

JULY 1, 2026—JUNE 30, 2027

EMPLOYEE BENEFITS

Eligibility ■ Enrollment ■ Medical ■ Dental
Vision ■ Life/AD&D ■ Disability



Taylor's Fire Department



We are pleased to offer you the 2026—2027 Benefits Package. This booklet is a summary of benefits offered through Taylors Fire Department. We hope all associates understand the value of the benefits offered. Our benefit package includes, but is not limited to major Medical, Dental, Vision, Life/AD&D, Voluntary Life/AD&D and Disability insurance plans that are an asset to you and your family.

We strongly encourage you to make use of the preventive services that are available through your Healthcare, Dental and Vision plans as these are at minimal or no cost to you. We thank all of you for your hard work and dedication.

Sincerely,

Taylors Fire Department

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This booklet provides a summary of plan highlights. Please consult the carrier's contract for complete information on covered charges, limitations, and exclusions. This is not a binding contract. The carrier's contract will prevail. If you have further questions, please contact the carrier or McGriff Insurance Services.



TOOLS & CONSIDERATIONS FOR 2026-2027

We ask you to continue to help us better manage our medical costs by leading a healthy lifestyle. You can impact the bottom line by:

- Using the ER only for true emergencies
- Taking advantage of generic prescriptions when available
- Utilizing the preventive care benefit
- Staying in-network whenever possible

CLAIM QUESTIONS OR ISSUES

McGriff Insurance Services is the advisory firm representing Taylors Fire Department. If you have a problem or a question about a claim:

1

Call your insurance carrier's customer service department. Phone numbers can be found on your ID cards and on page 19 of this booklet.

2

If you are not satisfied after speaking with the carrier, please contact your Human Resource Department.

BENEFITS ELIGIBILITY

Full-time employees are eligible for benefits on the first of the month following date of hire for Medical, Dental, Vision, Basic Life/AD&D, Voluntary Life/AD&D, Short-Term Disability and Long-Term Disability insurance plans.

Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian.

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children under age 26
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

Other dependents who may live with you, but are NOT eligible to be added to your benefit plans:

- Grandchildren, nieces, nephews or other children who do not meet specifications listed above
- Ex-spouses, unless required via court order (documentation required)
- Parents, step-parents, grandparents, aunts, uncles, or other relatives who are not qualified legal dependents (even if they live in your house)

MAKING CHANGES TO YOUR BENEFITS

Most benefit deductions are withheld from your paycheck on a pre-tax basis (Medical, Dental, Vision) and therefore your ability to make changes to these benefits is restricted by the IRS. Once enrolled, most pre-tax benefit elections cannot be changed until the next annual Open Enrollment period, unless you have a qualifying life status change.

Open Enrollment generally occurs in June with plan changes taking effect on July 1st of that plan year.

To make benefit changes as a result of a Life Status Change as allowed under Section 125 of the IRS Code, you must:

- Notify Human Resources within 30 days* of the date of the qualifying event
- Provide proof of your life status event

*Refer to your Plan Administrator as some events may allow for up to 60 days



The Most Common Life Status Changes

- Marriage and divorce
- Birth or adoption
- Change in you or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order or other court order

MEDICAL BENEFITS PROVIDED THROUGH CIGNA

Taylor's Fire Department will offer medical group benefits with CIGNA for the plan year 2026-2027. We will offer the CIGNA Copay Plan.

CIGNA OPEN ACCESS PLAN (PPO)		
Benefits	In-Network	Out-of-Network
Co-Insurance: Insurance / Insured	80% / 20%	50% / 50%
Deductible (Calendar Year: (1/1– 12/31))	Individual: \$1,000 Family: \$2,000	Individual: \$2,000 Family: \$4,000
Maximum Out-of-Pocket (Includes Deductible., Coinsurance & Copays)	Individual: \$2,500 Family: \$5,000	Individual: \$5,000 Family: \$10,000
Covered Services	Amounts You Pay	Amounts You Pay
Physician Services:	In-Network	Out-of-Network
Primary Care Physician (PCP) (Non-Routine/Sick Office Visit)	\$25 Copay	Deductible + 50%
Specialist Office Visit	\$40 Copay	Deductible + 50%
Urgent Care	\$50 Copay	Deductible + 20%
Telehealth Services	\$25 Copay	Not Covered
Chiropractic Benefits (Unlimited)	Deductible + 20%	Deductible + 50%
Preventive Care as Mandated by PPACA	\$0 (Covered at 100%)	Not Covered
Facility Services:		
Inpatient Facility	Deductible + 20%	Deductible + 50%
Outpatient Facility	Deductible + 20%	Deductible + 50%
Emergency Room (copay waived if admitted)	\$150 Copay	Same as In-Network

Prescription Services	Retail (31 Day Supply)	Mail Order (90 Day Supply)	Out-of-Network
Generic	\$10	\$25	Covered Only at a Participating Pharmacy
Preferred	\$35	\$88	
Non-Preferred	\$55	\$138	

Taylor's Fire Department will provide an HRA benefit of \$500 per individual (max 2 per family) towards the deductible per benefit year.

Your Cigna 90 Now pharmacy benefits.



