

## TOWN OF CARRBORO BENEFITS SUMMARY 7/1/2014 – 6/30/2015

PROGRAM	BENEFITS	WHO PAYS
Medical Insurance	Blue Cross/Blue Shield – See attached pages for more details. Benefits also extended to Town retirees who meet certain criteria	The Town pays the 100% of employee premium and 50% dependent coverage.
Life Insurance	American United Life Insurance Company \$15,000 coverage for each employee Dependent & Supplemental coverage available at employee's expense	The Town pays for employee's coverage. The employee pays for eligible dependents and/or supplemental coverage.
Vision	Blue Cross/Blue Shield - pays \$200 for Frames, Lenses, or Contacts each year In-Network, or \$100 maximum Out-of-Network.	The Town pays full premium.
Flexible Spending Acct Debit Card	Allows employees to set up Flexible Spending Account for health, dental, and disability premiums, as well as daycare and unreimbursed medical expenses, on a pre-tax basis with a DEBIT CARD.	Employee pays in equal bi-weekly installments through payroll deduction.
Dental Insurance	Ameritas Insurance Company	The employee pays full premium.
Fitness Center	02 Fitness – 24 hour Center next to Town Hall	The Town pays 100% of membership.
Disability Insurance	American United Life Insurance Company \$250 per month benefits provided by the Town; additional coverage available at employee's expense	The Town pays for \$250 per month benefit; employee pays for any coverage above \$250.
Retirement	Local Governmental Employees' Retirement System Full retirement benefits after 30 years of service credit; age 60 with 25 years of service credit, or age 65 with five years of service. Reduced retirement benefits at age 50 with at least 20 years of service credit, or age 60 with five years of service credit. Death benefit up to \$20,000 after one year of service credit. Additional benefits for law enforcement officers.	The employee contributes 6% of annual salary. The Town contributes an actuarially determined amount.
401(K) Plan	Supplemental retirement administered by Prudential Insurance Contributions tax-sheltered; Loan provisions. Employees may make voluntary contributions For additional information call (800) 722-4015	The Town contributes 3% of gross salary to 401k Acct for each employee; 5% for Law Enforcement Officers.
Vacation Leave	Earned according to years of service Less than 2 years - 12 days per year 2 but less than 5 years - 14 days per year 5 but less than 10 years- 17 days per year 10 but less than 15 years- 20 days per year 15 but less than 20 years- 23 days per year 20 years or more- 26 days per year May be used for vacation, illness, religious observance, adverse weather, other; maximum accumulation 240 hours *Shift employees of the Fire Department earn duty days according to years of service. See Personnel Ordinance for specifics.	The Town
Sick Leave	Earned at a rate of 8 hours per month May be used for employee's illness, medical appointments, or for the illness or death of a relative as defined in the Personnel Ordinance. No maximum on accumulation. Accept from other NC municipalities (new hires)	The Town
Holidays	Eleven paid holidays per year: New Year's Day, Dr. Martin Luther King Jr.'s birthday, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day (2 days), Christmas Day (3 days).	The Town
Parental School Leave	Four paid hours of leave per calendar year May be used to attend school functions, eat lunch with child, attend parent/teacher conferences, etc.	The Town
Family & Medical Leave	Up to 12 weeks paid/unpaid leave for qualifying conditions, which include: Caring for employee's child after birth, or placement for foster or adoptive care; caring for employee's spouse, child, or parent who has serious health condition; or serious health condition that renders employee unable to perform job.	The Town, if employee chooses to use any accumulated vacation or sick leave.
Bereavement Leave	Five working days per 12-month period (two working days for shift employees of the Fire Department) with pay for the death of an immediate family member.	The Town
Military Leave	Available to employees who are members of the National Guard or Armed Forces Reserve during active duty, including the required annual training period. See Personnel Ordinance for specifics.	The Town
Civil Leave	Paid leave for jury duty.	The Town
Petty Leave	70 minutes per month in addition to other leave provisions	The Town
Service Level Benefit	Dollar amounts awarded to permanent, full-time employees according to years of service: 5 -9 years (\$248.00); 10 -14 years (\$456.00); 15-19 years (\$659.00); 20+ years (\$868.00)	The Town
Employee Assistance Program	Free <b>confidential</b> counseling for employees and their dependents Available through Human Resource Consultants; 24 hours/day, 7 days/week. Call Chapel Hill, 929-1227 or (800) 640-0735	The Town
Credit Union	Employees may join the NC Local Government Employees' Credit Union; initial cost to join is \$25.00 savings deposit.	The Employee

**Please note: The information contained on this page is intended to provide brief highlights of Benefits. Employees should refer to detailed plan descriptions and Personnel Ordinances for relevant information, policies, and procedures.**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsnc.com](http://www.bcbsnc.com) or by calling **1-877-258-3334**.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$500</b> person/ <b>\$1,000</b> family in-network. <b>\$1,000</b> person/ <b>\$2,000</b> family out-of-network. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. For In-Network <b>\$1,500</b> person/ <b>\$3,000</b> family For Out-Of-Network <b>\$3,000</b> person/ <b>\$6,000</b> family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, pharmacy expenses and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. For a list of In-Network providers, see <a href="http://www.bcbsnc.com/content/providersearch/index.htm">www.bcbsnc.com/content/providersearch/index.htm</a> or	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term

