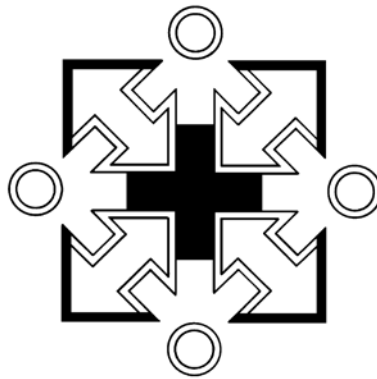


Carteret General Hospital Employee Benefits 2010-2011



- Health Insurance
- Dental Insurance
- Vision Insurance
- Life Insurance
- Short Term Disability
- Long Term Disability
- Cancer Insurance
- Critical Illness
- Accident Insurance
- Flexible Spending Accounts
- Retirement Savings
- Paid Time Off

Employee Benefits Plan Summary Handbook
October 1, 2010 – September 30, 2011

Welcome,

Carteret General Hospital is proud to offer its employees a comprehensive benefits package. In this benefits handbook we provide information on those benefits administered by the Employee Benefits Division of the Department of Human Resources, which include health, dental and vision insurance, retirement savings accounts, flexible spending accounts, group term life insurance, and long-term disability. Our voluntary supplemental benefits include short term disability, cancer insurance, critical illness and accident insurance. You can also find information on Paid Time Off.

Summary Plan Descriptions, forms and policies are available in the Human Resources Department located on the first floor or you may download a copy from the Carteret General Hospital intranet <http://mynet/Intranet>.

We are happy you have decided to make a career at Carteret General Hospital and we are here to help you make the best decisions on your benefits, both for now and in the future. Come see us anytime.

Brenda A. Waugh
Benefits Coordinator

What you will find in this booklet

If you are a new employee of Carteret General Hospital, or a current employee with benefit questions, this booklet will help you understand and make decisions on benefits available to you and your family.

It provides information on the Hospital's health, dental and vision plan coverage's, retirement savings plans, flexible spending account programs, life insurance, disability insurance, voluntary supplemental insurance as well as paid time off.

If you are a new employee; your effective date for coverage is the first of the month following 90 days of employment in a full-time or part-time benefited position. You must enroll in the various benefits 30 days prior to your effective date in order to avoid missed premiums. You may enroll in the 403(b) Retirement Plan at any time.

If you are a current employee, you are eligible to make changes to your health and dental plans, add or drop dependents, cancel your plan, enroll in flexible spending accounts for the next year, or request to increase or decrease your group term life insurance coverage and/or dependent coverage during the annual open enrollment period. You may also make changes within 30 days of a qualifying event such as marital status change, number of dependents change, loss of other coverage, dependent status change, employment status change, or a judgment, decree or order requiring coverage.

Table of Contents

- **How Much does it Cost?..... 4**
- **Wellness Premium Discount/Tobacco Surcharge.....5**
- **Medical, Dental & Prescription Drug Plan..... 6 - 15**
- **Life and Long Term Disability Insurance.....16 - 19**
- **Flexible Spending Accounts.....20 - 21**
- **Voluntary Supplemental Insurance.....22 - 23**
Aflac Cancer and Accident Insurance
Unum Short Term Disability and Critical Illness
- **Vision Insurance.....23**
- **Retirement Savings Accounts.....24 - 25**
- **Paid Time Off.....26 - 28**
- **Initial Cobra Notice.....29 – 31**
- **FMLA Policy.....32 - 33**

“How much does it cost?”

Plan Year 2010-2011 October 1, 2010 – September 30, 2011

Rates September 1, 2010 – August 30, 2011

Deductions begin two pay periods prior to your effective date.

Health Insurance Full Time Bi-Weekly	<u>PLAN A</u>	<u>PLAN B</u>	<u>PLAN C*</u>	<u>CGH HSA CONTRIBUTION*</u>
Employee	\$ 62.00	\$ 45.00	\$ 35.00	\$ 38.46
Employee/Child(ren)	\$ 159.00	\$ 120.00	\$ 108.50	\$ 57.69
Employee + Spouse	\$ 176.50	\$ 150.00	\$ 141.50	\$ 57.69
Employee + Family	\$ 241.50	\$ 200.00	\$ 191.50	\$ 57.69

****Plan C participants will receive a contribution into their Health Savings Account. See HSA Contribution column for bi-weekly contributions.***

The above premiums are affected by:

1. Part-Time medical premium is an additional \$50 bi-weekly.
2. If you are a tobacco user, your bi-weekly premium for medical coverage will be increased by \$18.50. If you are a tobacco user and complete a tobacco cessation program through Allwell, this surcharge may be removed. In order to avoid the Tobacco Surcharge, please enroll in a tobacco cessation program with Allwell 1 month prior to your effective date.
3. A Wellness Premium Discount of \$9.00 bi-weekly will be offered for benefited employees who participate in the Action Track or the Ultra Track on their annual performance evaluation (*new employees who have not been through their annual performance evaluation will receive the wellness discount until the time of their annual evaluation and may continue based on participation in the Action or Ultra Track*).

For those employees who have other health insurance coverage available to them, you may decline coverage and receive free dental insurance for yourself and your dependents. If you would like to receive the Opt-Out Bonus Dental, please submit proof of other health insurance with your enrollment.

Wellness Discount: To qualify for the Wellness Discount, you must complete the Action or Ultra track wellness program through Allwell during your annual evaluation. The wellness discount will automatically apply to new employees who have not completed their annual evaluation.

Tobacco Surcharge: To have the Tobacco Surcharge removed, please return your tobacco certification 30 days prior to your effective date.

<u>Dental Insurance</u> <i>Same for Full and Part Time Bi-Weekly Premium</i>		<u>Vision Insurance</u> <i>Same for Full and Part Time Bi-Weekly Premium</i>	
Employee	\$11.67	Employee	\$ 5.62
Employee + Spouse	\$26.26	Employee + One	\$ 10.90
Employee + Children	\$20.00	Employee + Family	\$ 16.04
Employee + Family	\$36.46		

Wellness Premium Discount

A Wellness Premium Discount of \$9.00 per pay period will be offered for benefited employees who participate in the Action Track or the Ultra Track on their annual performance evaluation (*new employees who have not been through their annual performance evaluation will receive the wellness discount until the time of their annual evaluation and may continue based on participation in the Action or Ultra Track*). Participating means you selected your Track, scheduled your AllWell appointment, completed the Personal Wellness Profile and blood work, and attend the AllWell appointment. Premium discounts are not based on any results, just participation in the Action or Ultra Track Programs.

Tobacco Surcharge

As part of our Wellness program, Carteret General Hospital rewards employees who are enrolled in our medical plan that do not use tobacco, by offering lower bi-weekly medical premiums. The design is to encourage a healthier lifestyle. Participants who do not provide the certification will be assessed an extra premium contribution for their medical benefits. A tobacco surcharge of \$18.50 will be added to your bi-weekly premium if you have used tobacco products in the previous twelve months. **The tobacco surcharge may be removed by participating in the tobacco cessation program. Employees will be randomly checked for tobacco use as a part of our random drug screening.**

Tobacco Cessation Program

Employees wishing to have the tobacco surcharge removed must enroll in the Tobacco Cessation Program through Allwell 30 days prior to your benefit effective date. If you have been enrolled or participated in a cessation program through Allwell within the past 2 years and were not successful, you may enroll in another program and have the surcharge removed. **If you have been enrolled or participated in more than one program in the past 2 years and have not been successful, you may enroll in another program, but must be assessed the surcharge.**

If it is unreasonably difficult due to a health factor for you to meet one of the above requirements (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge.