Get the most from your plan's coverage.

Your pharmacy benefits provide you with access to many Cigna HealthcareSM programs and services that can help you manage your health and prescription medication needs.

- **One ID card for both your pharmacy and medical needs.** Be sure to replace your ID card with your new Cigna Healthcare ID card as soon as your plan begins.
- 24/7 live, personalized customer support.
- Easy access to medications.
- One customer-focused team – medical, behavioral and pharmacy – working together to keep you healthy.
- One-on-one guidance to help you choose – and use – your health care wisely.

Use the myCigna® App or myCigna.com for 24/7 access to your plan's coverage info.

- Order, manage and track your home delivery prescription orders.
- See which medications your plan covers.
- Use the Price a Medication tool to find out how much your medication costs, and view lower-cost alternatives (if available).¹
- Find an in-network pharmacy.
- Ask a pharmacist a question.
- See your pharmacy claims and coverage details.

Your Prescription Drug List.

The Cigna Healthcare Prescription Drug List is a list of generic and brand name prescription medications your plan covers. All medications on the drug list are approved by the U.S. Food and Drug Administration (FDA). Covered medications are divided into tiers, or coverage/cost levels. Typically, the higher the tier, the higher the cost of the medication. Log in to the [myCigna App](#) or [myCigna.com](#), or check your plan materials, to learn more about the medications your plan covers.

Some medications on your drug list have extra requirements before your plan will cover them.²

- **Prior Authorization.**
Certain medications need approval from Cigna Healthcare before your plan will cover them. These medications have a **(PA)** next to them on your drug list.
- **Quantity Limits.**
For some medications, your plan only covers up to a certain amount over a certain length of time. For example, 30 mg a day for 30 days. These medications have a **(QL)** next to them on your drug list.
- **Step Therapy.**
Certain high-cost medications are part of the Step Therapy program. These medications have **(ST)** next to them on your drug list. Your plan doesn't cover Step Therapy medications until you try one or more generic and/or preferred brand alternative first (unless you receive approval from Cigna Healthcare).

Go generic and save.

When it comes to prescription medications, you and your doctor usually have a choice between a brand name medication and its generic equivalent. **Generics have the same strength and active ingredients and work in the same way as the brand name medication – but cost up to 85% less.³** Talk to your doctor to see if a generic is right for you.



Call us 24/7.

Express Scripts® Pharmacy – 800.835.3784

Accredo – 877.826.7657

Talk with a Cigna Healthcare pharmacist – 800.835.8981

Customer Service – 866.494.2111 or the number on your Cigna Healthcare ID card

If you need language assistance, or have a disability, please call us at 866.494.2111 (For TTY services, dial 711). Accommodations are available and provided at no cost to you.

Virtual Office Visits

Choice is good. More choice is even better.

Cigna provides access to **two** telehealth services as part of your medical plan – **Amwell** and **MDLIVE**.

Cigna Telehealth Connection lets you get the care you need – including most prescriptions (when appropriate) – for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office. When, where and how it works best for you!

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: Amwell or MDLIVE doctors.

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register on both Amwell and MDLIVE, you can speak with a doctor for help with:

- › Sore throats
- › Headaches
- › Stomachaches
- › Fevers
- › Colds and flu
- › Allergies
- › Rashes
- › Acne
- › Shingles
- › Bronchitis
- › Urinary tract infections and more

The cost savings are clear.

Televisits with Amwell and MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, your telehealth services are only available for minor, non-life-threatening conditions. In an emergency, dial 911 or go to the nearest hospital.



Amwell and MDLIVE are only available for medical visits. For covered services related to mental health and substance use disorder, you have access to the **Cigna Behavioral Health** network of providers.

- › Go to **myCigna.com** to search for a telehealth provider under Specialty in the Behavioral Directory link
- › Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

Choose with confidence.

Amwell and MDLIVE are both quality national telehealth providers, so you can choose your care confidently. When you can't get to your doctor, Cigna Telehealth Connection is here for you.

AmwellforCigna.com*

855.667.9722



MDLIVEforCigna.com*

888.726.3171



Signing up is easy!



Connect to both Amwell and MDLIVE through **myCigna.com**. No separate login needed.



Complete a medical history using their virtual clipboard.



Download the MyCigna App and you'll be able to access both telehealth providers on your smartphone/mobile device.**

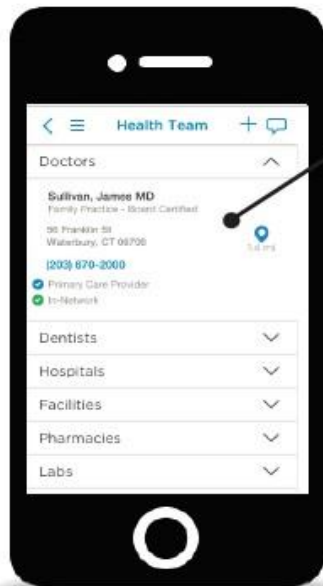
Cigna One Guide

The myCignaSM app now includes a Cigna One Guide[®] service upgrade with even more tools and support.

