit a Written Request for an advance payment of part of Your life insurance death benefit. The maximum amount of Living Benefits available is 50% of the amount of life insurance for You in effect at the time of the request or $25,000, whichever is less.

Additional Accidental Death and Dismemberment (AD&D) Benefit(s)

In addition to basic AD&D benefits, You are protected by the following benefit(s):

- Airbag
- Common Carrier
- Seat Belt

Continuation of Insurance for Layoff or Leave, Injury or Sickness, or Partial Disability

You may be able to continue insurance for You and Your Dependent(s) from the day You cease to be Actively Working, subject to certain conditions.

Continuation of Insurance for Total Disability with Waiver of Premium

You may be able to continue insurance for You from the day You cease to be Actively Working due to Your Total Disability, subject to certain conditions.

Portability

In the event Your insurance under the Policy ends, You have the right to continue receiving group life and accidental death and dismemberment insurance for You and/or Your Dependent(s), subject to certain conditions.

Conversion

If group life insurance ends or the benefit reduces, You or any of Your Dependent(s) may apply for an individual policy of life insurance, subject to certain conditions.

EXCLUSION(S)

Several exclusions apply to the accidental death and dismemberment (AD&D) benefits as described in the Certificate.

GROUP VOLUNTARY TERM LIFE CERTIFICATE SUMMARY

This summary describes the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. The capitalization of a term not normally capitalized according to standard punctuation rules indicates a word or phrase that is a defined term in the Certificate. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on November 9, 2015.

POLICY INFORMATION

Policyholder: Southern Mutual Church Insurance Company
Policy Effective Date: December 1, 2015
Policy Anniversary: December 1
Policy Number: GVTL-AY4G
Group Number: G000AY4G
Class(es): All Eligible Employees

ELIGIBILITY

You (the Employee) must be performing the normal duties of Your regular job for the Policyholder on a regular and continuous basis 30 or more hours each week to be eligible for insurance.

Your eligible Dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility) to be eligible for insurance.

WHEN INSURANCE BEGINS

An eligible Employee will become insured on the day the Employee becomes eligible, subject to certain conditions (as described in the Exceptions to When Insurance Begins provision in the Certificate).

An eligible Dependent will become insured on the latest of the day the Employee becomes insured, the Employee acquires the eligible Dependent, or the Employee submits a Written Request to enroll the Dependent for insurance (if required), subject to certain conditions (as described in the Exceptions to When Insurance Begins provision in the Certificate).

Additional eligibility conditions apply as described in the Certificate.

BENEFIT AMOUNT(S)

Insurance for You (The Employee)

You may elect to be insured for an amount of life insurance from $10,000 to $100,000, in increments of $10,000. In no event shall Your amount of life insurance exceed 5 times Your Annual Earnings, rounded to the next higher multiple of $10,000.

Provided You have elected some amount of life insurance, Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

Your Guarantee Issue Amount is 5 times Your Annual Earnings or $100,000, whichever is less. If You have questions regarding the amount of Your insurance, You may contact the Policyholder.

Insurance for Your Dependent(s)

You may elect to have Your Spouse insured for an amount of life insurance from $5,000 to $20,000, in increments of $5,000, provided the amount elected does not exceed 50% of Your amount of life insurance.

Provided You have elected some amount of life insurance for Your Spouse, Your Spouse's amount of accidental death and dismemberment (AD&D) insurance is equal to Your Spouse's amount of life insurance.

You may elect to have Your eligible Dependent child(ren) insured for an amount of life insurance from $2,000 to $10,000, in increments of $2,000, provided the amount elected does not exceed 50% of Your amount of life insurance. Each eligible Dependent child must have the same amount of insurance.

Provided You have elected some amount of life insurance for Your Dependent child(ren), the amount of accidental death and dismemberment (AD&D) insurance for Your Dependent child(ren) is equal to the amount of life insurance for Your Dependent child(ren).

The Guarantee Issue Amount for Your Spouse is 100% of Your elected amount of life insurance or $20,000, whichever is less. The Guarantee Issue Amount for Your Dependent child(ren) is 100% of Your elected amount of life insurance or $10,000, whichever is less. If You have questions regarding the amount of insurance for Your Dependent(s), You may contact the Policyholder.