THIS FORM MUST BE SIGNED ANNUALLY

Please return your tobacco certification prior to your effective date to avoid the tobacco surcharge.

BLUE OPTIONS PPO PLAN A

BLUE OPTIONS PPO—\$500 DEDUCTIBLE

Annual In-Network Deductible: \$500 per person (up to \$1,500 per family)

Physician Office Visits: Primary Care: \$20.00

Specialist: \$40.00

Urgent Care: \$40.00

Inpatient, Outpatient and Emergency Room Services:

You pay 10% (co-insurance) after deductible is met at CGH and 20% (co-insurance) to all other in network providers

Co-insurance Benefit Period Maximums:

\$2,000 per person (up to \$6,000 per family)

Co-pays for office visits and prescriptions are not included in the benefit period maximums. You will continue to pay co-pays after your deductible and co-insurance have been met.

Prescription Drug: Deductible: None

Prescription Drug:	Deductible:	None
	Generic:	\$10.00
	Preferred:	\$25.00
	Brand:	\$40.00
	Specialty:	25% up to \$100/mo

Full Time Bi-Weekly Premiums

Employee Only	\$62.00
Employee/Sp	\$176.50
Employee/Ch (ren)	\$159.00
Family	\$241.50

Above premiums do not include the \$9 wellness discount
Part Time premium is an additional \$50.00 per pay period

BLUE OPTIONS PPO PLAN B

BLUE OPTIONS PPO—\$1,000 DEDUCTIBLE

Annual In-Network Deductible: \$1,000 per person (up to \$3,000 per family)

Physician Office Visits: Primary Care: \$25.00

Specialist: \$50.00

Urgent Care: \$50.00

Inpatient, Outpatient and Emergency Room Services: You pay 10% (co-insurance) after deductible is met at CGH and 20% (co-insurance) all other in network providers

Co-insurance Benefit Period Maximums:

\$2,000 per person (up to \$6,000 per family)

Co-pays for office visits and prescriptions are not included in the benefit period maximums. You will continue to pay co-pays after your deductible and co-insurance have been met.

Prescription Drug: Deductible: \$100.00 (per member)

Prescription Drug:	Deductible:	\$100.00 (per member)
	Generic:	\$10.00
	Preferred:	\$25.00
	Brand:	\$40.00
	Specialty:	25% up to \$100/mo

Full Time Bi-Weekly Premiums

Employee Only	\$45.00
Employee/Sp	\$150.00
Employee/Ch (ren)	\$120.00
Family	\$200.00

Above premiums do not include the \$9 wellness discount
Part Time premium is an additional \$50.00 per pay period

BLUE OPTIONS HSA PLAN C

BLUE OPTIONS HSA—\$2,000 DEDUCTIBLE

Introducing the Qualified High Deductible Health Plan with Health Savings Account, below is a summary of benefits: Annual In-Network Deductible: \$2,000 Employee Only /\$4,000 Family (*all covered members claims are combined into one deductible*)

Physician Office Visits:

Once the deductible has been met, all in-network covered services are paid at 100% (*Preventative services are covered at 100%, no deductible, no co-pay*)

Prescription Drug:

Once the deductible has been met, all in-network covered services are paid at 100%

Inpatient, Outpatient and Emergency Room Services:

Once the deductible has been met, all in-network covered services are paid at 100%

There are no co-pays for office visits and prescriptions, you pay the BCBS discounted amount for services until your deductible has been met. Once the deductible has been met, all in-network covered services are paid at 100%

***For Plan C Participants Only - Carteret General Hospital contributes on a bi-weekly basis (\$38.46 employee only/ \$57.69 for family) into a Health Savings Account. Employees may also direct deposit pre-tax dollars into t** There are no co-pays for office visits and prescriptions, you pay the BCBS discounted amount for services until your deductible has been met. Once the deductible has been met, all in-network covered services are paid at 100% .

Full Time Bi-Weekly Premiums

Employee Only	\$35.00
Employee/Sp	\$141.50
Employee/Ch (ren)	\$108.50
Family	\$191.50

Above premiums do not include the \$9 wellness discount
Part Time premium is an additional \$50.00 per pay period

Blue OptionsSM Benefit Highlights (Plan A)

Physician Office Services <i>(See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)</i>	In-network	Out-of-network¹
Office Visit <i>Includes Office Surgery, Consultation, X-rays and Lab, and a benefit period maximum of 4 office visits for the assessment of obesity in and out of network. See "Inpatient and Outpatient Services"</i>		
Primary Care Provider	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible
Preventative Care <i>Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)</i>		
Primary Care Provider	\$20 copayment	Not Available*
Specialist	\$40 copayment	Not Available*
<i>*Pap Smears, Mammograms, and PSAs are covered Out-of-network.</i>		
Therapies <i>Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings): Physical/Occupational: 30 visits per Benefit Period Speech Therapy: 30 visits per Benefit Period</i>		
Primary Care	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	\$40 copayment	\$40 copayment
Emergency Room Visit** <i>(Inpatient Hospital benefits apply if admitted. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)</i>	80% after deductible	80% after deductible
Ambulatory Surgical Center**	80% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services**	80% after deductible	70% after deductible
Outpatient Clinic Services **	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services: **	80% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services:	100%	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and EKG's**	80% after deductible	70% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physician's office**	80% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility <i>(60 days per Benefit Period)</i>	80% after deductible	70% after deductible
Home Health Care, Ambulance, Durable Medical Equipment and Hospice	80% after deductible	70% after deductible
Maternity <i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services (Delivery)	80% after deductible	70% after deductible
Professional Services (Delivery)	80% after deductible	70% after deductible
Transplants		
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible

****If services performed at CARTERET COUNTY GENERAL HOSPITAL, 90% after deductible.**

Blue OptionsSM Benefit Highlights (PLAN A)

Deductibles & Coinsurance Maximums

The following Deductibles and Coinsurance Maximums only apply to the services on the previous page

Deductibles

Individual (per Benefit Period)	\$500	\$1,000
Family (per Benefit Period)	\$1,500	\$3,000

Coinsurance Maximum

Individual (per Benefit Period)	\$2,000	\$4,000
Family (per Benefit Period)	\$6,000	\$12,000

Mental Health and Substance Abuse Services (NCMHParity accepted)

*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422

Mental Health Services

Office (30 visits per Benefit Period)	\$40 copayment	70% coinsurance
Inpatient/Outpatient (30 Days per Benefit Period)	80% coinsurance	70% coinsurance

Substance Abuse Services

Office Visit	\$40 copayment	70% coinsurance
Inpatient/Outpatient	80% coinsurance	70% coinsurance
Benefit Period Maximum		\$8,000
Lifetime Maximum		\$16,000

Prescription Drugs

Up to 30 day supply, 31-90 day supply is two copayments for both retail and mail order.

61-90 day supply is three copayments.