The myCigna app still uses information specific to your plan so you can easily:

- › Find in-network doctors, labs and hospitals
- › Get cost estimates for care
- › Compare prescription prices
- › Manage and track claims
- › Access your ID cards to print, fax or email

But the One Guide service now lets you do so much more.



Build your custom health team - a personal list of the in-network doctors, dentists and facilities you use to keep track of their information all in one place.

Sign up for messages that can guide you to savings, coaching opportunities and more (if offered by your employer).



Get tips and reminders to help you stay on track with appointments and preventive care.

Access support quickly. You can chat online or by phone with a personal guide who can answer your questions and help you make the most of your plan.



DENTAL BENEFITS PROVIDED THROUGH CIGNA

Finding a Provider

CIGNA online directory makes it easy to find in-network dentists. Just follow these easy steps:

- [Cigna HealthCare Provider Directory](#)
- 'Click' Dental
- 'Click' Network Provider
- Search for a network provider by location
- Or call 800.244.6224



Visit Your Dentist Regularly

Regular preventive visits to your dentist can help protect your health, and we are talking about more than just your mouth. Recent studies have linked gum disease to damage elsewhere in the body. According to the Centers for Disease Control and Prevention, there may be associations between oral infections and diabetes, heart disease, stroke, and preterm, low-weight births. Research is underway to further examine these connections.

Your plan covers preventive services at 100% in-network, with no deductible for preventive services.

Dental Benefits	In-Network	Out-of-Network
Calendar Year Deductible	\$50 per individual \$150 per family	
Preventive Services Oral Exam, Cleanings, Routine X-rays, Non-Routine X-rays, Fluoride Application Sealants, Space Maintainers	100% no deductible	
Basic Services Filings (Amalgam and composite on all teeth), Oral Surgery (simple extractions), Surgical Extraction of impacted teeth, Anesthetics, Minor and Major Periodontics, Endodontics, Repairs– Bridges, Crowns and Inlays, Repairs-Dentures	80% after deductible	
Major Services Crowns, Inlays, Onlays, Stainless Steel, Resin Crowns, Dentures, Bridges	50% after deductible	
Orthodontics (dependent children only)	50% up to \$1,500 lifetime maximum	
Maximum Annual Benefit (per individual per calendar year)	\$2,000	

VISION BENEFITS PROVIDED THROUGH CIGNA (EYEMED NETWORK)

Cigna members can take care of their vision and have routine eye exams, while saving money on all of their eye care needs. To start using your benefit and find a provider, visit:

- myCigna.com
- or call 877-478-7557

Did you know?

Taking care of your vision can also mean early detection for symptoms of:

- Diabetes
- Hypertension
- High cholesterol
- Tumors
- Thyroid disorders
- Neurological disorders

A qualified vision care professional can help treat and manage:

- Cataracts
- Corneal diseases
- Diabetic retinopathy
- Eye infections
- Glaucoma
- Macular degeneration



Vision Benefits (Per Calendar Year)	In-Network (EyeMed)	Out-of-Network (Reimbursement)
Exams	\$10 Copay	Up to \$45
Materials (lenses or frames)	\$10 Copay	See Below
Frequency ■ Exam ■ Lenses ■ Frame	Once every 12 months Once every 12 months Once every 12 months	
Standard Plastic Lenses ■ Single Vision ■ Bifocal ■ Trifocal ■ Lenticular	Covered in Full (after \$10 copay)	Up to \$32 Up to \$55 Up to \$65 Up to \$80
Frames	\$200 Allowance	Up to \$110
Contact Lenses ■ Fit & Follow-up Exams ■ Elective ■ Medically Necessary	Up to \$60 \$200 Allowance Covered in Full	N/A Up to \$160 Up to \$210

BASIC LIFE/AD&D, VOLUNTARY LIFE/AD&D INSURANCE

PROVIDED THROUGH THE STANDARD

Basic Life/AD&D

Taylor's Fire Department provides all employees a Basic Life and AD&D insurance benefit of \$50,000 at **NO COST to you** through The Standard.

Dependent Life/AD&D

You can also purchase Dependent Life/AD&D coverage for your spouse and child(ren) through The Standard.

Why Buy Voluntary Life Coverage?

In addition to the insurance provided free by Taylor's Fire Department, you can purchase additional Voluntary Life coverage for yourself. Voluntary Life provides a lump sum cash benefit to surviving dependents to cover immediate costs such as funeral expenses or ongoing living expenses. Voluntary Life insurance benefits often help survivors adjust to the loss of income related to the death of a wage earner, or provide funds for college or retirement for the survivors.

*See page 13 for Employee Voluntary Life/AD&D Rates

EMPLOYEE VOLUNTARY LIFE/AD&D
Benefit Amount: \$10,000 increments to \$250,000 maximum Guarantee Issue: \$100,000 (New Hires Only)
DEPENDENT LIFE/AD&D: SPOUSE
Benefit Amount: \$15,000
DEPENDENT LIFE/AD&D: CHILD(REN)
Benefit Amount: \$7,500 Child means your child from live birth through age 20 (through age 24 if registered student in full-time attendance at an accredited educational institution)
DEPENDENT LIFE/AD&D RATE
Bi-Weekly Rate: Spouse \$15,000 / Child \$7,500 each: \$2.49

Exclusions

Basic Life benefits reduce to 65% at age 65, 50% at age 70 and 35% at age 75.

