SouthComm

CityBeat

MedicalNews INC

Nashville Scene

Creative Loafing Atlanta

Creative Loafing Tampa Bay

Nashville Post

Nashville Post

nFocus

nFocus

The Pitch

SouthComm Publishing Company, Inc.

target marketing

Washington City Paper

January 1st through December 31st 2017
Summary of Benefits

CBIZ Benefits & Insurance Services

At SouthComm we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure and maintain a work/life balance.

Stay Healthy

- **Employee Assistance Program (EAP)**
- **Medical**
- **Health Savings Account**
- **Dental**
- **Vision**
- **Life**
- **Voluntary Life and AD&D**
- **Long Term Disability**
- **Short Term Disability**
- **Critical Illness**
- **Accident Coverage**
- **Flexible Spending Account**

Contact Information

Refer to this list when you need to contact one of your benefit providers.
Contact our broker listed below for claims, eligibility, or escalated issues.

CBIZ Insurance and Benefit Services of Tennessee
12 Cadillac Drive
Suite 160
Brentwood, TN 37027
General Line: 615-742-0300
Fax: 615-742-8791

CBIZ Contacts:
Cathy Anthony, RHU, REBC
615-742-0311
canthony@cbiz.com

Vicki Wilkins
615-742-0314
vwilkins@cbiz.com

Beth Osteen
615-742-0316
bosteen@cbiz.com

Eligibility

All of our benefit plans will cover permanent full-time employees who work at least 30 hours per week.

New employees are eligible for benefits the first of the month following 30 days of full time employment.

Eligible Members:
Eligible Dependents include:

- Legal Spouse or Common Law Spouse if legally recognized in the following states:
  - Alabama
  - Colorado
  - Georgia (before 1997)
  - Idaho (before 1996)
  - Iowa
  - Kansas
  - Montana
  - Ohio (before 10/10/1991)
  - Oklahoma
  - Pennsylvania
  - Rhode Island
  - South Carolina
  - Texas
  - Utah
  - Washington D.C.

- **To age 26 for a married or unmarried child up for Medical/Dental/and Vision Plans**
- **To age 19 or 25 if full time student for Voluntary Life Benefits.**
  - Natural child born to you or your spouse (application must be made within 31 days of date of birth)
  - Step Child
  - Adopted Child (application should be made within 31 days the child is placed in your home)
  - Legal Guardianship (application should be made within 31 days the child is placed in your home)
  - Divorce Decree Obligation for you or your spouse

- Incapacitated Child over the age of 26
  - Permanently incapable of self-support due to physical handicap or mental retardation before reaching age 26.
  - Certificate of Dependency must be completed by employee and physician within 31 days of obtaining the age of 26.

- **Domestic Partner-Opposite Sex, Same Sex and coverage for children of domestic partners.**

  In order for a domestic partner to be eligible for coverage, the following requirements must be met (*certification form required*-see HR to obtain):

  (1) The subscriber and domestic partner must have shared a continuous committed relationship with each other for not less than 6 months, intend to do so indefinitely, and have no such relationship with any other person.

  (2) The subscriber and domestic partner are jointly responsible for each other's welfare and financial obligations.

  (3) The subscriber and domestic partner reside in the same household.

  (4) The subscriber and domestic partner are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence.

  (5) Both the subscriber and domestic partner are over age 18, or legal age, and are mentally and legally competent to enter into a contract.

(6) Neither the subscriber nor domestic partner is married to a third party.

(7) For same sex domestic partners: The subscriber and domestic partner must reside in a state where marriage between persons of the same sex is not recognized as a valid marriage, or if residing in a state that recognizes same sex unions, have entered into such union as recognized by the state.

Applications for eligible domestic partners will only be accepted as a new hire *or* at open enrollment. Acquiring a domestic partner is *not* considered a qualifying event eligible for special HIPAA enrollment.

Working Spouse/Domestic Partner Provision
SouthComm's objective is to provide a comprehensive medical/dental/vision programs to our associates. We believe that other employers should do the same. Participants enrolling in SouthComm's health, dental or vision insurance programs will be subject to the "Working Spouse/Domestic Partner Provision".