MAC B Pricing, Brand Penalty

	In-network	Out-of-network ¹
Tier 1(Generic)	\$10 copayment	Copayment + charge over In-network allowed amount
Tier 2(Preferred Brand)	\$25 copayment	Copayment + charge over In-network allowed amount
Tier 3(Brand)	\$40 copayment	Copayment + charge over In-network allowed amount
Tier 4(Specialty Brand)	75% coinsurance	Coinsurance + charge over In-network allowed amount

There is a \$50 per Drug Minimum and a \$100 per Drug Maximum for each 30-day supply of Tier 4 Specialty Brand drugs.

¹ NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine the payment obligations for BCBNC and its members.

****If services performed at CARTERET COUNTY GENERAL HOSPITAL, 90% after deductible.**

Blue OptionsSM Benefit Highlights (PLAN B)

Physician Office Services

(See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)

Office Visit

Includes Office Surgery, Consultation, X-rays and Lab, and a benefit period maximum of 4 office visits for the assessment of obesity in and out of network. See "Inpatient and Outpatient Services".

	In-network	Out-of-network¹
Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible

Preventative Care

Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)

	In-network	Out-of-network¹
Primary Care Provider	\$25 copayment	Not Available*
Specialist	\$50 copayment	Not Available*

*Pap Smears, Mammograms, and PSAs are covered Out-of-network.

Therapies

Short-term Rehabilitative Therapies

(Maximums apply to Home, Office and Outpatient Settings):

Physical/Occupational: 30 visits per Benefit Period

Speech Therapy: 30 visits per Benefit Period

	In-network	Out-of-network¹
Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible

Urgent Care Centers and Emergency Room

Urgent Care Centers

\$50 copayment

\$50 copayment

Emergency Room Visit**

80% after deductible

(Inpatient Hospital benefits apply if admitted. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)

	In-network	Out-of-network¹
Ambulatory Surgical Center**	80% after deductible	70% after deductible

Inpatient and Outpatient Hospital Services

	In-network	Out-of-network¹
Hospital and Hospital Based Services**	80% after deductible	70% after deductible
Outpatient Clinic Services**	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible

Hospital and Professional

	In-network	Out-of-network¹
Outpatient Labs and Mammograms with surgery or other services.**	80% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services.	100%	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and EKG's**, CT scans, MRI 's, MRA's and PET scans (in any location, including physician's office**)	80% after deductible	70% after deductible

Other Services

	In-network	Out-of-network¹
Skilled Nursing Facility (60 days per Benefit Period)	80% after deductible	70% after deductible
Home Health Care, Ambulance, Durable Medical Equipment and Hospice	80% after deductible	70% after deductible

**If services performed at CARTERET COUNTY GENERAL HOSPITAL, 90% after deductible.

Blue OptionsSM Benefit Highlights (PLAN B)

Maternity

Maternity Delivery includes Prenatal and Post-delivery care

	In-network	Out-of-network¹
Hospital Services** (Delivery)	80% after deductible	70% after deductible
Professional Services (Delivery)	80% after deductible	70% after deductible

Transplants

Hospital Services**	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible

Lifetime Maximum, Deductibles & Coinsurance Maximums In-network Out-of-network¹

The following Deductibles and Coinsurance Maximums only apply to the services on the previous page:

	In-network	Out-of-network¹
Deductibles		
Individual (per Benefit Period)	\$1,000	\$2,000
Family (per Benefit Period)	\$3,000	\$6,000
Coinsurance Maximum		
Individual (per Benefit Period)	\$2,000	\$4,000
Family (per Benefit Period)	\$6,000	\$12,000

Prescription Drugs - Annual Deductible of \$100 is required on prescription drug benefits. Up to 30 day supply. 31-90 day supply is two copayments for both retail and mail order. Benefit Limits on Erectile Dysfunction (4 pills per 30 days) and Hypnotics (20 pills per 30 days). Weight Loss Drugs require prior authorization. MAC B Pricing, Brand Penalty

	In-network	Out-of-network¹
Tier 1(Generic)	\$10 copayment	Copayment + charge over In-network allowed amount
Tier 2(Preferred Brand)	\$25 copayment	Copayment + charge over In-network allowed amount
Tier 3(Brand)	\$40 copayment	Copayment + charge over In-network allowed amount
Tier 4(Specialty Brand)	75% coinsurance	Coinsurance + charge over In-network allowed amount

There is a \$50 per Drug Minimum and a \$100 per Drug Maximum for each 30-day supply of Tier 4 Specialty Brand drugs.

Mental Health and Substance Abuse Services Certified* Not-Certified¹

*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.

Mental Health Services

	In-network	Out-of-network¹
Mental Health Services		
Office (30 visits per Benefit Period)	\$50 copayment	70% coinsurance
Inpatient/Outpatient (30 Days per Benefit Period)	80% coinsurance	70% coinsurance

Substance Abuse Services

Office Visit	\$50 copayment	70% coinsurance
Inpatient/Outpatient	80% coinsurance	70% coinsurance
	Benefit Period Maximum	\$8,000
	Lifetime Maximum	\$16,000

**If services performed at CARTERET COUNTY GENERAL HOSPITAL, 90% after deductible.

Blue Options HSASM Benefit Highlights (PLAN C)

Deductibles & Total Out of Pocket Maximums¹

The following Deductibles and Total Out of Pocket Maximums apply to all services unless otherwise indicated:

	In-network	Out-of-network ²
Deductibles		
Employee Coverage (per Benefit Period)	\$2,000	\$4,000
Family Coverage (per Benefit Period)	\$4,000	\$8,000
Total Out of Pocket Maximum		
Employee Coverage (per Benefit Period)	\$2,000	\$5,250
Family Coverage (per Benefit Period)	\$4,000	\$10,500

Physician Office Services

Office Visit

Includes Office Surgery, Consultation, X-rays, Lab and benefit period maximum of 4 office visits for the evaluation and treatment of obesity in and out of network.

Primary Care Provider or Specialist	100% after deductible	70% after deductible
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Preventive Care (Preventive Diagnosis Only)

Well-Child Care (Age 2 and under), Immunizations, and the first service each benefit period for annual routine examinations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs), and other specified screening tests.

Primary Care Provider or Specialist	100%, no deductible	70% after deductible
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Other Preventive Care

Primary Care Provider or Specialist	100% after deductible	70% after deductible
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Therapies

Short-Term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):

Physical/Occupational: 30 visits per Benefit Period

Speech Therapy: 30 visits per Benefit Period

Primary Care Provider or Specialist	100% after deductible	70% after deductible
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Urgent Care Centers and Emergency Room

Urgent Care Centers	100% after deductible	100% after deductible
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Emergency Room Visit	100% after deductible	100% after deductible
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Ambulatory Surgical Center

	100% after deductible	70% after deductible
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Outpatient Hospital Services (Includes physician services, hospital and hospital-based services, outpatient clinic services, outpatient diagnostic services, and therapy services including short-term rehabilitative therapies and other therapies.)

	100% after deductible	70% after deductible
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Inpatient Hospital Services (Includes physician services, hospital and hospital-based services, and maternity delivery, prenatal and post delivery care.)