Voluntary Life benefits reduce to 65% at age 65, 50% at age 70 and 35% at age 75.

There is no open enrollment for Life coverage. If you do not enroll when you are first eligible, or due to a qualifying life event, and later apply for coverage, you will have to submit evidence of insurability and may be turned down for coverage.

If you are currently enrolled in Additional Life insurance for an amount less than \$100,000, you may elect to increase your coverage by \$10,000 or \$20,000, up to, but not to exceed, the guarantee issue amount of \$100,000 without having to answer health questions. If you are currently enrolled in Additional Life insurance, you may elect \$10,000 or \$20,000 without having to answer health questions.

If you are no longer an active full-time employee and/or your employment ends, your Life coverage may be terminated. You may be eligible for conversion and/or portability which allows you to continue your Life coverage per the carrier guidelines. You must apply within the carrier's specified timeframe and submit the required premiums in order to continue your Life coverage. Please refer to the carrier website for conversion and/or portability forms or see your Human Resource Department for additional information.

VOLUNTARY LIFE/AD&D INSURANCE RATES

EMPLOYEE VOLUNTARY LIFE RATES Per \$1,000 (monthly)	
AGE BAND	RATE
0-29	\$0.060
30-34	\$0.060
35-39	\$0.080
40-44	\$0.150
45-49	\$0.290
50-54	\$0.440
55-59	\$0.750
60-64	\$1.280
65-69	\$2.260
70-74	\$3.490
75 and over	\$5.850

EMPLOYEE AD&D RATE (monthly)	
COVERAGE	RATE
Per \$1,000	\$0.030

Example for How to Calculate Your Voluntary Life/AD&D Bi-Weekly Premium (Employee)				
EXAMPLE: Employee Age 40-44				
Amount of Coverage	Divided by 1,000	Multiplied by Life + AD&D Rate	Example Monthly Cost	Example Bi-Weekly Cost
\$50,000	/1,000 = 50	x (0.150 + 0.030) =	\$9.00	\$9.00 x 12 / 26 = \$4.15

SHORT-TERM & LONG-TERM DISABILITY

PROVIDED THROUGH THE STANDARD

WHY IS DISABILITY INSURANCE SO IMPORTANT?

One third of all Americans between the ages of 35 and 65 will become disabled for more than 90 days, according to the American Council of Life Insurers. The Standard provides the ability for employees to obtain Short-Term and Long-Term Disability insurance which provides income continuation if you are ever unable to work due to an accident or illness.

SHORT-TERM DISABILITY—EMPLOYER PAID

60% of the first \$1,250 of your weekly pre-disability earnings as of the date of disability, reduced by deductible income (e.g. work earnings, workers' compensations, state disability, etc.)

- » **Weekly Benefit Maximum:** \$750
- » **Elimination Period:** 14 Days Accident / 14 Days Illness
- » **Benefit Duration:** 90 Days
- » **Pre-Existing Condition:** None

LONG-TERM DISABILITY—EMPLOYER PAID

Your Long-Term Disability (LTD) benefit provides a benefit of 60% of your monthly salary up to a maximum of \$3,500 per month.

- » **Monthly Benefit Maximum:** \$3,500
- » **Elimination Period:** 90 Days
- » **Benefit Duration:**
 - » To age 65 (if you become disabled before age 62)
 - » If you become disabled after age 62 the benefit duration is determined by the age when disability begins.
- » **Own Occupation:**
 - » Class 1: 12 Months
 - » Class 2: 24 Months
- » **Pre-Existing Condition:** 3 Months / 12 months / 12 months



LONG-TERM DISABILITY EXCLUSIONS

Pre-existing Condition means a mental or physical condition for which you have either consulted a physician, received medical treatment/services or taken prescribed drugs/medications at any time during the 90-day period just before the date your insurance becomes effective.

You are not covered for a Disability caused or contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become Disabled, you have been continuously insured under the Group Policy for 12 months or have served an entire 12 month Treatment-Free Period without having done any of the following in connection with the Preexisting Condition:

1. Consulted a Physician.
2. Received medical treatment or services.
3. Taken prescribed drugs or medications.

EMPLOYEE ASSISTANCE PROGRAM PROVIDED THROUGH THE STANDARD



Employee Assistance Program Services

Easy to Call. Easy to Use.

Through First Sun EAP you, your immediate family and members of your household have access to an award-winning Employee Assistance Program (EAP) with services specifically designed to enhance your wellbeing — both personally and professionally.

As our tagline states, “We Help People Be Better at Work.” Our highly seasoned and credentialed staff are invested in you and personally handle your call. They are professionally trained to assess your needs and get you to the right resources that will make a difference in your situation. It’s no wonder the First Sun client satisfaction rate is so high.

Counseling Services

8

You, your immediate family and members of your household are offered eight free services to apply toward confidential counseling sessions or life management services.