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	please call the number on the back of your card	in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a <b>specialist</b>?</b>	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about <b>excluded services</b> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you visit a health care <b>provider's</b> office or clinic</b>	Primary care visit to treat an injury or illness	\$10/visit	30% coinsurance	---none---
	Specialist visit	\$20/visit	30% coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Other practitioner office visit	\$20/Chiropractic visit	30% coinsurance/ Chiropractic visit	-Visit limits may apply
	Preventive care/screening/immunization	No Charge	Not Covered	-Limits may apply
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	-No coverage for tests not ordered by a doctor
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	-Prior authorization may be required for benefits to be provided.
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="http://www.bcbsnc.com/content/services/formulary/presdrugben.htm">prescription drug coverage</a> is available at <a href="http://www.bcbsnc.com/content/services/formulary/presdrugben.htm">http://www.bcbsnc.com/content/services/formulary/presdrugben.htm</a>	Generic drugs	\$10/prescription	\$10/prescription	-No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug
	Preferred brand drugs	\$25/prescription	\$25/prescription	Same as above
	Non-preferred brand drugs	\$40/prescription	\$40/prescription	Same as above
	Specialty drugs	25% coinsurance	25% coinsurance	-Coverage is limited to a 30 day supply -Minimum of \$50 in co-insurance but no more than \$100
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance	30% coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need immediate medical attention</b>	Emergency room services	\$150/visit	\$150/visit	---none---
	Emergency medical transportation	10% coinsurance	10% coinsurance	---none---
	Urgent care	\$20/visit	\$20/visit	---none---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	-Precertification required
	Physician/surgeon fee	10% coinsurance	30% coinsurance	---none---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20/office visit and 10% coinsurance/ outpatient	30% coinsurance	-Prior authorization may be required
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	-Precertification required
	Substance use disorder outpatient services	\$20/office visit and 10% coinsurance/ outpatient	30% coinsurance	-Prior authorization may be required
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	-Precertification required
<b>If you are pregnant</b>	Prenatal and postnatal care	10% coinsurance	30% coinsurance	No coverage for maternity for dependent children
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	-Precertification may be required
<b>If you need help recovering or have</b>	Home health care	10% coinsurance	30% coinsurance	- Prior authorization may be required for benefits to be provided

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>other special health needs</b>	Rehabilitation services	\$20/visit	30% coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for OT/PT/Chiropractic and 30 visits per benefit period for Speech Therapy
	Habilitation services	\$20/visit	30% coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for OT/PT/Chiropractic and 30 visits per benefit period for Speech Therapy
	Skilled nursing care	10% coinsurance	30% coinsurance	-Coverage is limited to 60 days per benefit period -Precertification required
	Durable medical equipment	10% coinsurance	30% coinsurance	-Prior authorization may be required for benefits to be provided -Limits may apply
	Hospice services	10% coinsurance	30% coinsurance	Precertification required for inpatient services
<b>If your child needs dental or eye care</b>	Eye exam	No Charge	Not Covered	-Limits may apply
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

\*HSA/HRA funds, if available, may be used to cover eligible medical expenses

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other [excluded services.](#))

- Acupuncture
- Long-term care, respite care, rest cures
- Cosmetic surgery and services
- Routine Foot Care
- Dental care (Adult)
- Weight loss programs

\*HSA/HRA funds, if available, may be used to cover eligible medical expenses

\*\*Self-funded groups may cover this service; check your benefit booklet for details

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult)
- Chiropractic care
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See [www.bcbsnc.com](http://www.bcbsnc.com)
- Termination of Pregnancy (subscriber and spouse)
- Hearing aids up to age 22
- Private duty nursing

\*\*\*Self-funded groups may not cover this service; check your benefit booklet for details

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at the number listed on your ID card. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-258-3334 or [mybcbsnc.com](http://mybcbsnc.com). You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), if applicable. You may also contact North Carolina Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201, or 800-546-5664 (outside North Carolina), 919-807-6750 (in North Carolina), if applicable.

Additionally, a consumer assistance program can help you file your appeal. Services provided by the Managed Care Patient Assistance Program are available through the North Carolina Department of Insurance. Contact Health Insurance Smart NC, North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, Toll free: (877) 885-0231.

## Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

## Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

\*Please note that although amounts contributed by an employer to an employee's HSA or intergrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

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## Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.

Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.

Chinese (中文): 如需國語或廣東話協助，請致電您保險卡背面的電話號碼。

Navajo (Dine): Diné bizaad bee shiká'adoowoł nínzingo kwoji' hólne', naaltsoos áłts'ísí nantinígíí bine'déé' binámboo bikáá'.

-----To see examples how this plan might cover costs for a sample medical situation, see the next page -----

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,200
- **You pay** \$1,300

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$500
Copays	\$30
Coinsurance	\$600
Limits or exclusions	\$200
<b>Total</b>	<b>\$1,300</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,100
- **Plan pays** \$3,900
- **You pay** \$1,200

#### Sample care costs:

Prescriptions	\$2,700
Medical Equipment and Supplies	\$1,200
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,100</b>

#### Patient pays:

Deductibles	\$500
Copays	\$500
Coinsurance	\$100
Limits or exclusions	\$50
<b>Total</b>	<b>\$1,200</b>

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## Questions and answers about Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should consider also contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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