	100% after deductible	70% after deductible
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Other Services

Skilled Nursing Facility (60 days per Benefit Period)

	100% after deductible	70% after deductible
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Home Health Care, Ambulance, Durable

	100% after deductible	70% after deductible
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Medical Equipment and Hospice

Maternity

Maternity Delivery includes Prenatal and Post-delivery care

Hospital Services (Delivery)

	100% after deductible	70% after deductible
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Professional Services (Delivery)

	100% after deductible	70% after deductible
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Transplants

Hospital Services

	100% after deductible	70% after deductible
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Professional Services

	100% after deductible	70% after deductible
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Blue Options HSASM Benefit Highlights (PLAN C)

Mental Health and Substance Abuse Services

**Inpatient/Outpatient Certification is required.
Call Magellan Behavioral Health at 1-800-359-2422.*

Mental Health Services

Office (30 visits per Benefit Period)
Inpatient/Outpatient (30 Days per Benefit Period)

Certified*

100% after deductible
100% after deductible

Not-Certified²

70% after deductible
70% after deductible

Substance Abuse Services

Office Visit
Inpatient/Outpatient

100% after deductible
100% after deductible

70% after deductible
70% after deductible

Benefit Period Maximum \$8,000
Lifetime Maximum \$16,000

Prescription Drugs

MAC B Pricing, Open Formulary

100% after deductible

100% after deductible

¹NOTICE: If you selected Employee Coverage, the Employee Coverage deductible and total out of pocket maximum will apply; if you selected Family Coverage the Family Coverage deductible and total out of pocket maximum will apply.

²NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage amount because actual provider charges may not be used to determine the payment obligations for BCBSNC and its members.

BLUE OPTIONS HSA-PLAN

You have an opportunity to enroll in a High Deductible PPO Health Plan and establish a Health Savings Account (HSA) with Mellon HSA. Unlike a Health Care Flexible Spending Account, once you set-up an HSA account you can start, stop or change your contribution amounts at any time and your account balance will rollover from year to year with no "use it or lose it" penalty. In addition, Carteret General Hospital will contribute an amount biweekly to your account. This account is yours to keep after you retire or separate employment. The information below is a short summary of the information you'll need to make a decision about enrolling in an HSA.

Who is Eligible to Enroll in an HSA?

In order to be eligible to establish and contribute to an HSA you must meet three conditions:

- You must enroll in an HSA compatible high deductible health plan.
- Have no other first-dollar medical coverage (other types of insurance like specific injury insurance or accident, disability, dental care, vision care, or long-term care insurance are permitted).
- If over 65, you must waive enrollment in Medicare A, B & D
- You cannot be claimed as a dependant on another person's tax return (does not apply to joint filing of taxes)

What is a Health Savings Account?

An HSA allows individuals to pay for qualified health expenses and save for future medical and retiree health expenses on a tax-free basis. An HSA is similar to an Individual Retirement Account (IRA), often referred to as a medical IRA. Like an IRA, an HSA is for the benefit of the individual employee, is owned by you and is "portable," so if you leave employment, your HSA stays with you. Mellon HSA is the HSA administrator that the hospital works with to administer your account under your direction. The ACS|Mellon HSA Solution begins with an FDIC insured, interest-bearing checking account where all HSA deposits are first credited. No minimum balance is required to open and maintain the ACS|Mellon HSA checking account. Once an HSA checking account balance reaches \$1,500, an account holder can set up an ACS|Mellon HSA Investment Account and begin to diversify accumulated HSA savings into a wide selection of mutual funds. HSA account holders are able to transfer funds back and forth between their ACS|Mellon HSA checking account and their ACS|Mellon HSA Investment Account online and at any time!

Why Do I Need to Enroll in a High Deductible Health Plan?

The IRS requires that anyone who establishes an HSA to be covered by an HSA compatible, high deductible health plan that meets IRS requirements. Carteret General Hospital offers the Blue Options HSA which satisfies the IRS rules. **The main features of this plan are:**

- A deductible of \$2,000 per individual or \$4,000 per family—deductible applies to both covered medical and prescription drug expenses
 - **What is a deductible?** It is a set dollar amount that you must pay, out-of-pocket or from your HSA account, before insurance coverage for medical expenses can begin.
- Preventative Services covered at 100% (preventative diagnosis only)
- Once the deductible is met, any additional covered services including prescription drugs, are paid at 100%

Blue Options HSA has two parts: a high-deductible health plan (HDHP) and a health savings account (HSA) for medical expenses.¹

Here's how it works:

The health plan – You pay 100 percent of all your medical expenses until you meet your deductible. This includes visits to your primary care provider, hospital stays and prescription drugs.² After you've met your deductible, covered services are covered at 100%.³

Preventive care – You're covered for certain preventive care services, like annual routine physical exams, even before you've met your deductible.⁴

+ The HSA – You can use the money in your HSA to pay for qualified medical expenses.² so, even though you are paying for 100% of the cost of services, the money can come out of your HSA. And, all of this is tax-free.

Using your HSA checkbook and debit card – You can pay for medical expenses at the doctor or pharmacy using the HSA checkbook or debit card that you'll receive in the mail.

Contributing to your HSA – Anyone can contribute to your HSA account, including your employer, your family members and you.

Using your HSA long term – Your HSA rolls over from year to year. It also goes with you from job to job and can be used after you retire.

It's all tax-free! – And, the money in your HSA account is "triple tax-free." It goes into the account tax-free, earns interest tax-free, and it can be used for qualified medical expenses tax-free.⁵

¹ Blue Options HSA combines a high-deductible health plan and a health savings account (HSA). BCBSNC does not administer your HSA and is not affiliated with your HSA custodian or administrator.

² A full list of qualified medical expenses can be found in IRS publication 502, available at irs.gov.

³ Employees who receive covered services out-of-network may be required to pay the difference between the provider's actual charge and the BCBSNC allowed amount, in addition to the coinsurance amount.

⁴ Includes in-network annual routine physical exam, well-baby and well-child care and certain immunizations and screenings. Other covered services may be subject to deductible and coinsurance.

⁵ Withdrawals are tax-free only if used for qualified medical expenses. See irs.gov for specific regulations

Medical Opt-Out (Plan D) Bonus:

For those employees who have other health insurance coverage available to them, you may decline coverage for the hospital health insurance and receive free dental insurance for yourself and your dependents.

If you would like to receive the Opt-Out Bonus Dental, please submit proof of other health insurance with your enrollment.

Dental Benefit Highlights - CIGNA

Dental Services¹

Diagnostic & Preventive Care	100%
Basic Restorative Care (includes Endodontics)	80% after Dental deductible
Major Restorative Care (includes Periodontics)	50% after Dental deductible
Individual Dental Deductible (per Benefit Period)	\$25
Family Dental Deductible (per Benefit Period)	\$75
Combined Benefit Period Maximum (includes Diagnostic and Preventive, Basic and Major Restorative Care)	\$1,200

Cigna Dental

- ***There will be a 6 month waiting period for Major Services***

Dental Insurance Bi-Weekly (pre-tax) Premium

Employee	\$11.67
Employee + Spouse	\$26.26
Employee + Children	\$20.00
Employee + Family	\$36.46

Pre-existing conditions:

You and your dependents over the age of 19 may have to satisfy a waiting period for pre-existing conditions under the Plan. Any waiting period for pre-existing conditions begins on the enrollment date. For purposes of a pre-existing condition waiting period, the enrollment date is the first day of coverage under the Plan or the first day of any probationary period, whichever is earlier.