The "Working Spouse/Domestic Partner Provision" requires that the spouse/domestic partner of a covered associate, who is eligible for insurance coverage through his/her employer enroll in their employer's program as primary and SouthComm's program only as secondary coverage. The working spouse/domestic partner provision will not be applicable to spouses/domestic partners of SouthComm employees that are required to pay 100% of the cost for medical, dental or vision insurance through their employer's plan. If a spouse/domestic partner is required to pay the full price of coverage, they are permitted to join the SouthComm plans as a primary dependent. Proof of financial responsibility under their employer's plan is required prior to enrollment.

If your spouse/domestic partner is eligible to enroll for health/dental and/or vision insurance benefits through his/her employer, he/she must enroll in that plan in order to remain eligible for participation in the SouthComm, Inc. Group Plans. Please see HR to obtain the necessary Working Spouse Affidavit to enroll your working spouse.

Life Event Changes:

You may change your coverage for you and any of your dependents if you have a qualifying life event. The change must be reported within 31 days of the event otherwise the change cannot be made until open enrollment. The allowable changes include:

- Marriage
- Divorce/Legal Separation
- Addition of newborn
- Death of dependent
- Court ordered coverage for dependent child
- Dependent loss of coverage
- Significant change in health insurance coverage offered by employee or spouse's employer.
- Change in eligibility of employee or spouse
- Spouse commencement or termination of employment

Open Enrollment

Our open enrollment period will be in November of each calendar year. You are permitted to make changes to any of your coverage during this time period. All changes will be effective on January 1st.

Employee Assistance Program (EAP)

We offer an EAP benefit through Magellan, is provided to you at no cost, to assist with work, life, and personal issues. The EAP has experienced and helpful specialists available to help with life's most important needs 24/7, 365 days a year. The EAP specialists can help you with resources and information, providers, products and services in parenting, senior care, legal and financial services, home services, wellness, etc. The EAP services are completely confidential and are available to you and the family members in your household. To speak with a counselor 24/7, call 800-450-1327. The EAP website is www.magellanhealth.com/member.

Medical Insurance

United Health Care (UHC)
866-314-0335

At SouthComm, we understand how important coverage is to help protect you and your family from the financial loss or hardship that could result from illness. With the rising cost of health care, few of us could afford to pay medical expenses out of our own pocket.

Pre-existing waiting periods

United Health Care will no longer impose a pre-existing waiting period for any existing or new employee as stated in the Affordable Health Care Law Requirements.

Choice Plus Network/Alliance Network

The Choice Plus Network provides national and international in-network access to any UMR contracted physician or facility. When using in-network physicians or hospitals, you receive the greatest benefit and cannot be balanced billed. In the event of a life threatening emergency, please go to the nearest hospital or emergency room. UHC will cover an out-of-network facility with in-network benefits. If an out of network facility is used, then you may still be balance billed for any amount that is over the usual and customary charges.

The Alliance Network provides additional local access to physicians and hospitals when seeking services in certain areas in Wisconsin. Please refer to the network coverage brochure for additional network information.

UMR Go Mobile

Anytime Access to Your Health Information

The UMR app from UnitedHealthcare is your go-to resource for everything related to your health. From finding a doctor to estimating treatment costs and managing prescriptions on the go, the UMR Mobile gives you anytime access to the tools you need.

Simply visit www.umr.com from your mobile device

- Find a doctor, vision provider or health care facility
- Review deductibles, account balances and claims
- Download mobile ID Card and much more!

UMR Member Services Portal

Register for online access through the UMR member services portal by visiting **www.umr.com** and registering with your member ID number.

