CITY OF CHARLESTON

2025 BENEFITS GUIDE

YOUR BENEFIT OPTIONS

The City of Charleston strives to provide you and your family with a comprehensive and valuable benefits package. A complete benefit plan is more than good health coverage – it includes financial protection from unexpected expenses and encourages healthy behaviors. Great benefit choices are just one way the City of Charleston looks after the health and wealth of the people who make our city special. Our benefits package includes a range of options to fit everyone's needs.

ENROLLING IN BENEFITS

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline the different benefits City of Charleston offers, so you can identify which offerings are best for you and your family. Benefits eligible employees have an annual opportunity to enroll or make changes unless you experience a qualifying life event. When electing coverages, your tier of coverage must match for all coverage types elected.

WHO IS ELIGIBLE FOR BENEFITS?

Full-time and part-time employees regularly scheduled 30 hours per week are eligible for the benefits described in this guide. For health, dental, and vision benefits, employees are eligible on the first day of the month following your hire date. For some other benefits, you are eligible on the first day of the month following 30 days of employment.

Your dependents can also be enrolled in plans which offer dependent coverage. Eligible dependents include your legal spouse (same or opposite sex), children up to age 26 regardless of marital or tax-dependent status (natural, step, legally adopted, and/or children for whom you have been appointed legal guardianship by a court of law), and your children of any age who are unable to care for themselves due to mental or physical condition.

QUALIFYING LIFE EVENTS (QLE)

Choose your benefits carefully. In most cases, the coverage you choose must remain in effect for the entire plan year unless you experience a QLE. You must notify HR of any such event within 31 days, and all supporting documentation must be submitted within 60 days.

Qualifying Life Events Include:

- Marriage or Divorce
- Birth or Adoption of a child
- Death of your spouse or dependent
- Change of employment
- Termination of Existing Coverage

IN THIS GUIDE

BENEFITS & ENROLLMENT

The City's medical plans have been designed to keep you healthy and protect you and your family. The City offers two medical plan options through Cigna both designed to encourage proactive health care by giving employees the information and tools to be actively involved in making decisions about your health.

IMPORTANT UPDATES FOR 2025!

Every year, the City of Charleston carefully evaluates our benefit plans to support a comprehensive total rewards strategy. Our goal is to offer competitive benefit choices that encourage a healthy lifestyle.

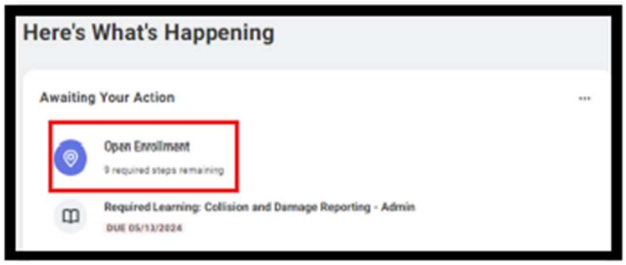
- **New Enrollment Platform, Workday for 2025**
  Please see instructions on page 4 to help in navigating and making benefit elections for next year.

BENEFIT TYPE	EFFECTIVE DATE	WHO PAYS?	WHEN CAN I CHANGE?	ENROLLMENT RESPONSIBILITY
Medical	1st of the month following date of hire	You and the City	Open Enrollment, Qualifying Life Event	Enrollment Required
Dental	1st of the month following date of hire	You and the City	Open Enrollment, Qualifying Life Event	Enrollment Required
Vision	1st of the month following date of hire	You and the City	Open Enrollment, Qualifying Life Event	Enrollment Required
Flexible Spending Accounts	1st of the month following date of hire	You	Open Enrollment, Qualifying Life Event	Enrollment Required
Health Savings Account	1st of the month following date of hire	You and the City	Anytime	Enrollment Required
Short Term Disability	1st of the month following date of hire	the City	Auto Enrollment	Auto Enrollment
Long Term Disability	1st of the month following date of hire	the City	Auto Enrollment	Auto Enrollment
Basic Life/AD&D	1st of the month following date of hire	the City	Auto Enrollment	Auto Enrollment
Supplemental Life/AD&D	1st of the month following 30 days of employment	You	Open Enrollment	Enrollment Required
Annual and Sick Leave	Date of hire	the City	Annual Accrual by Years of Service	Auto Enrollment
Employee Assistance Program	1st of the month following date of hire	the City	Auto Enrollment	Auto Enrollment
SC Retirement System	Date of hire	You and the City	Auto Enrollment	Auto Enrollment
Deferred Compensation	Date of hire	You	Anytime	Enrollment Required

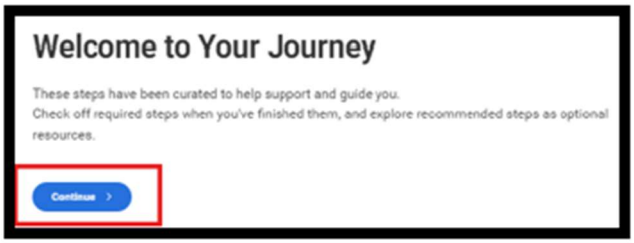
Workday Open Enrollment Journey

Welcome to Workday Journeys: This is a step-by-step guide to help you navigate through Open Enrollment. These instructions will assist you in starting the Open Enrollment Journey to complete your 2025 benefits enrollment smoothly.

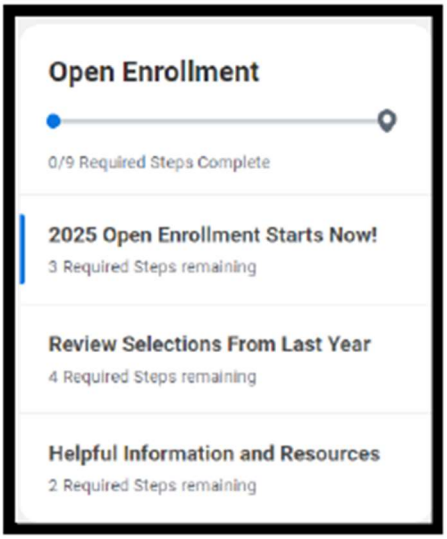
Step 1: After logging into Workday, navigate to your 'Awaiting Your Action' list, where you'll find the 'Open Enrollment' task ready for your review.