During a waiting period for pre-existing conditions neither you nor your dependents (over the age of 19) will receive benefits for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months immediately preceding the enrollment date. However, provided there was no significant break in coverage, a waiting period for pre-existing conditions will not apply to any condition first identified, treated and covered under prior creditable coverage. Medical records may be ordered to make these determinations. The waiting period for pre-existing conditions will be reduced by the number of days you or your dependents had prior creditable coverage, so long as there was no significant break in coverage.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS FROM BCBSNC

Benefit Period

The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Allowed Amount

The charge that BCBSNC determines using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.

Coinsurance Maximum

The dollar amount of coinsurance a member must pay prior to BCBSNC paying 100% for certain services. NOTE: In some plans, there is no coinsurance maximum; members are responsible for coinsurance once the deductible has been met.

Day and Visit Maximums

All day and visit maximums are on a combined In- and Out-of Network basis.

Utilization Management

To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review. If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

Certification

Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner. If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by BCBSNC, if medically necessary.

All inpatient and outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network provider. Obtaining certification for Mental Health and Substance Abuse services is the member's responsibility.

Failure to obtain certification for Mental Health and Substance Abuse services will result in these services being paid at the out-of-network benefit level.

Medical and Prescription Drug Plan Blue OptionsSM Benefit Highlights (PPO)

Health and Wellness Program

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of HealthLine Blue, our 24-hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also receive Active Blue, our health magazine, and have access to online health and wellness information at www.bcbsnc.com. With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

What is Not Covered?

- The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.
- Your health benefit plan does not cover services, supplies, drugs or charges that are:
 - Not medically necessary
 - For injury or illness resulting from an act of war
 - For personal hygiene and convenience items
 - For inpatient admissions that are primarily for diagnostic studies
 - For palliative or cosmetic foot care
 - For investigative or experimental purposes
 - For hearing aids or tinnitus maskers
 - For cosmetic services or cosmetic surgery
 - For custodial care, domiciliary care or rest cures
 - For reversal of sterilization
 - For treatment of sexual dysfunction not related to organic disease
 - For conception by artificial means
 - For self-injectable drugs in the provider's office

A waiting period for coverage of pre-existing conditions may apply to your coverage. BCBSNC defines pre-existing conditions as those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your [BCBSNC] coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage. The benefit highlights is a summary of Blue Options benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from BCBSNC Customer Services.

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Women's Health and Cancer Rights Act

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option.

Following cancer surgery, the plan covers:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and Reconstruction of the other breast to achieve a symmetrical appearance.
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Note: Reconstructive surgery requires prior approval, and all inpatient admissions require prior notification.

For more information please refer to your summary plan description.

BASIC LIFE INSURANCE

Life

Equal to 1 times the Employee's Basic Annual Earnings rounded to the next higher \$1,000, if not already a multiple of \$1,000

Accidental Death & Dismemberment

An amount equal to the Employee's amount of Basic Life Insurance in force

The **Basic Maximum Benefit** is \$200,000.

The **Waiting Period** for Basic Life and AD&D is the first of the month following 90 days.

OPTIONAL LIFE INSURANCE

Life

An Employee may elect an amount of Optional Life Insurance in \$10,000 increments up to 5 times their salary.

To calculate your Bi-weekly cost, please see page 15 for rates.

Accidental Death & Dismemberment

An amount equal to the Employee's amount of Optional Life Insurance in force

The **Optional Maximum Benefit** is the lesser of:

- \$500,000; or
- 5 times the Employee's Basic Annual Earnings.

The **Guaranteed Issue Amounts** for Optional Life Insurance is \$150,000

The **Waiting Period** for Optional Life and AD&D is the first of the month following 90 days.

An Employee's amount of Basic and Optional Life and Accidental Death and Dismemberment Insurance shown in the Schedule will reduce to 50% when he attains age 70.

An Employee's Basic and Optional Life and Accidental Death and Dismemberment Insurance will terminate at the Employee's retirement.

Evidence of Insurability, satisfactory to UNUM, will be required for any of the following reasons:

- an Employee who, on his initial Eligibility Date, elects Basic Life Insurance only and subsequently elects Optional Life Insurance; or
- an Employee who elects an increase in his amount of Optional Life Insurance; or
- an Employee whose amount of Life Insurance is in excess of the Guaranteed Issue Amount.

DEPENDENT OPTIONAL LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

CLASSIFICATION

All Eligible Employees enrolled in Employee Optional Life Insurance

Spouse **

An Employee may elect an amount of Dependent Spouse Optional Life Insurance in \$10,000 increments

Child under age 19

An Employee may elect one of the following options:

Option I \$5,000* Option II \$10,000*

The Dependent Spouse **Optional Maximum Benefit** is \$250,000

(The amount of Dependent Optional Life Insurance cannot exceed 50% of the Employee's total amount of Basic and Optional Life Insurance combined)

The Employee's Dependent Spouse is insured for an amount of Dependent Spouse Optional Accidental Death and Dismemberment Insurance that equals the Dependent Spouse's amount of Optional Life Insurance in force.

* the amount of Dependent Optional Life Insurance for a child under 14 days is None.

* the amount of Dependent Optional Life Insurance for a child age 14 days but under 6 months is \$1,000.

** to age 25 if the Employee's child is an enrolled full-time student and depends on the Employee for 50% or more of his support.

The **Guaranteed Issue Amount** for Dependent Spouse Optional Life Insurance is \$50,000.

An Employee's amount of Dependent Spouse Optional Life and Accidental Death and Dismemberment Insurance shown in the schedule will reduce to 50% when the Dependent Spouse attains age 70.

Evidence of Insurability, satisfactory to UNUM will be required for an Employee's Dependent for any of the following reasons:

- an Employee who, on his initial Eligibility Date, elects no Dependent Life coverage and subsequently elects Dependent Optional Life Insurance; or
- an Employee who elects Employee Basic Life Insurance only and subsequently elects Employee Optional Life Insurance and Dependent Optional Life Insurance; or
- an Employee who elects an amount of Life Insurance for a Dependent in excess of the Guaranteed Issue Amount; or
- an Employee who elects an increase in his amount of Dependent Optional Life Insurance.