- Find a doctor, vision provider or health care facility
- Review deductibles, account balances and claims
- Mail order prescriptions

Medical Insurance

1-800-826-9781
www.umr.com

In Network Benefits	PPO Plan	Qualified High Deductible Plan (QHDP)
Deductible: Amount you pay first in a calendar year for certain services.	$750 Individual $1,500 Two-person $2,250 Family	$2,000 Individual $4,000 Family*
Coinsurance: Amount UHC pays after you have met the deductible and before you meet the out-of-pocket maximum.	80%-You pay 20% after the deductible has been met.	80%-You pay 20% after the deductible has been met.
Out-of-Pocket: Maximum that you pay in a calendar year. Once you reach this in medical expenses, you are covered at 100%-includes office visit and prescription drug copays	$2,500 Individual $5,000 Two-Person $7,500 Family	$3,000 Individual $6,000 Family*
Office Visit Copay	$20 Primary Care; $40 Specialist	Plan pays 80% after deductible and 100% after out of pocket.
Preventive Care:	Plan pays 100%; You pay 0%	Plan pays 100%; You pay 0%
Inpatient Facility Charges	Plan pays 80% after deductible and 100% after out of pocket	Plan pays 80% after deductible and 100% after out of pocket
Emergency Room Charges:	Plan pays 100% after $200 Copay	Plan pays 80% after deductible and 100% after out of pocket
Urgent Care Visit	Plan pays 100% after $50 Copay	Plan pays 80% after deductible and 100% after out of pocket
Inpatient Behavioral Health	Plan pays 80% after deductible and 100% after out of pocket	Plan pays 80% after deductible and 100% after out of pocket
Outpatient Behavioral Health	Plan pays 100% after $40 Copay	Plan pays 80% after deductible and 100% after out of pocket
Prescription Drug Benefit: **30 Day Supply/Mail Order**	Tier 1: $10 Copay/$20 Copay Tier 2: $35 Copay/$70 Copay Tier 3: $55 Copay/$110 Copay	Plan pays 80% after deductible and 100% after out of pocket

- If you have more than one person covered under the QHDP Plan, then you will share the family deductible and out of pocket. One person or a combination of family members must meet the family deductible first before UMR will pay 80% and then reach the family out of pocket before the plan pays 100%.

- All in-network services will be discounted according to United Health Care contracted rates. You are never responsible for the network savings amount the provider is required to discount your balance by. This includes all covered services and prescription drugs.

Dental Insurance

www.deltadentaltn.com
800-223-3104

Our dental plan offered through Delta Dental of Tennessee. As a member of Delta Dental you have access to two different networks, the PPO Network or Premier Network. As long as your dentist participates in either network, then you will receive in-network benefits and cannot be balance billed. Your benefits do go farther using a PPO Dentist.

Delta Dental Mobile App

- Mobile Member ID Card
- View Claims and Check Network Providers
- Download through ITunes or Google Play by Searching “Delta Dental”

Delta Dental Online Access

- Download ID card
- View claims, benefits, and find a provider
- Register at www.deltadentaltn.com

In-Network Benefits	PPO or Premier Network
Preventive Services: • 2 in 12 month period • Cleanings and X-rays	Plan pays 100%
Basic Services: (fillings/root canals) • Minor Restorative • Basic and Major Endodontics • Basic and Major Periodontics • Basic and Major Oral Surgery	Plan pays 80%
Major Services (crowns, bridges, dentures) • Major Restorative, Implants, and Prosthodontics	Plan pays 50%
Calendar Year Deductible (Basic and Major Services Only)	$50 Per person to family max of $150
Calendar Year Maximum for Preventive/Basic/ and Major Services	**$1,500 per covered person**
Orthodontics for Dependent Children to Age 19	**50% to Lifetime Maximum of $1,500 per covered child**

Vision Insurance

866-314-0335
www.mvuhc.com

Our vision program is offered through United Health Care and is part of the Spectera Network. As long as your provider is in-network, you will receive full in-network benefits.