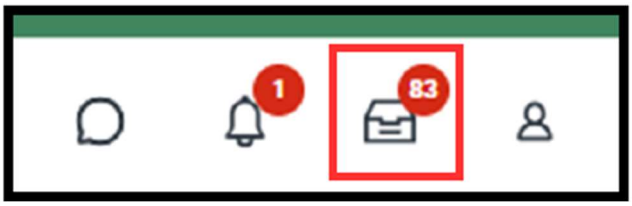
Step 2: Once you click on the 'Open Enrollment' icon, you'll be prompted to begin.



Step 3: When you begin your journey, you'll be able to review your current benefit elections, beneficiaries, and dependents. Make sure to complete all necessary steps.

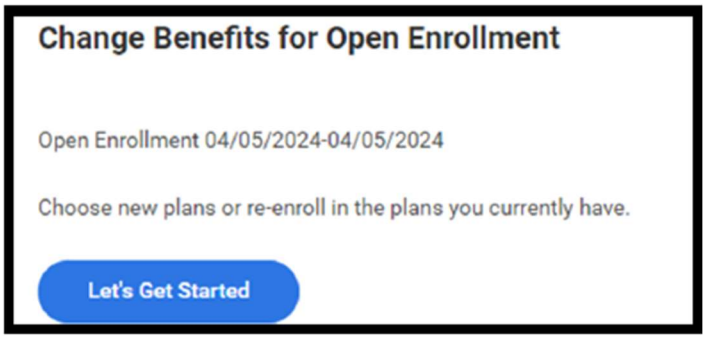


Step 4: After completing your Journey, navigate to your 'Task Box' located in the top right corner of your screen.



Step 5: Next, go to 'My Tasks' and click on the 'Open Enrollment Change' item in your inbox.

Step 6: You will now see a 'Let's Get Started' icon on your screen. Click on it to begin your 2025 Open Enrollment elections.



For assistance, please use the Workday Assistant tool. For additional help, contact Benefits@charleston-sc.gov or call 843-724-7388.

MEDICAL BENEFITS AT-A-GLANCE

The information below is a summary of medical coverage only. Please review the plan booklets for coverage details, limitations, and exclusions. The deductibles, coinsurance, copays, and out of pocket maximums are what you, the employee, are responsible for paying.

BENEFIT	OAP PLAN OPTION	HSA PLAN OPTION
HSA Contributions (paid by the City)	N/A	$350/$700
Deductible	**Embedded**	**Aggregate**
In-Network Deductible (Single/Family)	$550/$1,100	$1,650/$3,300
Out-of-Network Deductible (Single/Family)	$1,100/$2,200	$5,000/$10,000
Coinsurance		
In-Network Out-of-Network	20% 40%	20% 50%
Out of Pocket Maximum (Deductible, copays & coinsurance)	**Embedded**	**Embedded**
In-Network OOP Max (Single/Family)	$5,000/$10,000	$5,000/$10,000
Out-of-Network OOP Max	Unlimited	Unlimited
Physician Services – Office Visit		
In-Network Out-of-Network	$25 copay for PCP, $75 Specialty Deductible, 40%	Deductible, 20% Deductible, 50%
Wellness Benefits (based on Health Care Reform Guidelines; includes routine mammogram, pap smear, prostate screening, colonoscopy)		
In-Network Out-of-Network	100% Deductible, 40%	100% Deductible, 50%
Diagnostic Colonoscopies and Sigmoidoscopies		
In-Network Out-of-Network	1st at 100%, then Deductible, 20% Deductible, 40%	Deductible, 20% Deductible, 50%
Inpatient & Emergency Room Facility Charges		
In-Network Out-of-Network	$250 Copay, Deductible, 20% $250 Copay, Deductible, 40%	Deductible, 20% Deductible, 50%
Ambulance		
In-Network Out-of-Network	Deductible, 20% In-Network Deductible, 20%	Deductible, 20% In-Network Deductible, 20%
Outpatient Facility Charges		
In-Network Out-of-Network	Deductible, 20% Deductible, 40%	Deductible, 20% Deductible, 50%
Chiropractic Care (50 visit limit)		
In-Network Out-of-Network	Deductible, 20% Deductible, 40%	Deductible, 20% Deductible, 50%
Impacted Tooth Removal		
In-Network Out-of-Network	Deductible, 20% Deductible, 20%	Deductible, 20% Deductible, 20%
Speech Therapy (20 visits), Physical/Occupational Therapy (30 combined visits)		
In-Network Out-of-Network	Deductible, 20% Deductible, 40%	Deductible, 20% Deductible, 50%

Mental Health and Substance Abuse		
Inpatient / Emergency Room Facility Charges In-Network Out-of-Network	 $250 Copay, Deductible, 20% $250 Copay, Deductible, 40%	 Deductible, 20% Deductible, 50%
Physician Services in the Office In-Network Out-of-Network	 $25 copay Deductible, 40%	 Deductible, 20% Deductible, 50%
Outpatient Facility / Professional Charges In-Network Out-of-Network	 Deductible, 20% Deductible, 40%	. Deductible, 20% Deductible, 50%
Emergency Room Professional Charges In-Network Out-of-Network	 Deductible, 20% Deductible, 40%	 Deductible, 20% In-Network Deductible, 50%

PHARMACY BENEFITS AT-A-GLANCE

The information below is a summary of prescription drug coverage included with your medical plan.

BENEFITS	OAP		HSA	
Pharmacy Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Retail Pharmacy (30 Day Supply) Generic Drug Preferred Drug Non-Preferred Drug	$7 Co-Pay $40 Co-Pay $60 Co-Pay	Member pays 50%	After Medical Deductible is met, Member Pays $7 Co-Pay $40 Co-Pay $60 Co-Pay	After Medical Deductible is met, Member pays 50%.
Mail Order Pharmacy (90 Day Supply) Generic Drug Preferred Drug Non-Preferred Drug	$14 Co-Pay $80 Co-pay $120 Co-Pay	Not Covered	After Medical Deductible is met, Member Pays $14 Co-Pay $80 Co-Pay $120 Co-Pay	Not Covered
Specialty Drugs	**Specialty Pharmacy** $150 Co-Pay per 30-day supply		**Specialty Pharmacy** After Deductible, Member pays $150 Co-Pay per 30-day supply	

For more information about your medical benefits, please visit https://my.cigna.com or download the mobile app.