Benefit Reduction(s)

As You grow older, the amount of life and AD&D insurance for You and Your Spouse will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce to:
65	65%
70	50%

FEATURE(S)

Living Benefits

In the event You or Your Spouse incur a Terminal Condition while insured under the Policy, You, Your Spouse or Your legal representative may submit a Written Request for an advance payment of part of Your or Your Spouse's life insurance death benefit. The maximum amount of Living Benefits available is 50% of the amount of life insurance for You or Your Spouse in effect at the time of the request or $50,000, whichever is less.

Continuation of Insurance for Layoff or Leave, Injury or Sickness, or Partial Disability

You may be able to continue insurance for You and Your Dependent(s) from the day You cease to be Actively Working, subject to certain conditions.

Continuation of Insurance for Total Disability with Waiver of Premium

You may be able to continue insurance for You from the day You cease to be Actively Working due to Your Total Disability, subject to certain conditions.

Portability

In the event Your insurance under the Policy ends, You have the right to continue receiving group life and accidental death and dismemberment insurance for You and/or Your Dependent(s), subject to certain conditions.

Conversion

If group life insurance ends or the benefit reduces, You or any of Your Dependent(s) may apply for an individual policy of life insurance, subject to certain conditions.

EXCLUSION(S)

We will not pay benefits for a death which results from suicide, while sane or insane, within two years from the date insurance begins (under the Policy or any Prior Plan). Instead, We will refund the total of the premiums paid for insurance under the Policy.

If death results from suicide, while sane or insane, within two years from the effective date of any increase in the amount of insurance under the Policy, benefits in the amount of the increase will not be paid. Instead, We will refund the total of the premiums paid under the Policy for said increase in insurance.

Several exclusions apply to the accidental death and dismemberment (AD&D) benefits as described in the Certificate.

GROUP SHORT-TERM DISABILITY CERTIFICATE SUMMARY

This summary describes some of the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on November 9, 2015.

POLICY INFORMATION

Policyholder:	Southern Mutual Church Insurance Company
Policy Effective Date:	December 1, 2015
Policy Anniversary:	December 1
Policy Number:	GUG-AY4G
Group Number:	G000AY4G
Classification:	All Eligible Employees
Minimum Work Hours Required:	30 hours per week
Eligibility Present Waiting Period:	None
Eligibility Future Waiting Period:	None
When Insurance Begins:	the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	
Injury:	30 calendar days
Sickness:	30 calendar days

BENEFITS

Weekly Benefit Percentage:	60%
Maximum Weekly Benefit:	$1,500
Maximum Benefit Period:	9 weeks
Vocational Rehabilitation Benefit:	5%

GROUP LONG-TERM DISABILITY CERTIFICATE SUMMARY

This summary describes some of the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on November 9, 2015.

POLICY INFORMATION

Policyholder:	Southern Mutual Church Insurance Company
Policy Effective Date:	December 1, 2015
Policy Anniversary:	December 1
Policy Number:	GLTD-AY4G
Group Number:	G000AY4G
Classification:	All Eligible Employees
Minimum Work Hours Required:	30 hours per week
Eligibility Present Waiting Period:	None
Eligibility Future Waiting Period:	None
When Insurance Begins:	the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	The later of: a) 90 calendar days; or b) the date Your short-term Disability ends.

BENEFITS

Monthly Benefit Percentage:	60%	
Maximum Monthly Benefit:	$7,500	
Minimum Monthly Benefit:	$100	
Maximum Benefit Period:	**Age at Disability**	**Maximum Benefit Period**
	61 or less	to age 65, Your SSNRA, or 3 years and 6 months, whichever is longest;
	62	Your SSNRA, or 3 years and 6 months, whichever is longer;
	63	Your SSNRA, or 3 years, whichever is longer;
	64	Your SSNRA, or 2 years and 6 months, whichever is longer;
	65	2 years;
	66	1 year and 9 months;
	67	1 year and 6 months;
	68	1 year and 3 months;
	69 or older	1 year.
Own Occupation Definition:	2 years	
Survivor Benefit:	3 months	
Vocational Rehabilitation Benefit:	5%	

LIMITATIONS/EXCLUSIONS

Alcohol/Drug Abuse/Substance Abuse Limitation:	24 months
Mental Disorder Limitation:	24 months
Pre-existing Condition Exclusion:	3/12

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

- **Allowed Amount**

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

- **Appeal**

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

- **Balance Billing**

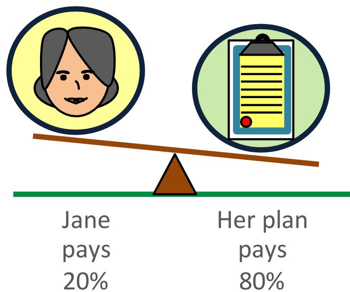
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining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

- **Claim**

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

- **Coinsurance**

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



(See page 6 for a detailed example.)