	Spectera Network
Annual Eye Exam (Every 12 months)	100% after $10 Copay
Standard Lenses (Every 12 months)	Plan pays 100% for standard plastic lenses after $25 Copay. Additional lens options are available with a discount.
Frames (Every 12 months)	Plan pays up to $150
Contact Lenses (in lieu of glasses)	Plan pays up to $150
Optional Services	Please refer to Benefit Summary for Additional features

Life Insurance

Principal
www.pincipal.com

SouthComm understands the unexpected expenses that could arise in the unfortunate event of death. We provide all regular full-time employees with the lesser of one times your annual salary to a maximum benefit of $200,000 at no cost to you. It is important to maintain accurate beneficiary information.

Voluntary Life and AD&D

Principal
www.principal.com

SouthComm provides the opportunity for all full time employees to purchase additional life insurance to help you provide for your family in the unfortunate event of death. As a SouthComm employee, you may elect voluntary term life insurance through Principal Financial.

- **Employee Coverage:**
  - **Guaranteed Coverage (no questions asked):** You may elect up to $200,000 in $10,000 increments without answering medical questions. Minimum coverage of $10,000 is required.
  - **Maximum Coverage (statement of health required):** You may elect up to the lesser of 5 times your annual salary to a maximum of $500,000. Any amount over $200,000 will require a statement of health for approval.

- **Spouse Coverage**
  - **Guaranteed issue amount (no questions asked):** Spouse may elect up to the lesser of 100% of the employee elected amount or $50,000 in $5,000 increments without answering medical questions. Minimum coverage of $5,000 is required.
  - **Maximum Coverage (statement of health required):** Spouse may elect up to the lesser of $250,000 or 100% of the employee elected amount. Any amount over $50,000 will require a statement of health for approval.

- **Child(ren) Coverage:**
  - **Guaranteed issue and maximum amount:** You may elect up to $10,000 of coverage for your dependent children without answering medical questions**.** Minimum coverage of $5,000 is required. Refer to full benefit summary for age limitations for newborn children.

- You must have coverage on yourself to purchase spouse or child coverage.

Disability Insurance

Principal

1-800- 247-6875

A disability can happen to anyone. Pregnancy, an accident or an illness can turn into months out of work without any income. At SouthComm we understand the importance of providing protection for the unexpected. In the event you become disabled from a non work-related injury or sickness, disability income benefits are provided as a source of income. SouthComm provides Short Term Disability Coverage at no cost to you. The Long Term Disability coverage will be provided by adding the premium cost to your salary and then reducing your salary by the same amount. This is considered a “gross up” benefit which allows any benefits payable to be tax free.

Elimination Period

The elimination period is the amount of time that you must be out of work from the date your physician deems you disabled to the time your benefits begin. No benefits are payable during this time from Principal. You may use any SouthComm provided paid time off to supplement your income during this time.

Pre-existing limitation: Any injury or sickness which you received medical treatment (including prescription drugs), consultation, care or services prior to the effective date will not be covered until the limitation period has expired.

Benefits for you	Short-Term Disability	Long Term Disability
Elimination Period	8th day for accident or sickness	180 days for accident or sickness
Benefit Duration	Up to 25 weeks	Up to Normal Retirement Age for not being able to perform any occupation; 2 years for own occupation
Percentage of Income Replaced	Lesser of 60% of weekly earnings up to a maximum of $1,500 per week	Lesser of 60% to a monthly maximum of $10,000
Pre-existing exclusion	3 month prior to effective date; not covered for first 12 months after	3 month prior to effective date; not covered for first 12 months after effective date.
Benefits Taxable	Yes	No

Critical Illness and Accident Coverage

Voya
1-877-236-7654

Critical Illness

This plan is designed to help you with out-of-pocket expenses and lost wages associated with a serious illness. Your critical illness benefit can be used for an purpose, such as: lost time from work, mortgage/rental/utilities, copays/deductibles/coinsurance, home health care costs and childcare expenses.

When you enroll, you elect a benefit amount between $5,000 and $20,000. This benefit then pays a lump-sum benefit, tax free, if you are diagnosed with one of the covered illnesses. Some of the illnesses covered by the plan this plan include: heart attack, stroke, major organ failure, permanent paralysis, end stage renal failure, coma and coronary artery bypass. This coverage is available to you, your spouse and dependent children (to age 26). Below are the post-tax premium amounts.