DENTAL INSURANCE

In addition to protecting your smile, the City offers you dental insurance which includes regular checkups, cleanings, X-rays, and more. Offered through Delta Dental, our plan gives you the freedom to see any dentist you choose. Receiving regular preventative dental care is encouraged for ongoing dental health and can protect you and your family from the high cost of dental disease and surgery by detecting problems early.

The following chart outlines your dental benefits. See the certificate of coverage for a detailed description. Check with your dental provider to obtain a pre-treatment cost estimate from Delta Dental for services.

BENEFIT	Delta Dental Network: Delta Dental PPO
Class I	**Diagnostic & Preventative Services**
Oral Exams – 2 per year	Covered at 100% No Deductible
X-Rays – Bitewings (2 per year), Full Mouth (1 per 3 years)	
Cleanings – 2 per year	
Fluoride Treatments – 2 per year under age 19	
Sealants – under age 16 (once in 5 years)	
Space Maintainers – under age 19 (once in 5 years)	
Palliative (Emergency) Treatment	
Class II	**Basic Services**
Basic Restorative – fillings, etc.	Covered at 80% After Deductible
Endodontics	
Periodontics	
Repairs and re-cementing	
Inlays, Onlays, Crowns, Jackets, Labial Veneers (once in 5 years)	
Simple and Surgical Extractions	
Surgical Periodontics	
Oral Surgery	
General Anesthesia	
Class III	**Major Services**
Bridges and dentures (1 per 5 years)	Covered at 50% After Deductible
Implants (1 per 5 years per tooth)	
Occlusal guards (1 per year)	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)	
Calendar Year Deductible (per member/per family)	$50/$100 Excludes Class I & Orthodontics
Calendar Year Maximum (per member per year)	$2,000 Excludes Orthodontics
Yearly Orthodontic Maximum (children under age 19)	$1,000

*Reimbursement is based on the schedule of maximum allowable charges (MAC). Network dentists agree to accept the Delta Dental allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between the UC allowance and their fee (also known as balance billing). Delta Dental's standard exclusions and limitations apply.

VISION INSURANCE

The vision plan offered by the City through EyeMed rounds out your health care benefits. Our plan pays a rich benefit for a variety of services, designed to help you save money on exams, glasses, contact lenses, and more. Our plan also offers discounts on additional pairs of glasses and balances beyond plan coverage. EyeMed will submit in-network claims on your behalf. Out-of-network claim forms are available on the City intranet.

Our vision benefits run on a calendar year basis – regardless of when you receive vision care benefits during the plan year, your benefits will reset every January 1.

BENEFIT	Member Cost In-Network Network: Insight
Exam with Dilation as Necessary	$10 Copay
Retinal Imaging Benefit	Up to $39
Exam Options:	
Standard Contact Lens Fit and Follow-Up:	Up to $40
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price
Frames:	
Any available frame at provider location	$0 Copay; $150 Allowance, 20% off balance over $150
Standard Plastic Lenses	
Single Vision/ Bifocal/ Trifocal/ Lenticular	$15 Copay
Standard Progressive Lens	$80 Copay
Premium Progressive Lens	See Fixed Premium Progressive list
Lens Options:	
UV Treatment	$15
Tint (Solid and Gradient)	$15
Standard Plastic Scratch Coating	$15
Standard Polycarbonate- Adult / Kids under 19	$40
Standard Anti-Reflective Coating	$45
Polarized	20% off Retail Price
Photochromatic / Transitions Plastic	$75
Premium Anti-Reflective	See Fixed Premium Anti-Reflective Coating list
Other Add-Ons	20% off Retail Price
Contact Lenses (allowance includes materials only)	
Conventional	$0 Copay; $150 allowance, 15% off balance over $150
Disposable	$0 Copay; $150 allowance, plus balance over $150
Medically Necessary	$0 Copay, Paid-in-Full
Laser Vision Correction	
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price
Additional Pairs Benefit:	Members also receive a 40% discount off additional complete pair of prescription eyeglass and a 20% discount off non-covered items, including non-prescription sunglasses.
Frequency:	
Examination	Once every calendar year
Lenses or Contact Lenses	Once every calendar year
Frame	Once every two calendar years

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care[1] from MDLIVE.®

It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE®

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost[2] to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology[4]

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

Cigna.

961333 11/21

Offered by: Cigna Health and Life Insurance Company or its affiliates.

3 easy steps to connect to care

Virtual care visits are convenient and easy.
To schedule an appointment:

- Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)
- Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE
- Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.

Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®

Cigna.

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

WELL-CHECK INCENTIVE PROGRAM

You can earn money for certain preventative visits processed through your city medical, dental, and vision plans. We will continue to partner with IncentFit for a wellness app and web platform. To participate in the Well Check program, you will need to authorize that information from Cigna Medical, Delta Dental, and EyeMed Vision be sent to our vendor, IncentFit, when enrolling in your 2024 benefits. The Well Check program is automated – completion of certain preventative visits will trigger the applicable Well Check Incentive deposits into your account. For more information, please log into your IncentFit account via the mobile app.

SPENDING ACCOUNTS

FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts help you save money by allowing you to pay for certain types of health care and dependent daycare expenses on a pre-tax basis. You decide how much money to put aside each pay period to cover these expenses up to the maximum amount allowed. Each year the IRS sets limits on how much you can contribute to your FSA. There are also limits to what you can purchase with FSA funds. Visit www.irs.gov for a full list of eligible expenses and contribution limits. The City's plan is administered by Cigna Healthcare and offers a debit card for your convenience. There are a variety of different benefits of using an FSA:

- Saves you money. Allows you to put aside money pre-tax which can be used for qualified expenses. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- Flexibility. You can use your FSA funds at any time, even if it's the beginning of the year. Dependent care FSA funds are not available until they are in your account and cannot be reimbursed until expenses are incurred.
- Rolls over. You can roll over up to $640 of unused funds into the next plan year. However, it is important to make your elections carefully! Any unused funds over $640 at the end of the year will be lost. To use rollover funds, you must re-enroll in the FSA the following year.

HEALTH SAVINGS ACCOUNT (HSA)

Health Savings Accounts are designed to fund healthcare expenses if you are enrolled in a high deductible health plan. The HSA is a savings account which secures pre-tax dollars in a fund to help you meet your deductible and pay for a variety of eligible services. HSAs allow flexibility in how you use your funds now and in the future and serve as a great investment tool for retirement. There are limits to how much you can contribute to your HSA, set annually by the IRS. Our plan is administered by HSA Bank and offers a debit card for your convenience. Benefits of an HSA include:

- Long-term savings tool. Contributions to your account earn interest over time and can be used for any purpose after you turn 65.
- It is portable. The money in your HSA carries over year to year with no rollover limits. The account is yours to keep, even if you leave employment with the City.
- Makes you a better health care consumer. Because HSAs are partnered with high deductible health plans, you are encouraged to shop around for the best value for your health care needs.