- **Complications of Pregnancy**

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

- **Copayment**

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

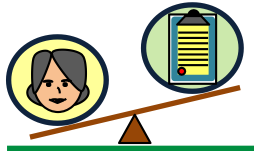
- **Cost Sharing**

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

- **Cost-sharing Reductions**

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

- **Deductible**
An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays pays 100% Her plan pay 0%

(See page 6 for a detailed example.)

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

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

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

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

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

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

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

- **Grievance**
A complaint that you communicate to your health insure or plan.

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

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

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

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

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

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

- **Individual Responsibility Requirement**

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

- **In-network Coinsurance**

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

- **In-network Copayment**

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

- **Marketplace**

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

- **Maximum Out-of-pocket Limit**

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

- **Medically Necessary**

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

- **Minimum Essential Coverage**

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

- **Minimum Value Standard**

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

- **Network**

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

- **Network Provider (Preferred Provider)**

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

- **Orthotics and Prosthetics**

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

- **Out-of-network Coinsurance**

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

- **Out-of-network Copayment**

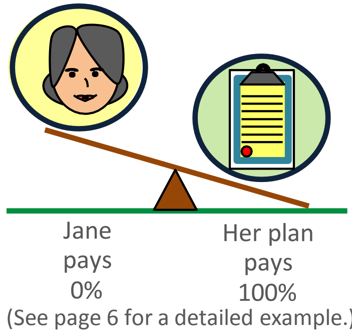
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

- **Out-of-network Provider (Non-Preferred Provider)**

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

- **Out-of-pocket Limit**

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

- **Physician Services**

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

- **Plan**

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

- **Preauthorization**

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

- **Premium**

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

- **Premium Tax Credits**

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

- **Prescription Drug Coverage**

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

- **Prescription Drugs**

Drugs and medications that by law require a prescription.

- **Preventive Care (Preventive Service)**

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

- **Primary Care Physician**

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

- **Primary Care Provider**

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

- **Provider**

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

the accredited as required by state law.

- **Reconstructive Surgery**

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

- **Referral**

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

- **Rehabilitation Services**

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

- **Screening**

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

- **Skilled Nursing Care**

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

- **Specialist**

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

- **Specialty Drug**

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

- **UCR (Usual, Customary and Reasonable)**

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

- **Urgent Care**

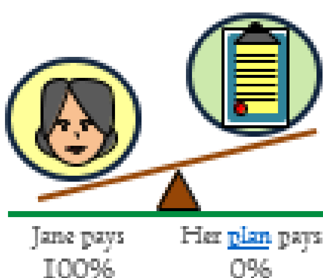
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Coinsurance: 20%** **Out-of-Pocket Limit: $5,000**

January 1st
Beginning of Coverage Period

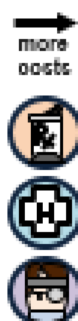
December 31st
End of Coverage Period

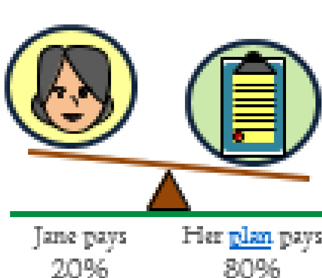


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

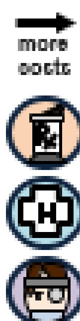


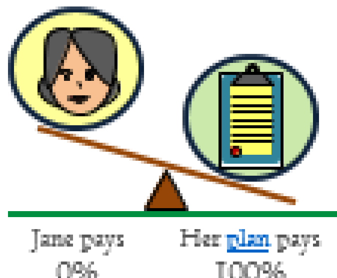


Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100





Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

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