Age	10,000	20,000	30,000	40,000	50,000	60,000	70,000	80,000	90,000	100,000
0-29	0.25	0.51	0.76	1.02	1.27	1.52	1.78	2.03	2.28	2.54
30-34	0.25	0.51	0.76	1.02	1.27	1.52	1.78	2.03	2.28	2.54
35-39	0.33	0.66	0.98	1.31	1.64	1.97	2.29	2.62	2.95	3.28
40-44	0.51	1.02	1.54	2.05	2.56	3.07	3.59	4.10	4.61	5.12
45-49	0.81	1.62	2.42	3.23	4.04	4.85	5.65	6.46	7.27	8.08
50-54	1.18	2.35	3.53	4.71	5.88	7.06	8.24	9.42	10.59	11.77
55-59	1.58	3.17	4.75	6.33	7.92	9.50	11.08	12.66	14.25	15.83
60-64	2.76	5.53	8.29	11.06	13.82	16.59	19.35	22.12	24.88	27.65
65-69	4.87	9.74	14.61	19.48	24.35	29.22	34.08	38.95	43.82	48.69
70-74	6.90	13.80	20.70	27.60	34.50	41.40	48.30	55.20	62.10	69.00
75+	14.80	29.60	44.40	59.21	74.01	88.81	103.61	118.41	133.21	148.02
Age	110,000	120,000	130,000	140,000	150,000	160,000	170,000	180,000	190,000	200,000
0-29	2.79	3.05	3.30	3.55	3.81	4.06	4.32	4.57	4.82	5.08
30-34	2.79	3.05	3.30	3.55	3.81	4.06	4.32	4.57	4.82	5.08
35-39	3.60	3.93	4.26	4.59	4.92	5.24	5.57	5.90	6.23	6.55
40-44	5.64	6.15	6.66	7.17	7.68	8.20	8.71	9.22	9.73	10.25
45-49	8.88	9.69	10.50	11.31	12.12	12.92	13.73	14.54	15.35	16.15
50-54	12.95	14.12	15.30	16.48	17.65	18.83	20.01	21.18	22.36	23.54
55-59	17.41	19.00	20.58	22.16	23.75	25.33	26.91	28.50	30.08	31.66
60-64	30.41	33.18	35.94	38.70	41.47	44.23	47.00	49.76	52.53	55.29
65-69	53.56	58.43	63.30	68.17	73.04	77.91	82.78	87.65	92.52	97.38
70-74	94.94	103.57	112.20	120.83	129.46	138.09	146.72	155.35	163.98	172.62
75-99	162.82	177.62	192.42	207.22	222.02	236.82	251.63	266.43	281.23	296.03
Age	210,000	220,000	230,000	240,000	250,000	260,000	270,000	280,000	290,000	300,000
0-29	5.33	5.58	5.84	6.09	6.35	6.60	6.85	7.11	7.36	7.62
30-34	5.33	5.58	5.84	6.09	6.35	6.60	6.85	7.11	7.36	7.62
35-39	6.88	7.21	7.54	7.86	8.19	8.52	8.85	9.18	9.50	9.83
40-44	10.76	11.27	11.78	12.30	12.81	13.32	13.83	14.34	14.86	15.37
45-49	16.96	17.77	18.58	19.38	20.19	21.00	21.81	22.62	23.42	24.23
50-54	24.72	25.89	27.07	28.25	29.42	30.60	31.78	32.95	34.13	35.31
55-59	33.24	34.83	36.41	37.99	39.58	41.16	42.74	44.33	45.91	47.49
60-64	58.06	60.82	63.59	66.35	69.12	71.88	74.64	77.41	80.17	82.94
65-69	102.25	107.12	111.99	116.86	121.73	126.60	131.47	136.34	141.21	146.08
70-74	144.90	151.80	158.70	165.60	172.50	179.40	186.30	193.20	200.10	207.00
75-99	310.83	325.63	340.44	355.24	370.04	384.84	399.64	414.44	429.24	444.05
Age	310,000	320,000	330,000	340,000	350,000	360,000	370,000	380,000	390,000	400,000
0-29	7.87	8.12	8.38	8.63	8.88	9.14	9.39	9.65	9.90	10.15
30-34	7.87	8.12	8.38	8.63	8.88	9.14	9.39	9.65	9.90	10.15
35-39	10.16	10.49	10.81	11.14	11.47	11.80	12.12	12.45	12.78	13.11
40-44	15.88	16.39	16.91	17.42	17.93	18.44	18.96	19.47	19.98	20.49
45-49	25.04	25.85	26.65	27.46	28.27	29.08	29.88	30.69	31.50	32.31
50-54	36.48	37.66	38.84	40.02	41.19	42.37	43.55	44.72	45.90	47.08
55-59	49.08	50.66	52.24	53.82	55.41	56.99	58.57	60.16	61.74	63.32
60-64	85.70	88.47	91.23	94.00	96.76	99.53	102.29	105.06	107.82	110.58
65-69	150.95	155.82	160.68	165.55	170.42	175.29	180.16	185.03	189.90	194.77
70-74	213.90	220.80	227.70	234.60	241.50	248.40	255.30	262.20	269.10	276.00
75-99	458.85	473.65	488.45	503.25	518.05	532.86	547.66	562.46	577.26	592.06
Age	410,000	420,000	430,000	440,000	450,000	460,000	470,000	480,000	490,000	500,000
0-29	10.41	10.66	10.92	11.17	11.42	11.68	11.93	12.18	12.44	12.69
30-34	10.41	10.66	10.92	11.17	11.42	11.68	11.93	12.18	12.44	12.69
35-39	13.44	13.76	14.09	14.42	14.75	15.07	15.40	15.73	16.06	16.38
40-44	21.00	21.52	22.03	22.54	23.05	23.57	24.08	24.59	25.10	25.62
45-49	33.12	33.92	34.73	35.54	36.35	37.15	37.96	38.77	39.58	40.38
50-54	48.25	49.43	50.61	51.78	52.96	54.14	55.32	56.49	57.67	58.85
55-59	64.91	66.49	68.07	69.66	71.24	72.82	74.40	75.99	77.57	79.15
60-64	113.35	116.11	118.88	121.64	124.41	127.17	129.94	132.70	135.47	138.23
65-69	199.64	204.51	209.38	214.25	219.12	223.98	228.85	233.72	238.59	243.46
70-74	282.90	289.80	296.70	303.60	310.50	317.40	324.30	331.20	338.10	345.00
75-99	606.86	621.66	636.47	651.27	666.07	680.87	695.67	710.47	725.28	740.08

Dependent Child Rates: .46 for 5,000 OR .92 for 10,000 in coverage

LONG TERM DISABILITY INCOME INSURANCE

CLASSIFICATION

- 1 - Managers, Physicians, Pharmacists and Certified Registered Nurse Anesthetist
- 2 - All Other Full-Time Employees

Class 1

- a. The **Benefit Percentage** is: 60% of Total Monthly Earnings.
- b. The **Maximum Monthly Benefit** is: \$9,000.

Class 2

- a. The **Benefit Percentage** is: 60% of Total Monthly Earnings.
- b. The **Maximum Monthly Benefit** is: \$6,000.

The **Minimum Monthly Benefit** is \$100 or 10% of the Gross Monthly Benefit, whichever is greater.

Elimination Period

Class 1	Class 2
90 days	180 days

Waiting Period

180 days – All eligible employees regularly scheduled to work 20 hours a week will be automatically enrolled in the Long Term Disability Policy after 180 days of eligible employment.

Flexible Spending Account

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

Essentially, the Internal Revenue Service set up FSAs as a means to provide a tax break to employees and their employers. As an employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to Social Security (FICA), federal, state, or local income taxes — effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each year can be reduced significantly, depending on your tax bracket. And, as a result of the personal tax savings you realize, your spendable income will increase.

Health Care Reimbursement FSA

The Health Care Reimbursement FSA lets you pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. For example, cash that you now spend on deductibles, copayments, or other out-of-pocket medical expenses can instead be placed in the Health Care Reimbursement FSA pre-tax, to pay for these expenses. The annual maximum contribution to the Health Care Reimbursement FSA is **\$3,000**.

Eligible Expenses

Eligible health care expenses for the Health Care Reimbursement FSA include more than just your deductible and copayments. Generally, any medically necessary health care expense that you can deduct on your tax return is considered an eligible expense. Some examples include:

- ✓ Hearing services, including hearing aids
- ✓ Vision services, including contact lenses, eye examinations, and eyeglasses
- ✓ Dental services and orthodontia
- ✓ Chiropractic services
- ✓ Acupuncture
- ✓ Prescription contraceptives
- ✓ Over-the-counter (OTC) drugs and medicines purchased to treat an illness with prescription

For more information about eligible medical expenses, please refer to the attached list of example eligible and ineligible expenses, or refer to *IRS Publication 502, Medical and Dental Expenses*. available at <http://www.irs.gov/pub/irs-pdf/p502.pdf>

Flexible Spending Accounts - Cont.