COMPARISON OF HSAs AND FSAs

Spending Account Type	HSA	Health Care FSA
Account Owner	Individual/employee	Employer
Account Funding	You and the City	You
City Contribution to your account	$350 Individual / $700 Family	N/A
2025 Annual Contribution Limits*	$4,300 Individual / $8,550 Family Catch-up Contribution: $1,000/year for ages 55 and older	For 2024, employees may elect to contribute up to a maximum of $3,200 per year. *The IRS has not yet released the 2025 FSA maximums.
Rollover Options	Your entire unused account balance rolls over year after year.	You can roll over up to $640 of unused funds to the next plan year as long as you elect the minimum amount of $100 during Open Enrollment. Unused funds over $640 are lost.

DOWNLOAD THE CIGNA APP

Enjoy an easier way to manage your spending accounts. You can pay bills, view transactions, upload receipts, and more. Download today on your Apple or Android device.

Download on the App Store GET IT ON Google Play

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

Dependent Care Flexible Spending Accounts (DCFSA) provide you the option of contributing pre-tax dollars into your DCFSA and using those funds to pay for eligible expenses, including the care of your children, a disabled spouse, or legally dependent parent during your working hours. Since the money you contribute to your account is pre-tax, you receive an important tax break when you use that money to pay for eligible expenses. The maximum DCFSA election for 2024 is $5,000* - 2025 maximums have not yet been announced by the IRS. Expenses usually include the following:

For **children under 13** while you are working:

- Before- and after-school care
- Day care and preschool
- Summer and holiday camp
- Nanny or au pair

For **adult dependents** who need care, such as a spouse or live-in parent:

- Care of an incapacitated adult who lives with you
- Expenses for an in-home caregiver

*$5,000 per household or $2,500 if married, filing separately

DISABILITY INCOME BENEFITS

The City of Charleston provides employees with short- and long-term disability income benefits should you become unable to work due to an injury or illness. Our plans are designed to protect you and your family from financial hardship if you become disabled, which is why the City pays the full cost of these benefits for you. Disability income benefits provide a partial replacement of lost income. Both benefits are offered through New York Life. Contact New York Life at 800-225-5695 for information about your life insurance or call 888-842-4462 to file a disability claim.

	STD	LTD
Benefits Begin	15th day of injury or illness	180 days of disability
Benefits Payable	6 months	Up to age 65, if disability begins before age 62. Please see plan documents for additional age paid benefits.
Percentage of Income Replaced	60% of weekly salary	60% of base pay
Maximum Benefit	$1,000 per week	$6,000 per month
Benefit Limitations	Pre-existing conditions don't apply	Benefit is reduced by any additional disability income such as workers' compensation, Social Security, state disability plans, pensions, etc.

FAMILY MEDICAL LEAVE ADMINISTRATION (FMLA)

When you or a loved one experiences a serious health condition that requires you to take time off from work, the stress from worrying about keeping your job while away can add to an already difficult situation. The Family and Medical Leave Act (FMLA) provides 12 weeks per year of unpaid, job-protected leave which can be taken all at once or intermittently as the medical condition requires. There are rules set by the US Department of Labor around who can take FMLA and when. Our FMLA is administered by New York Life. You should let New York Life (888-842-4462) and HR know as soon as possible if you need to take FMLA, and submit any required documentation as instructed.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

We all experience times when we need a little help with life's challenges. The City of Charleston understands how challenging it can be to balance your work and personal life and we are committed to helping you do just that! The City's Employee Assistance Program (EAP) and associated work-life services are provided through our affiliation with Cigna. This company-sponsored benefit is available to all employees of the City of Charleston and their family members (those covered under their insurance) at no cost. Each person may use up to 5 visit(s) per need per plan year.

The EAP is strictly confidential, as mandated by law. The City encourages you to take advantage of this benefit to help you and your family manage personal challenges. A professional is available 24 hours a day, seven days a week, at 888-371-1125. You can find more information at https://www.cigna.com/individuals-families/member-guide/employee-assistance-program and access the EAP online at www.mycigna.com using **cityofcharleston** for the Employer ID.

LIFE INSURANCE BENEFITS

BASIC LIFE/AD&D INSURANCE

Life insurance can help provide a foundation of financial security for your loved ones in the event of your death. The City of Charleston provides full-time employees with this benefit, which is offered through New York Life, at no cost to you.

Full-time employees receive a benefit equal to 1x their annual salary to a maximum of $250,000. Council members, judges, and attorneys receive a flat benefit of $10,000. Please note this benefit reduces to 65% of the basic benefit at age 70.

VOLUNTARY LIFE/AD&D INSURANCE

To supplement the basic life and AD&D coverage offered by the City, you may purchase additional life insurance for yourself and eligible dependents. You are responsible for paying the full cost of this benefit. Keep in mind your insurance needs may increase as your life changes.

EMPLOYEE	MONTHLY COST PER $1,000			
	<20	$.091	60-64	$1.051
	20-24	$.091	65-69	$1.162
	25-29	$.091	70-74	$3.134
	30-34	$.108	75-79	$3.134
	35-39	$.133	80-84	$3.134
	40-44	$.210	85-89	$3.134
	45-49	$.337	90-94	$3.134
	50-54	$.660	>95	$3.134
	55-59	$.958		
SPOUSE & DEPENDENT CHILD(REN)	Option 1 - $1.04 per pay period			
	Spouse		$10,000 benefit	
	Child(ren)		$5,000 benefit	
	Option 2 - $2.31 per pay period			
	Spouse		$20,000 benefit	
	Child(ren)		$10,000 benefit	
	For both options - Children under the age of 26 are eligible for coverage. Maximum benefit for a child less than 15 days old is $500.			