When you are challenged by personal or emotional issues, our licensed counselors* are here to help. Your sessions may be used for personal and workplace issues. We are just a phone call away, 24 hours a days, 7 days a week. Eight free face-to-face and video counseling sessions are available to each employee, immediate family and members of your household.

When your personal or professional life becomes unbalanced, we are here to help you regain that balance. Here are some of the issues your EAP addresses:

- Grief and Loss
- Stress Management
- Alcohol/Substance Use
- Marital/Relationship
- Anxiety
- Depression
- Personal Growth
- Trauma
- Anger Management
- Family Conflicts
- Spiritual Matters
- Workplace Concerns
- Work-life Balance
- Behavioral Change

* All counseling services are confidential in compliance with the law.

You are eligible for eight free counseling sessions and five life management services. Your EAP services are made available to you, your immediate family and members of your household by your employer. You may use the services whether or not you have chosen to participate in an employer insurance plan.

Please see other side for more services.



Call us 24/7/365 at 800-968-8143 or visit www.firstsuneap.com



Life Management Services

5

You, your immediate family and members of your household are offered five free services to apply toward confidential counseling sessions or life management services.



2026 PAID TIME OFF

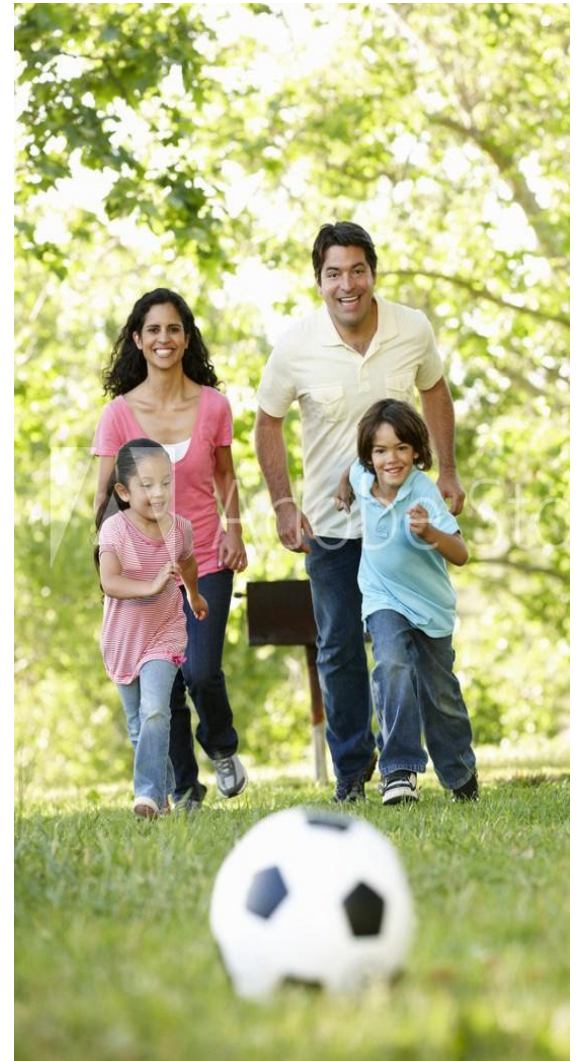
Holiday Schedule

FD Shift Personnel

- New Year's Day – Thursday, January 1, 2026
- Martin Luther King Day – Monday, January 19, 2026
- Good Friday – Friday, April 3, 2026
- Easter Sunday – Sunday, April 5, 2026
- Confederate Memorial Day – Sunday, May 10, 2026
- National Memorial Day – Monday, May 25, 2026
- Independence Day – Saturday, July 4, 2026
- Labor Day – Monday, September 7, 2026
- Veterans Day – Wednesday, November 11, 2026
- Thanksgiving Day – Thursday, November 26, 2026
- Day After Thanksgiving – Friday, November 27, 2026
- Christmas Eve – Thursday, December 24, 2026
- Christmas Day – Friday, December 25, 2026
- Day After Christmas – Saturday, December 26, 2026

FD Admin Personnel

- New Year's Day – Thursday, January 1, 2026
- Martin Luther King Day – Monday, January 19, 2026
- Good Friday (observed) – Thursday, April 2, 2026
- Confederate Memorial Day (observed) – Monday, May 11, 2026
- National Memorial Day – Monday, May 25, 2026
- Independence Day (observed) – Thursday, July 2, 2026
- Labor Day – Monday, September 7, 2026
- Veterans Day – Wednesday, November 11, 2026
- Thanksgiving Day (observed) – Wednesday, November 25, 2026
- Day After Thanksgiving (observed) – Thursday, November 26, 2026
- Christmas Eve (observed) – Tuesday, December 22, 2026
- Christmas Day (observed) – Wednesday, December 23, 2026
- Day After Christmas (observed) – Thursday, December 24, 2026