Dependent Care FSA

The Dependent Care FSA lets you use pre-tax dollars towards qualified dependent care. The annual maximum amount you may contribute to the Dependent Care FSA is **\$5,000** (or \$2,500 if married and filing separately) per calendar year.

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

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

Eligible Expenses

In order for dependent care services to be eligible, they must be for the care of a tax dependent child under age 13 who lives with you, or a tax dependent parent, spouse, or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours — Saturday night babysitting does not qualify — and cannot be provided by another of your dependents.

Important: Use it or Lose It Rules Have Changed!

If you decide to contribute to the Health Care Reimbursement FSA or the Dependent Care FSA, you must carefully determine your annual election amount and your spending during the plan year. According to IRS regulations, the money you set aside must be used for expenses incurred during the plan year (October 1 to September 30) in which you make the election. If you have any funds left in the account at the end of the year, you will be able to get services between October 1, 2010 and December 15, 2011. If you do not utilize services during this extended time you will forfeit your balance.

You will receive regular statements that will help you track the dollars you have left in your accounts. You have until December 31, 2011 to submit any claims for expenses incurred during 2010-2011

Voluntary Supplemental Insurance



ACCIDENT INSURANCE COVERAGE BI-WEEKLY RATES (pre-tax):

Individual:	\$ 13.32
Emp & Spouse:	\$ 17.46
Single parent family:	\$ 19.56
Full Family:	\$ 24.36

Aflac pays cash benefits when qualified accidents result in:

Admission to a hospital * Dislocations, fractures, eye injuries, broken teeth, paralysis, burns, lacerations, concussions and others * Emergency transportation in an ambulance * Family lodging for a member of the immediate family * Emergency treatment in a hospital emergency room or even a physician's office * Confinement in an intensive care unit * Physical Therapy * Others

MAXIMUM DIFFERENCE CANCER PLAN COVERAGE BI-WEEKLY RATES (pre-tax):

Aflac's cancer policy will pay cash benefits to you for such things as cancer treatments, hospitalization, surgery & anesthesia, skin cancer, nursing homes, nursing care, home health, ambulance, travel expenses, hotel stays, wigs and so much more. With the current cost of health care, most families would not be without basic personal medical insurance. However, even the best medical plan will not cover 100% of your cost. The majority of cancer costs come from out-of-pocket expenses normally not covered by major medical insurance. Aflac's policies pay benefits directly to you regardless of any other insurance you may have.

Age	Individual	Husband/wife	
18-35	\$ 7.44	\$ 13.80	
36-45	\$ 10.80	\$ 19.44	Children are always covered
46-55	\$ 15.24	\$ 28.50	FREE on this policy
56-64	\$ 20.10	\$ 39.54	

Optional Riders:

First Occurrence:	\$2,500	Wellness benefit:	\$50
	\$5,000		\$75
	\$7,000		\$100
	\$10,000		\$125

Voluntary Supplemental Insurance – Cont.



Short-Term Disability

Help protect your finances with Unum's individual short term disability insurance. Individual short term disability is offered to all eligible employees ages 17 to 69 who are actively at work. You decide if it's right for you.

Critical Illness

Can your wallet survive a serious illness? The answer can be "yes" with specified critical illness insurance from Unum. Critical Illness insurance is offered to all employees age 16 to 69 who are actively at work. Choose the benefit amount that's right for you – from \$5,000 to \$50,000 in \$1,000 increments.

Vision Insurance

Community Eye Care

One routine eye examination annually
A \$150 allowance for eyewear annually
A contact lens fitting, as needed



Vision Insurance Premium

Same for Full and Part Time

Bi-Weekly Premium – (pre-tax)

Employee	\$	5.62
Employee + One	\$	10.90
Employee + Family	\$	16.04

Retirement Savings Account

Carteret General Hospital Money Purchase Pension Plan

The Money Purchase Pension Plan is a defined contribution plan, which guarantees a specified contribution each year you are eligible. Presently, the hospital contributes 4% of your earnings to this account. The plan year is October 1 to September 30 each year. In order to receive a year of creditable service you must work at least 1000 hours. In order to receive the 4% contribution you must be an active employee during the entire Plan Year. In order to be vested, which means you own the contributions; you must have 5 years of creditable service for contributions made prior to 2008 and 3 years of creditable services for contribution made in 2008 and thereafter. You may obtain a summary plan description from the Human Resources Department or download a copy for the CGH Website at www.ccgh.org.

Carteret General Hospital 403(b) Retirement Savings Plan

The Carteret General Hospital 403(b) Savings Plan is a special type of retirement plan qualified under Internal Revenue Code §403(b) which is designed to provide employees with retirement benefits on a tax-deferred basis. The Plan allows you, as an employee, to save for retirement without incurring any tax liability until you withdraw amounts from the Plan. You are entitled to withdraw amounts from the Plan upon your retirement or termination of employment.

You may elect to have your compensation reduced by a specific percentage or dollar amount, and have that amount contributed to the Plan as a Salary Deferral.

Beginning October 1, 2009, when benefited employees contribute to the 403(b) plan, Carteret General Hospital will begin matching \$1.00 for every \$1.00 of your base pay that you contribute up to the first 2%. It is important to note that the match will be made on your own pre-tax elective deferrals and not any Roth contributions.

Your matching contributions will be invested in the same manner as your elective contributions. If you would like to invest them differently, simply access Prudential Retirement's Online Retirement Center at www.prudential.com/online/retirement or the Interactive Voice Response (IVR) system by calling toll-free, 877-PRU-2100, 24 hours a day, 7 days a week. Participant Service representatives are also available Monday through Friday from 8 a.m. to 9 p.m. ET.

Vesting

Vesting refers to the ownership of the money that is in your account. The following table illustrates the vesting schedule for the new employer matching contributions.

Years of Service	Percentage Vested
1 year	0%
2 years	0%
3 years	100%

You are always 100% vested in your own contributions.

Retirement Savings Account

The IRS imposes a limit on the maximum amount you may contribute as Salary Deferrals during any calendar year. For the 2010 calendar year, the maximum amount you can contribute as Salary Deferrals is \$16,500.

If you are at least 50 years old at any time during the calendar year, you may contribute an additional amount to the Plan as a “catch-up contribution.” A catch-up contribution is an additional Salary Deferral that may be made above the IRS limit for the year. For the 2010 calendar year, the maximum catch-up contribution you may make to the Plan is \$5,500.

You will be automatically enrolled in the 403(b) plan at a rate of 1% of your gross salary within 30 days of your first pay period, (please see the instructions for declining automatic enrollment if you are not interested in participating).

Once you are enrolled, contribution accelerator will increase your savings by 1% each year until you have reached a contribution rate of 8%.