CALCULATING YOUR BENEFIT

Monthly Cost per $1,000 X 10 =
Monthly Cost per $10,000

Monthly Cost per $10,000 X number of units =
Monthly Cost of your elected amount

Monthly Cost of your elected amount x 12 =
Annual Cost

Annual Cost / 26 = Bi-Weekly Cost

Example for a 42-year-old employee electing $30,000

$.210 X 10 = $2.10
$2.10 X 3 = $6.30
$6.30 X 12 = $75.60
$75.60 / 26 = $2.91

At New York Life Group Benefit Solutions (NYL GBS), we understand that the emotional stress related to losing a loved one is difficult enough. And while it's hard to think about, would your family have the financial protection they'll need if you pass away? NYL GBS Term Life insurance can help offer you the peace of mind that your family will not suffer an undue financial burden during a time that's already difficult enough.

Why is life insurance important?
NYL GBS Term Life insurance can provide your loved ones with financial security if you're no longer there to support them. It can help pay for:

- Daily living expenses
- The mortgage and other debts
- Your children's education
- Your spouse's retirement

Who's eligible and how much coverage can I buy?

All active full-time employees regularly working a minimum of 40 per week are eligible to apply. The amount of coverage varies, based on your family's needs and who's being covered.

Employee	Your Spouse	Children
➢ Benefit amounts available in increments of $10,000 ➢ Maximum benefit amount of $500,000	➢ Option 1: $10,000 ➢ Option 2: $20,000	➢ Option 1: $5,000 each child ➢ Option 2: $10,000 each child

Do I have to provide evidence of insurability?

If you have declined coverage when first eligible, you will be required to provide proof of good health acceptable to NYL. If you are currently covered, you may increase your Voluntary Life Insurance Benefit by two Benefit Levels, as long as the total Benefit does not exceed the maximum guaranteed amount. Therefore, you may buy up to 2 increments ($20,000 total) at each annual enrollment without providing proof of good health up to the **maximum guaranteed amount of $250,000**. This is not available for Spouse.

Even if you already have some life insurance, is it enough? Use our insurance needs calculator at nyl.com/life to help you find out how much you might need.

VOLUNTARY MEDICAL BENEFITS

Please Note: *These benefit elections are only available during open enrollment!*

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance is designed to protect your income and personal assets when your out-of-pocket expenses increase as a result of an illness. Health insurance is not always enough to cover all the unforeseen expenses associated with a serious medical condition like a heart attack or cancer. Critical Illness Insurance pays a lump sum benefit that can be used any way you choose, and benefits are paid in addition to any other insurance coverage you may have.

COVERED ILLNESSES	PAYMENT PERCENTAGES
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
End Stage Renal (Kidney) Failure	100%
Coronary Artery Bypass Surgery*	25%
Note: Cancer and Carcinoma in Situ* coverage may be available as an optional rider.	

PLAN FEATURES

- You do not have to be terminally ill to receive benefits.
- Coverage options are available for your spouse and children as riders to your coverage.
- Coverage is portable — you can take your policy with you if you change jobs or retire.

NOTE: *The coverage pays 25% of the face amount of the policy once per lifetime for coronary bypass surgery and carcinoma in situ.*
NOTE: *The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.*

ACCIDENT INSURANCE

You don't have to be especially clumsy to experience accidents. These events are all too common, and so are the high medical expenses that come with them.

Accidents are unplanned and unpredictable, but the financial impact that they have on you doesn't have to be either of those things. Voluntary Accident Insurance pays direct benefits for a range of injuries and accident-related expenses such as:

- Initial Hospital Confinement
- Daily Hospital Confinement
- Intensive Care

Additional riders are also available to add to your base plan:

- Accident Treatment and Urgent Care Rider
- Dislocation or Fracture Rider
- Emergency Room Services Rider
- Outpatient Physician's Benefit Rider

Benefit amounts are based on the type of injury and treatment needed. No matter how great your medical plan is, you will have to share the costs of medical care and rehabilitation that follow an accident. Accident Insurance is designed to help you pay for out-of-pocket expenses that insurance doesn't cover, like copays and deductibles, but the benefit payout can be used however you'd like.

PLAN FEATURES

No health questions or physical exams are required for enrolling yourself, your spouse, or your children in the plan. If you retire or leave the City of Charleston, the plan also offers the option for portability.

NOTE: *The policy/certificate of coverage or its provisions may vary or be unavailable in some states. The policy/ certificate of coverage has exclusions and limitations which may affect any benefits payable.*

unum

City of Charleston

Whole Life Insurance

How does it work?

You can keep Whole Life Insurance as long as you want. Once you've bought coverage, your cost won't increase as you age. The benefit amount stays the same, too — it doesn't decrease as you get older. That means you get protection during your working years and into retirement.

Whole Life Insurance also builds cash value at a guaranteed rate of 4.5%.* You can borrow from that cash value, or you can buy a smaller, paid-up policy — with no more premiums due.

Why should I buy coverage now?

- It's more affordable when you're younger. Once you've purchased coverage, your premium remains the same as long as premiums are paid.
- You get better rates when you buy coverage through your workplace
- The cost is conveniently deducted from your paycheck.
- Whole life gives you valuable protection in addition to any term life insurance you might have.

What's included?

A "Living" Benefit

You can request an early payout of your policy's death benefit (up to $150,000 maximum) if you're diagnosed with a terminal illness and expected to live 12 months or less. It can help cover your costs while you're still alive. The payout would reduce the benefit that's paid when you die.

Waiver of Premium

If you're disabled for at least six months before age 65 and you remain disabled, you won't have to pay premiums until you recover and return to work.

Long Term Care Rider

You may be able to use your death benefit to pay for long term care. Subject to rider conditions. See your plan administrator for more information.

Whole Life Insurance can pay money to your family if you die. It can help them with basic living expenses, final arrangements, tuition and more.

Who can get coverage?

You:	You can purchase coverage for as little as $3 weekly, as long as the minimum benefit is at least $5,000. The benefit amount is based on the premium amount you select, your age when coverage begins, and whether you use tobacco.
Your spouse: Individual coverage	Available for your spouse between the ages of 15 to 80, even if you don't purchase coverage for yourself. If you leave your employer, you can keep this coverage and be billed at home. You can purchase coverage for as little as $3 weekly, as long as the minimum benefit is at least $5,000. The benefit amount is based on the premium amount you choose, your spouse's age when coverage begins, and whether they use tobacco.
Your children: Individual coverage	Your children can have individual coverage, even if you don't get coverage for yourself. If you leave your employer, your children can keep their coverage. You can purchase coverage for each child for as little as $1 a week.