2027 PAID TIME OFF

FD Shift Personnel

- New Year's Day – Friday, January 1, 2027
- Martin Luther King Day – Monday, January 18, 2027
- Good Friday – Friday, March 26, 2027
- Easter Sunday – Sunday, March 28, 2027
- Confederate Memorial Day – Monday, May 10, 2027
- National Memorial Day – Monday, May 31, 2027
- Independence Day – Sunday, July 4, 2027
- Labor Day – Monday, September 6, 2027
- Veterans Day – Thursday, November 11, 2027
- Thanksgiving Day – Thursday, November 25, 2027
- Day After Thanksgiving – Friday, November 26, 2027
- Christmas Eve – Friday, December 24, 2027
- Christmas Day – Saturday, December 25, 2027
- Day After Christmas – Sunday, December 26, 2027

FD Admin Personnel

- New Year's Day (observed) – Thursday, Dec 31, 2026
- Martin Luther King Day – Monday, January 18, 2027
- Good Friday (observed) – Thursday, March 25, 2027
- Confederate Memorial Day – Monday, May 10, 2027
- National Memorial Day – Monday, May 31, 2027
- Independence Day (observed) – Monday, July 5, 2027
- Labor Day – Monday, September 6, 2027
- Veterans Day – Thursday, November 11, 2027
- Thanksgiving Day (observed) – Wednesday, November 24, 2027
- Day After Thanksgiving (observed) – Thursday, November 25, 2027
- Christmas Eve (observed) – Wednesday, December 22, 2027
- Christmas Day (observed) – Thursday, December 23, 2027
- Day After Christmas (observed) – Monday, December 27, 2027

Additional Voluntary Benefits

- Liberty National
- Legal Shield
- MASA
- Aflac
- Credit Union
- SC Deferred Comp: Two Options (visit www.southcarolinadcp.com for additional information and plan comparisons)

Bi-Weekly Benefit Costs

Bi-Weekly Contributions	Medical Copay Plan
Employee Only	\$20.00
Employee + Spouse	\$100.00
Employee + Child(ren)	\$80.00
Employee + Family	\$120.00

Bi-Weekly Contributions	Dental Plan
Employee Only	\$17.30
Employee + Spouse	\$48.59
Employee + Child(ren)	\$37.12
Employee + Family	\$67.80

Bi-Weekly Contributions	Vision Plan
Employee Only	\$3.85
Employee + Spouse	\$7.40
Employee + Child(ren)	\$6.76
Employee + Family	\$10.31

Basic Life / AD&D	Employer Paid
Dependent Life / AD&D	See page 14 for rates and premium calculations
Voluntary Life / AD&D	See page 14 for rates and premium calculations
Short-Term & Long-Term Disability	Employer Paid

RESOURCES

YOUR BENEFIT RESOURCES	PHONE	WEB
Medical - Cigna	800.997.1654	myCigna.com
Dental - Cigna	800.244.6224	myCigna.com
Vision - Cigna (EyeMed Network)	877-478-7557	myCigna.com
Life/AD&D, Voluntary Life/AD&D - The Standard	800.628.8600	standard.com
Short-Term & Long-Term Disability - The Standard	800.628.8600	standard.com
Employee Assistance Program - First Sun	800.968.8143	firstsuneap.com
HR Department - Stephanie Hackler	864.244.5596	email: stephanieh@taylorsdistrict.org

This Guide is only intended to offer an outline of benefits. All details and contract obligations of plans are stated in the group contract/insurance documents, client policies and procedures, including any disclosures (whether regarding “grandfathering” of plans or others) required by the new health reform law, the Patient Protection and Affordable Care Act (PPACA). In the event of conflict between this guide and the group contract/insurance documents, the group contract/insurance documents will prevail. Please contact your Human Resources Department for further information.

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TERMS TO KNOW

Deductible - Amount an employee pays out of pocket prior to the insurance company paying a percentage of the provider charges.

Coinsurance - The amount of payment split between the employee and the insurance company. Example: Insurance company pays 80% and employee pays 20% of the charges after the deductible is met.

Out of Pocket Maximum - The maximum an employee is responsible for paying out of pocket in any one calendar year prior to the insurance company paying the entire eligible amount for the remaining of the calendar year.

Network Providers - Doctors, Hospitals and other healthcare providers who have an agreement/contract with insurance companies agreeing to charge a discounted amount for services they render.

Pre-Authorization - Certain procedures or hospitalizations may require that the provider receive authorization. The provider is typically the one to go through this process with the insurance company and obtain pre-authorization.

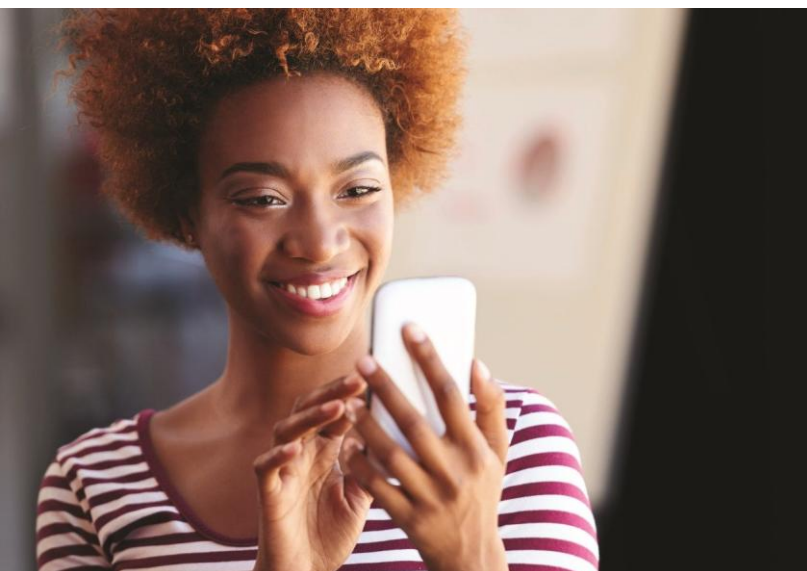
Pre-Determination - If you are having a major procedure done, your doctor or dentist can submit a pre-determination to the insurance company so you can know in advance of treatment how much of the bill you will be responsible for.