Employee /Spouse Age	$5,000	$10,000	$15,000	$20,000
Under 30	$3.05	$6.10	$9.15	$12.20
30-39	$3.55	$7.10	$10.65	$14.20
40-49	$6.60	$13.20	$19.80	$26.40
50-59	$14.15	$28.30	$42.45	$56.60
60-64	$23.45	$46.90	$70.35	$93.80
65-69	$30.85	$61.70	$92.55	$123.40
70+	$41.25	$82.50	$123.75	$165.00

Accident Coverage

This option is designed to financially assist you in the event of any injury, on or off the job. It pays benefits based on the type of injury (or covered incident) you sustain or the type of treatment you need. The benefits are paid directly to you rather than your doctor or hospital. You can cover yourself, your spouse and dependent children (to age 26). The plan is guarantee issue, which means no medical questions or tests required for coverage. Below are post-tax premium amounts.

Monthly Rates			
Employee	Employee and Spouse	Employee and Children	Family
$15.70	$26.68	$30.96	$41.94

For a complete description of available benefits along with applicable provisions, exclusions and limitations, see the certificate of insurance.

VOYA FINANCIAL

Health Savings Account (HSA) HDHP Plan Only

HSA Bank www.hsabank.com
800-357-6246

Regular full-time employees are eligible to participate in the Health Savings Account (HSA) with HSA Bank if you are enrolled in the **HDHP plan**. The HSA allows you to deposit funds into an account to help pay for deductibles, vision, dental, COBRA premiums, etc.

You are eligible to deposit additional funds pre-tax into the account up to a total of $3,400 for employee only or $6,750 if you have more than one person covered. Employees age 55 and older may deposit an additional $1,000 annually into the account.

HSA Benefits:

1. You own the account. Any funds deposited belong to you.
2. "Use-it or keep it"-any unused funds rollover from year to year.
3. Pre-tax contributions go into your account, and qualified withdrawals are not taxed.
4. Funds in your HSA account may be used to pay for qualified expenses for your dependents regardless if covered by your insurance.
5. No timely filing or documentation required for reimbursement. As long as your HSA account has been established and your expense was incurred after that date, you can reimburse yourself at any time.
6. Funds may be withdrawn at any time for qualified or non-qualified expenses. If it is a non-qualified withdrawal, then a 20% penalty will apply, plus your tax bracket. Employees age 65 and older, will not incur a penalty if it is a non-qualifying expense.
7. Funds do have to be in your account before you can use them-just like a personal checking account.

Requirements- The IRS does require you to meet certain requirements to be eligible for the HSA:

1. You must be enrolled in a HDHP plan of insurance, and must not be enrolled in any other plan of insurance (including an FSA that reimburses medical expenses).
2. You must not be entitled to Medicare.
3. Please refer to the full FAQ's for additional details.

Flexible Spending Account (FSA)

TASC
www.tasconline.com 800-422-4661

Medical Out-of-Pocket Expenses (You cannot be contributing into an HSA):
You may elect to contribute up to **$2,600** pre-tax annually into a Flexible Spending Account (FSA) to reimburse for qualified medical expenses for yourself or any dependents (even if not covered by your medical plan).

Benefits:

1. All elections are pre-tax. This means that you pay for your known qualified expenses from this account without paying taxes.
2. No medical election required. You do not have to be enrolled in the medical insurance plan to participate.

3. Your annual election is made immediately available to you on the effective date. If your annual election is $2,600 for a January effective date, then on January 1st, you have the full $2,600 available to you.
4. This plan is for your known qualified medical expenses. Any funds remaining minus the rollover amount will be forfeited at the end of the plan year.
5. Deductions are based on our plan year ending 12/31-not on a calendar year basis. Please plan carefully based on the number of pay periods left until the end of the plan year.
6. Your election cannot be changed without a qualifying event.
7. Funds may be used for any dependents even if not covered by your medical plan.
8. Funds can also be used for out-of-pocket dental and vision expenses
9. Funds that remain in your account after 12/31/2017 may carry over and be used for the first 2 ½ months of the following calendar year. You may incur and pay for expenses during this time, but mut file a manual claim for reimbursement. Any funds that remain after March 15, 2018 will be forfeited.