Please Note: *These benefit elections are only available during open enrollment!*

RETIREMENT BENEFITS

THE FOUNDATIONS FOR RETIREMENT

Financial security at retirement is not something that just happens. It takes years of planning to build a foundation that allows you to enjoy the good life during those golden years. It also takes a commitment to saving money now during your active working years. Aside from contributing to Social Security on your behalf, the City offers two important plans that provide special incentives to help you save for retirement.

- South Carolina Retirement Systems
- Voluntary 401(k) and 457 savings plans

SOUTH CAROLINA RETIREMENT SYSTEMS

State law requires that full-time, part-time, and certain temporary employees belong to the South Carolina Retirement Systems (SCRS). Sworn police officers and firefighters belong to the Police Officers Retirement System (PORS). Both you and the City contribute to the retirement system. For those employees in SCRS, the City contributes 18.56% of your gross salary each year while you contribute 9.00%. For those employees in PORS, the City contributes 21.24% of your gross salary each year while you contribute 9.75%. Your contributions are deducted from your pay on a pre-tax basis.

The retirement programs also include life insurance coverage. In addition, PORS includes accidental death coverage. The South Carolina Retirement Systems also provide a disability retirement benefit for employees who are permanently unable to work due to injury or illness and who meet certain qualifications.

VOLUNTARY 401(k) AND 457 SAVINGS PLANS

The voluntary 401(k) and 457 plans offered through the South Carolina Deferred Compensation Program offer tax treatment for your retirement savings. Here are some important plan features:

- You decide how much to save, subject to the minimum and maximum amounts set by the federal government. Your savings are deducted from your paychecks and deposited in your 401(k) or 457 account before you pay federal and most state and local income taxes. This lowers your current taxable income and you save by paying less in taxes.
- You also have the option to contribute on a post-tax basis via a Roth 401(k) or Roth 457 account.
- You may increase, decrease, or stop your savings at any time.
- Saving is easy with automatic payroll deductions.
- You may choose from a variety of professionally managed investment funds for investing your savings. Any interest earned is tax deferred, meaning no taxes are due until you withdraw funds from the plan.
- You always have complete ownership of your savings and investment earnings. If you leave the City, your savings and interest go with you.

Keep in mind, 401(k) and 457 plans are designed for long-term savings. The IRS applies an early withdrawal penalty tax on any funds you receive before age 59 ½. If you leave the City of Charleston, you can avoid financial penalties by rolling over your distribution into another qualified savings plan.

TIME AWAY FROM WORK

ANNUAL LEAVE

The City recognizes the hard work of its employees and encourages the opportunity for rest and relaxation. The City offers an annual leave benefit to allow employees scheduled rest away from work with pay. Full-time employees accrue annual leave according to the table below:

Non-Sworn 37.5 Hour Schedule Positions				
Years of Service	Accrual Rate Per Year	Accrual Rate Per Pay Period	Max. Accumulation In Days	Max. Accumulation In Hours
0-4 years	12 days	3.46 hours	25.6 days	192 hours
5-9 years	15 days	4.33 hours	32 days	240 hours
10-14 years	18 days	5.19 hours	38.4 days	288 hours
15-19 years	21 days	6.06 hours	44.8 days	336 hours
20+ year	24 days	6.92 hours	51.2 days	384 hours

Sworn Police and Fire 40 Hour Schedule Positions				
Years of Service	Accrual Rate Per Year	Accrual Rate Per Pay Period	Max. Accumulation In Days	Max. Accumulation In Hours
0-4 years	12 days	3.69 hours	24 days	192 hours
5-9 years	15 days	4.62 hours	30 days	240 hours
10-14 years	18 days	5.54 hours	36 days	288 hours
15-19 years	21 days	6.46 hours	42 days	336 hours
20+ year	24 days	7.38 hours	48 days	384 hours

Firefighting 24 Hour Schedule Positions				
Years of Service	Accrual Rate Per Year	Accrual Rate Per Pay Period	Max. Accumulation In Days	Max. Accumulation In Hours
0-4 years	6 shifts	5.54 hours	12 shifts	288 hours
5-9 years	7.5 shifts	6.92 hours	15 shifts	360 hours
10-14 years	9 shifts	8.31hours	18 shifts	432 hours
15-19 years	10.5 shifts	9.69 hours	21 shifts	504 hours
20+ years	12 shifts	11.08 hours	24 shifts	576 hours

Part-time employees accrue annual leave on a pro-rated basis based on the number of hours worked in each pay period. Full-time employees will accrue annual leave on a prorated basis based on the number of hours worked or in a paid sick leave status in each pay period.

Any number of hours equal to or less that two-times your annual accrual rate (see “Maximum Accumulation in Hours” column in table above) may be carried over from the last pay period in one year to the first pay period in the following year.

SICK LEAVE

We understand our employees and their immediate family sometimes become ill. The City offers a sick leave benefit to provide time away from work during illness and recovery. Full-time Non-Sworn employees on the 37.5 hours schedule accrue 3.46 hours each bi-weekly pay period. Full-time sworn employees on the 40 hours schedule accrue 3.69 hours each bi-weekly pay period. Part-time and Full-time employees accrue sick leave on a prorated basis when less than 80 hours are worked or paid in a pay period. Employees in firefighting positions accrue 5.54 hours of sick leave each pay period. This is reflected on your paycheck as "Sick Leave Balance."

Sick leave may be used for personal or immediate family members only for Illness, medical appointments, and similar purposes as long as the employee is present. If you end your employment with the City, you will not be paid for unused sick time. However, the South Carolina Retirement System does use your sick leave balance to calculate retirement benefits for Class 2 members.