Explanation of Benefits (EOB) - The EOB is mailed to the employee after a claim is received and processed by the insurance company. The EOB will describe how the claim was processed and outline what portion of the charges are applied to the deductible, what portion the employee is responsible for, and explain if there is a denial or error processing the claim.

Appeal - If your health insurance company doesn't pay for a specific health care provider or service, you have the right to appeal the decision and have it reviewed by an independent third party.

Guaranteed Issue - The maximum amount of voluntary life insurance you can choose when making your initial election that does not require the answering of medical questions.

Evidence of Insurability (EOI) - The form containing medical questions that are required to be answered if you decide to elect voluntary life insurance after you have previously declined coverage, or if you decide to increase your current coverage. This may also be needed if you decide to add disability coverage after you have previously declined.



INSURANCE COMPANY WEBSITES AND APPS

Registering on your insurance company websites and downloading the smart phone apps gives you instant access to valuable resources. In most cases you can access:

- Specific plan details
- ID cards
- In-network provider search
- Your claims history
- And other tools and resources

WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to Amwell and MDLIVE for virtual visits.

	Conditions Treated*	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	- Sudden numbness, weakness - Uncontrolled bleeding - Seizure or loss of consciousness - Shortness of breath - Chest pain - Head injury/major trauma - Blurry or loss of vision - Severe cuts or burns - Overdose	- Costs are highest - No appointment needed - Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	- Minor cuts, sprains, burns, rashes - Fever and flu symptoms - Headaches - Chronic lower back pain - Joint pain - Minor respiratory symptoms - Urinary tract infections	- Costs are lower than an ER visit - No appointment needed - Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	- General health issues - Preventive services - Routine checkups - Immunizations and screenings	- May include coinsurance and/or deductible - Appointment usually needed - May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	- Common cold/flu - Rashes or skin conditions - Sore throat, earache, sinus pain - Minor cuts or burns - Pregnancy testing - Vaccinations	- Costs are same or lower than office visit - No appointment needed - Wait times typically 15 minutes or less
Virtual Medicine		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app.	- Cold and flu symptoms such as a cough, fever and headaches - Allergies - Sinus infections - Family health questions	- Cost is lower than office visit - No appointment needed - Immediate, private, and secure visits

GREATER

*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

NOTICES

HIPAA PRIVACY AND SECURITY – NOTICE OF PRIVACY PRACTICES

Summary: HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices.

HIPAA PORTABILITY – NOTICE OF SPECIAL ENROLLMENT RIGHTS

Summary: This notice describes a group health plan's special enrollment rules including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement of a child for adoption, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.

COBRA – FIRST NOTICE OF COBRA RIGHTS

Summary: This notice advises covered employees, covered spouses, and covered dependents of the right to purchase a temporary extension of group health coverage when coverage is lost due to a qualifying event.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT NOTICE (CHIPRA)

Summary: This annual notice notifies employees of potential state opportunities for premium assistance to help pay for employer-sponsored health coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

Summary: Participants and beneficiaries of group health plans who are receiving mastectomy-related benefits can choose to have breast reconstruction following a mastectomy.

PRESCRIPTION DRUG COVERAGE AND MEDICARE

Summary: Entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals – must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage.

HEALTH CARE REFORM NOTICE: NOTICE OF EXCHANGE/ MARKETPLACE

Summary: Employer must provide all employees with an Exchange Notice that includes a description of services provided by the Exchange. The notice must explain the premium tax credit available if a qualified health plan is purchased through the Exchange. The employee must also be informed that they may lose the employer contribution to any benefit plans offered by the employer if a health plan through the Exchange is elected.

MEDICAL PRE-TAX PREMIUMS PLAN

Summary: Enrollment in a pre-tax premium plan authorizes premiums for group health plan benefits to be payroll deducted on a pre-tax basis.

WELLNESS PROGRAM DISCLOSURE

If it is unreasonably difficult due to a medical condition for you to achieve the standard for reward or if it is medically inadvisable for you to attempt to achieve the standard for reward under your employer's wellness program, please contact your employer's Human Resources representative to develop another way for you to qualify for the wellness program reward.

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

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

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) to join a Part D plan.