Limited Purpose FSA for Vision and Dental Only Out-of-Pocket Expenses (You <u>can</u> be contributing into an HSA):
You may elect to contribute up to **$2,600** pre-tax annually into a FSA to reimburse for qualified medical expenses for yourself or any dependents for vision and dental expenses only if you are contributing into a HSA.

Benefits:
1. Same benefits as the full medical out-of-pocket with the exception of you having known qualified vision or dental expenses (child in braces), then you may save the funds in your HSA and pay for these expenses.
2. Allows you to take full advantage of 2 tax savings plans for the HSA and FSA.

Dependent Day Care Expenses (You can be contributing into an HSA):
You may elect to contribute up to **$5000** pre-tax annually into a FSA to reimburse for qualified dependent day care expenses if you are married filing jointly.

Benefits:
1. Allows you to maximize your tax savings to pay for your child's dependent care expenses to allow you and/or your spouse to **work or go to school.**
2. Expense must be incurred and the funds must be in your account to obtain reimbursement.

Insurance Premiums
January 1, 2017 through December 31, 2017

Payroll deduction amounts for each of our benefit plans are indicated in the chart below. We have twenty-six pay periods per year.

Coverage Type	PPO Option	QDHP	Dental	Vision
Employee Only	$84.58	$47.60	$13.56	$2.38
Employee + 1	$169.04	$95.29	$26.31	$4.89
Employee + 2 or more (Family)	$274.73	$154.94	$47.47	$7.43

MEDICARE PART D Notice

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

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

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

2. SouthComm has determined that the prescription drug coverage offered by UMR is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, if you decide to keep this coverage and not join when you first become eligible, then you will **not** pay a higher premium (a penalty) if you later decide to join a Medicare drug plan .

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current SouthComm coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D. See pages 7-9 of the CMA Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available.

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

Because your current coverage is not creditable, the 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 HR Department at 800/547-7377. 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 SouthComm changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**October 15, 2016**
Name of Entity/Sender:	**Southcomm**
Contact--Position/Office:	**Human Resources**
Address:	**1233 Janesville Avenue** **Fort Atkinson, WI 53538**
Phone Number:	**800/547-7377 x1703**
Email:	vfrohmader@southcomm.com

New Health Insurance Marketplace Coverage

Options and Your Health Coverage

Form Approved OMB No. 1210-0149 (expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2015, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2015 for coverage starting as early as January 1, 2016.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: The HR Department at 800/547-7377

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name SouthComm Communications		4. Employer Identification Number (EIN) 26-1327596
5. Employer address 210 12th Avenue South, Suite 100		6. Employer phone number
7.City Nashville	8. State TN	9. ZIP code 37203
10. Who can we contact about employee health coverage at this job? HR Department		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are:
  Employees working at least 30 hours per week

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are: Spouse, Certified Domestic Partner, Children up to age 26.

  ☐ We do not offer coverage.

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

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

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

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean 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). Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. *It is the employee's responsibility to notify the Human Resources Department of their pregnancy so they can be provided their statement of rights under the Newborn's and Mother's Health Protection Act.*

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

· All stages of reconstruction of the breast on which the mastectomy was performed;
· Surgery and reconstruction of the other breast to produce a symmetrical appearance;
· Prostheses; and
· Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 800/547-7377 x1703.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

· All stages of reconstruction of the breast on which the mastectomy was performed;
· Surgery and reconstruction of the other breast to produce a symmetrical appearance;
· Prostheses; and
· Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 800/547-7377 x1703.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself andor your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO – Medicaid

Medicaid Website: https://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

INDIANA – Medicaid

Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/id
Click on Health Care, then Medical Assistance
Phone: 800-657-3629

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: http://hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: http://www.health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2016, or for more information on special enrollment 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

OMB Control Number 1210-0137 (expires 10/31/2016)