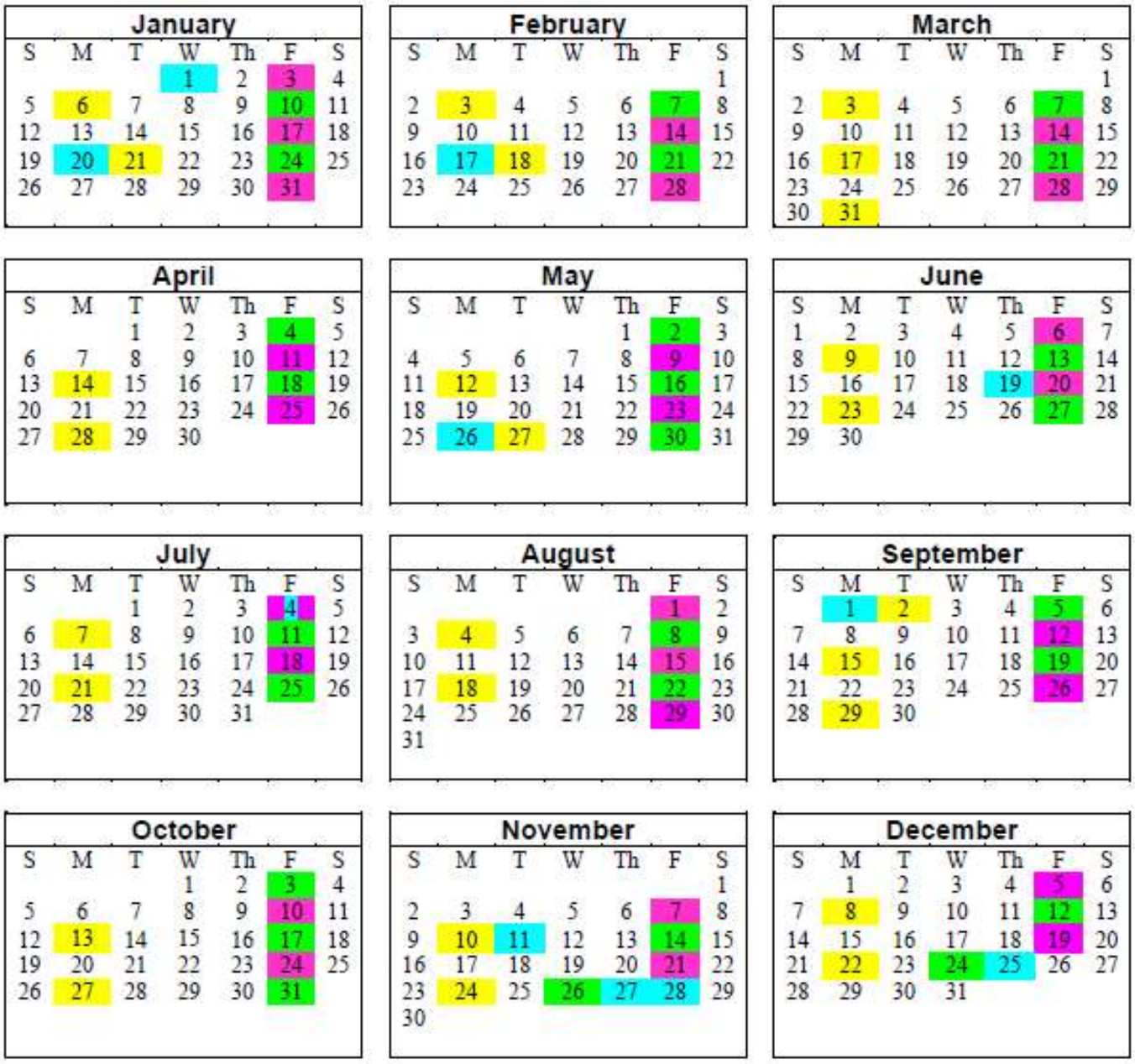
HOLIDAYS

For the purpose of enjoying holidays away from work without a loss in pay, the City provides the benefit of paid holidays. The City observes eleven paid holidays per year. Generally, full-time and part-time employees are paid for these days:

Holidays	
New Year's Day	January 1st
Martin Luther King's Birthday	3rd Monday in January
President's Day	3rd Monday in February
Memorial Day	Last Monday in May
Juneteenth	June 19th
Independence Day	July 4th
Labor Day	1st Monday in September
Veteran's Day	November 11th
Thanksgiving	4th Thursday in November
Day After Thanksgiving	Day following Thanksgiving
Christmas	December 25th

In addition, regular full-time employees may take two Personal Holidays per calendar year. These Personal Holidays are used similar to an annual leave day except that it must be taken at one time in a full-day increment. Use of a Personal Holiday requires pre-approval and a Request for Leave form.

2025 Payroll Calendar



Workweek – The workweek begins each Saturday and ends on the following Friday.
Holidays – If a payday falls on a City-observed holiday, then paychecks will be distributed on the previous workday.
Annual Leave / Personal Holiday – For 2025, the cutoff date for using excess annual leave and the personal holidays is December 19, 2025.

Biweekly Payday Biweekly Payroll Ending Date City Observed Holiday Orientation

2025 HEALTH, DENTAL & VISION PREMIUMS*

CIGNA OAP MEDICAL PLAN RATES – BI-WEEKLY				
Tobacco Status	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Non-Tobacco Discounted Rate**	$32.00	$132.00	$101.00	$159.00
Regular Non-Discounted Rate	$42.25	$185.00	$137.50	$217.00

CIGNA HSA MEDICAL PLAN RATES – BI-WEEKLY				
Tobacco Status	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Non-Tobacco Discounted Rate**	$15.50	$83.25	$59.00	$104.50
Regular Non-Discounted Rate	$21.50	$118.50	$83.50	$148.50

**Non-Tobacco Discounted rates are only available to employees who are tobacco and nicotine free. To receive the Non-Tobacco User discount for 2025 you must complete a Non-Tobacco User Insurance Premium Affidavit even if you currently receive the discount. This discount does not carry over from year to year.

DELTA DENTAL PLAN RATES – BI-WEEKLY	
Employee Only	$4.00
Employee & Spouse	$17.00
Employee & Child(ren)	$12.75
Employee & Family	$21.00

EYEMED VISION PLAN RATES – BI-WEEKLY	
Employee Only	$1.00
Employee & Spouse	$2.00
Employee & Child(ren)	$1.50
Employee & Family	$2.50

*Employees enrolling in multiple coverages must elect the same tier for all coverages (e.g., if you are electing employee + spouse medical, you must elect employee + spouse dental if choose to elect both medical and dental; you cannot have employee + spouse medical and employee-only dental.)

Apps to Download

Scan this QR Code to be taken to the app store!

Cigna Healthcare

Shows an image of your medical ID card
Allows you to request a new ID card
Shows your benefits and claims
Shows your deductible and how much has been met
Allows you to find in-network doctors

Scan this QR Code to be taken to the app store!

Delta Dental

Shows an image of your dental ID card
Allows you to request a new dental ID card
Shows your benefits and claims
Allows you to find in-network doctors

Scan this QR Code to be taken to the app store!