If you decide to join a Medicare drug plan, your coverage may be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. If you do decide to join a Medicare drug plan and drop your prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with **your employer** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage, contact your employer's Benefits Department.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **your employer** changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Benefit Premiums

Your employer sponsors a Flexible Benefits Plan to allow you to pay your share of applicable insurance premiums on a pre-tax basis. This "Pre-Tax Plan" allows you to maximize your take-home pay by saving state, federal, and FICA/Social Security taxes on premiums you make through salary withholdings for qualified plans you participate in. This is an employee benefit that we hope will be an asset to you and your family.

You are automatically enrolled in this Pre-Tax Plan and receive full tax savings if you are paying any out-of-pocket premiums for qualified insurance programs included in the Plan. If for some reason you wish to waive this benefit and pay your share of any premiums on a post-tax basis, you may elect to do so by completing and signing a Waiver Form.

It is important to be aware that there are certain restrictions that accompany participation in the Pre-Tax Plan. **According to IRS rules, participants may only change their insurance coverage election during the open enrollment period prior to the plan's renewal date. The only exceptions are for qualifying events or "changes in status" that are consistent with the requested change. Some examples of status changes are marriage, divorce, change in the number of dependents, or change in employment status for you or your spouse.**

If you have questions about the benefits for which you are currently enrolled, benefits which you may be eligible for, or the current costs or expected costs of the benefits for the next plan year, please contact Human Resources.

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Newborn's Act Notice

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

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 30 days after your 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 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

Important Notice

ALABAMA – Medicaid myalhipp.com 855-692-5447
ALASKA – The AK Health Insurance Premium Payment Program myakhipp.com 866-251-4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid myarhipp.com 855-MyARHIPP (855-692-7447)
COLORADO –Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: healthfirstcolorado.com 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 800-359-1991/ State Relay 711
FLORIDA –Medicaid flmedicaidtpirecovery.com 877-357-3268
GEORGIA –Medicaid dch.georgia.gov/medicaid (Click Health Insurance Premium Payment (HIPP) 404-866-4507
INDIANA –Healthy Indiana Plan for low-income adults 19-64 in. gov/fssa/hip/ 877-438-4479 All other Medicaid: indianamedicaid.com 800-403-0864
IOWA –Medicaid dhs.iowa.gov/hawk-i 800-257-8563
KANSAS –Medicaid kdheks.gov/hc/ 785-296-3512
KENTUCKY –Medicaid chfs.ky.gov 800-635-2570
LOUISIANA –Medicaid dhh.louisiana.gov/index.cfm/subhome/1/n/331 888-695-2447
MAINE –Medicaid maine.gov/dhhs/ofi/public-assistance/index.html 800-442-6003 TTY: Maine relay 711
MASSACHUSETTS –Medicaid and CHIP mass.gov/eohhs/gov/departments/masshealth/ 800-862-4840
MINNESOTA –Medicaid mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800-657-3739
MISSOURI –Medicaid dss.mo.gov/mhd/participants/pages/hipp.htm 573-751-2005
NEW HAMPSHIRE –Medicaid dhhs.nh.gov/ombp/nhnhpp/ 603-271-5218 Hotline: NH Medicaid Service Center at 888-901-4999
NEW JERSEY –Medicaid and CHIP Medicaid: state.nj.us/humanservices/dmahs/clients/medicaid/ 609-631-2392 CHIP: njfamilycare.org/index.html 800-701-0710
NEW YORK –Medicaid health.ny.gov/health_care/medicaid/ 800-541-2831
NORTH CAROLINA –Medicaid dma.ncdhhs.gov/ 919-855-4100
NORTH DAKOTA –Medicaid nd.gov/dhs/services/medicalserv/medicaid/ 844-854-4825
OKLAHOMA –Medicaid and CHIP insureoklahoma.org 888-365-3742
OREGON –Medicaid and CHIP oregonhealthcare.gov/Pages/index.aspx 800-699-9075
PENNSYLVANIA –Medicaid dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/ind_ex.htm 800-692-7462
RHODE ISLAND –Medicaid eohhs.ri.gov/ 844-697-4347
SOUTH CAROLINA –Medicaid scdhhs.gov 888-549-0820
TEXAS –Medicaid gethipptexas.com/ 800-440-0493
UTAH –Medicaid and CHIP Medicaid: medicaid.utah.gov/medicaid CHIP: health.utah.gov/chip 877-543-7669

To see if any other states have added a premium assistance program since January 1, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

U.S. Department of Labor

Employee Benefits Security Administration

dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

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



New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resource Manager.

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

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer name Taylors Fire Department		4. Employer Identification Number (EIN) 57-0405236	
5. Employer address 463 W. Main Street		6. Employer phone number (864) 244-5596	
7. City Taylors	8. State SC	9. ZIP code 29687	
10. Who can we contact about employee health coverage at this job? Stephanie Hackler			
11. Phone number (if different from above)		12. Email address stephanieh@taylorsdistrict.org	

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

As your employer, we offer a health plan to:

✓ **All employees. Eligible employees are: Full Time Eligible**

With respect to dependents:

✓ **We do offer coverage. Eligible dependents are: Spouse and Dependent Child(ren)**

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

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

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

GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Group Health Plan and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. The plan requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs. However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information, the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Taylors Fire and Sewer for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Human Resources

864-244-5596

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