EyeMed

Shows an image of your vision ID card
Allows you to request a new ID card
Shows your benefits and claims
Shows your deductible and how much has been met
Allows you to find in-network doctors

TAKE PRIDE IN YOUR WORKDAY

GLOSSARY

In-Network – The doctors, hospitals and pharmacies that participate in the plan by accepting negotiated discounts to their fees.

Co-pay – A flat dollar amount that you are required to pay for some in-network services, such as doctor visits or emergency room use.

PCP – Primary Care Physician is an Internist, Family Practice, Pediatrician, OB/GYN.

Specialist – Any physician other than listed as a PCP.

Deductible – The amount you are required to pay (excluding copays) before the plan will begin to pay for covered expenses, each calendar year.

Aggregate Deductible – Any combination of individuals with a family policy can meet the family deductible and the entire family shares the benefit. On a family plan, no one member will begin coinsurance until the entire family deductible is met.

Coinsurance – The percentage split that you are required to pay after the plan pays its share. Coinsurance applies after your deductible is met.

Out-of-Pocket Maximum – The maximum amount that you could be responsible to pay in any calendar year - above your deductible - before the health plan covers 100% of most remaining covered expenses. The out-of-pocket maximums do not include your deductible or copays. There are separate out-of-pocket maximums for in-network and out-of-network services.

Embedded Out-of-Pocket Maximum – Each individual with a family policy has their own "embedded" out of pocket limit within the family out of pocket maximum. Once the embedded individual out of pocket maximum is met, the plan will cover most remaining services at 100%.

Maximum Allowable Amount (MAA) Charges – The most a plan will consider eligible for a covered expense. MAA charges are based on the range of fees charged by providers with comparable training for the same or similar service in your area. When you receive care in-network, MAA allowance limitations do not apply.

IMPORTANT NOTICES

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. The City of Charleston reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

REMINDER OF AVAILABILITY OF PRIVACY NOTICE

This is to remind plan participants and beneficiaries of the City of Charleston Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and disclosed protected health information (PHI). You can obtain a copy of the City of Charleston Welfare Plan Privacy Notice upon your written request to Human Resources.

If you have any questions, please contact The City of Charleston Human Resources Office.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted, and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact the City of Charleston Human Resources for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstate in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

GENETIC INFORMATION

Title II of the Genetic Information Nondiscrimination Act of 2008 ("GINA") protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. For further information on GINA, please see the poster "Equal Employment Opportunity is The Law," which should be posted in a common area at your employment location.

IMPORTANT NOTICE FROM THE CITY OF CHARLESTON 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 the City of Charleston and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Charleston has determined that the prescription drug coverage offered by the City of Charleston, Cigna Healthcare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

FREQUENTLY ASKED QUESTIONS

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, and drop your current City of Charleston coverage, your medical coverage will also be affected. You cannot drop your City of Charleston prescription drug coverage unless you also drop your medical coverage.

If you do decide to join a Medicare drug plan and drop your current City of Charleston coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the Human Resources department for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Charleston changes. You also may request a copy of this notice at any time.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost

because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:
    - Your spouse dies;
    - Your spouse's hours of employment are reduced;
    - Your spouse's employment ends for any reason other than his or her gross misconduct;
    - Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
    - You become divorced or legally separated from your spouse
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:
    - The parent-employee dies;
    - The parent-employee's hours of employment are reduced;
    - The parent-employee's employment ends for any reason other than his or her gross misconduct;
    - The parent become divorced or legally separated
    - The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: The City of Charleston Human Resources.

How is COBRA Coverage Provided?

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

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

minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

For further information regarding the plan and COBRA continuation, please contact: City of Charleston Human Resources at 843-724-7388.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private.

You have the right to inspect and copy protected health information which is maintained by and for the plan for enrollment, payment claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources.

DISCLAIMER: The HIPAA Privacy Rule is effective beginning April 14, 2003. The Privacy Rule is intended to safeguard protected health information (PHI) created and held by health care providers, health plans, health information clearing houses and their business associates. The provisions of the Privacy Rule have a significant impact on those who deal with

health information and on all citizens with regard to their personal PHI. Our health insurance broker and all our contracted plans adhere to the HIPAA Privacy Rule.

WELLNESS PROGRAM DISCLOSURE

If it is unreasonably difficult due to a medical condition for you to achieve the standards for reward for any of our Wellness programs, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, contact Human Resources and we will work with you to develop another way to qualify for the reward.

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).

For South Carolina residents, contact South Carolina Medicaid for more information on eligibility.

SOUTH CAROLINA – MEDICAID
Website: http://www.scdhhs.gov Phone: 1-888-549-0820

To see information for other states' premium assistance programs since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the City of Charleston.

CONTACT INFORMATION

BENEFIT	VENDOR	WEBSITE	PHONE NUMBER
Human Resources	City of Charleston	www.charleston-sc.gov	843-724-7388
Benefits Enrollment (for OE support only)	WorkPlace Solutions	www.wpsenroll.com	855-791-3096
Medical	Cigna	www.mycigna.com or download the mobile app	800-244-6224
Pharmacy	Cigna	www.mycigna.com or download the mobile app	800-244-6224
Specialty Pharmacy	Cigna	www.mycigna.com or download the mobile app	800-244-6224
Health Savings Account (HSA)	HSA Bank	www.mycigna.com or download the mobile app	800-244-6224
Flexible Spending Accounts (FSA/DCFSA)	Cigna	www.mycigna.com or download the mobile app	800-244-6224
Wellness	Wellness Manager		843-958-6412
Dental	Delta Dental	www.DeltaDentalSC.com or download the mobile app	800-335-8266
Vision	EyeMed	www.EyeMedVisionCare.com or download the mobile app	866-939-3633
Life & Disability	New York Life	www.MyNYLGBS.com	800-225-5695
Accident & Critical Illness	Aflac	www.AflacGroupInsurance.com	800-433-3036
Whole Life	Unum		800-635-5597
Family Medical Leave Administration	New York Life	www.MyNYLGBS.com	888-842-4462
Employee Assistance Program	Cigna	www.mycigna.com Employer ID: cityofcharleston	888-371-1125
SC Deferred Compensation	401(k) & 457 Retirement Savings	www.southcarolinadcp.com	877-457-6263
Public Employee Benefit Authority	South Carolina Retirement System Police Officers Retirement System	www.Peba.SC.gov	888-260-9430

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.