Carteret General Hospital 403(b) Savings Plan

Instructions for Declining Automatic Enrollment Automatic Enrollment with Contribution Accelerator

- The Carteret General Hospital 403(b) Savings Plan offers Automatic Enrollment. This means that if you do not actively decline enrollment in the Plan, you will be automatically enrolled.
- Beginning October 1, 2008, if you are automatically enrolled, you will be enrolled at a deferral rate of 1.0% and in a Moderate GoalMaker®1 With Age Migration Portfolio. (This will also apply if you have an existing account with Prudential Retirement and are re-hired by Carteret General Hospital).
- You may enroll in the plan at anytime.

To decline enrollment, visit www.prudential.com/online/retirement and click “First Time Logging In?”

- Enter the requested information on the next screen. Please note that your account number is your Social Security number. Click “*Submit*.”
- On the next screen, click the “*Auto-Enrolled*” link under the blue “Retirement Planning” button.
- Click the “Decline your Auto Enrollment” link.
- Input your email address and select “Decline my Auto-Enrollment.”
- A verification screen will confirm that you have successfully declined enrollment.

Remember, you may also call Prudential at 800-458-6333 to decline enrollment. Representatives are available to assist you Monday through Friday from 8 a.m. to 9 p.m. ET.

1 Keep in mind that application of asset allocation and diversification concepts does not ensure safety of investments. **It is possible to lose money by investing in securities.**

Securities products and services are offered by Prudential Investment Management Services LLC (PIMS), Three Gateway Center, 14th Floor, Newark, NJ 07102-4077. PIMS is a Prudential Financial company.

Insurance products and services are provided by Prudential Retirement Insurance and Annuity Company, Hartford, CT, or its affiliates.

GoalMaker's model allocations are based on generally accepted financial theories that take into account the historic returns of different asset classes. But, of course, past performance of any investment does not guarantee future results. Prudential Financial encourages participants to consider their other assets, income, and investments when enrolling in the GoalMaker program. We also recommend participants periodically reassess their GoalMaker investments to make sure their model portfolio continues to correspond to their changing attitudes and retirement time horizon.

Prudential Retirement, Prudential Financial, PRU, Prudential and the Rock Logo are registered service marks of The Prudential Insurance Company of America, Newark, NJ and its affiliates. Prudential Retirement is a Prudential Financial business.

Paid Time Off

Paid Time Off (PTO) is a flexible time off plan for eligible employees to use for vacation, holidays, personal illness or injury, and personal or family matters. It combines traditional vacation and sick leave plans into one flexible, paid time off policy. In addition to the PTO bank, time may be transferred to your Catastrophic Sick Bank. Time off earned but not used may be carried over to the following year in amounts based on years of service. In addition, employees may build a Catastrophic Sick Bank of up to 360 hours by transferring a portion (up to 80 hours each year) of earned PTO hours into a Catastrophic Sick Bank. Time accumulated in the Catastrophic Sick Bank is for use only in the event of extended personal illness or injury and may not be used for a family member's illness. When the maximum of 480 hours has been reached in the Paid Time Off Bank, additional PTO hours will not accrue until the balance drops beneath the maximum.

Eligibility

Employees in the following employment classification(s) are eligible to earn and use PTO as described in this policy:

- Regular full time employees
- Regular part time employees with benefits

Part time employees budgeted less than 20 hours per week, PRN, temporary and contract employees are not eligible for PTO.

Employees earn PTO based on their length of service with Carteret General Hospital and their job classification and can request use of PTO *after* it is earned.

Requesting Paid Time Off

To schedule planned PTO, employees should request advance approval from their Managers. Requests will be considered based on departmental needs and staffing requirements. Emergencies and personal situations will be taken into consideration. Departmental policies for requesting time off will apply. **PTO must be used for all approved absences and requested time off.** All accrued PTO is available for use for approved absences. Employees may opt to use or not use PTO if they are on call due to reduced census. PTO will not be used in any week in which overtime is earned.

Employees may not take time off without pay unless the Department closes for a designated holiday, reduced census or there are other catastrophic circumstances and management approves time off. If an employee does not have PTO accrued, requests for time off will be denied, unless the request is covered under the Family Medical Leave Act of 1993.

PTO is accrued based on hours paid per pay period up to a maximum of 80 hours per pay period. PTO will not accrue on hours worked over 80 hours. When the maximum of 480 hours has been reached in the Paid Time Off Bank, additional PTO hours will not accrue until the balance drops beneath the maximum.

Paid Time Off – Cont.

The length of eligible service is calculated on the basis of a “benefit year”. This is the 12-month period that begins when the employee starts to earn PTO. An employee’s benefit year may be extended for any significant leave of absence except military leaves of absence, which has no effect on this calculation. (See appropriate policy) PTO is paid at the employee’s base pay rate at the time of absence. It does not include overtime or any special forms of compensation such as certification pay or shift differentials.

The amount of PTO employees receive each year increases with the length of their employment as shown in the following table:

Status	Years of Service Completed	PTO Hours Earned Bi-Weekly for 80 HRS	PTO Days Earned Per Year	Maximum Carry-Over (as of last payday in September)
Full-time	1-12 Months	6.15 or .076 per hour	20	120 hours
	1-3 years	7.07 or .088 per hour	23	200 hours
	4-9 years	8.62 or .107 per hour	28	300 hours
	10-14 years	9.23 or .115 per hour	30	380 hours
	15 or more years	10.15 or .126 per hour	33	480 hours
Part Time (40 hr. example)	1-12 Months	6.15 or .076 per hour	10	60 hours
	1-3 years	7.07 or .088 per hour	11.5	100 hours
	4-9 years	8.62 or .107 per hour	14	150 hours
	10-14 years	9.23 or .115 per hour	15	190 hours
	15 or more years	10.15 or .126 per hour	16.5	240 hours

New managers earn PTO beginning at the 4 – 9 year level of 28 PTO days per year.

PTO Carry-Over

In the event that available PTO is not used by the end of the fiscal year (September 30), employees may carry unused time forward to the next benefit year in amounts based on years of service (see table above). Unused PTO that exceeds the max annual carryover amount as of September 30 will be deleted the first payday in October. The maximum amount of PTO any individual may accrue is 480 hours. Accrual will stop when this limit is reached. PTO may be transferred to the Catastrophic Sick Bank, up to 360 hours.

Catastrophic Sick Bank

Employees may build a Catastrophic Sick Bank of up to 360 hours by transferring a portion (up to 80 hours each year) of earned PTO hours into their Catastrophic Sick Bank. PTO may be transferred to Catastrophic Sick Bank twice each year at the pay periods designated for PTO buybacks. Time accumulated in the Catastrophic Sick Bank is for use only in the event of extended personal illness or injury and may not be used for a family member’s illness. If available, Catastrophic Sick time must be used when an employee is absent due to personal illness for over 40 hours. PTO time must be used for the first 40 hours of absence.

No Advances

Generally, no PTO may be used before it is earned, except in cases of emergency, extenuating circumstances with management approval or recognized holidays.

Buy Back

Twice a year employees may “buy back” PTO that has accrued but has not been used. The amount of buy back allowed is based on years of service. See the table below. Employees may buy back PTO down to a minimum balance of 80 hours in the PTO bank for Full-time employees and 40 hours for Part-time employees. Buy back requests must be submitted by 5:00 pm on the 15th of April and by 5:00 pm on the 15th of September. Payment of those buy backs will be processed and received the second pay periods in May and October. PTO “buy backs” will not be processed after a resignation has been submitted. **The PTO buy back benefit is subject to change at any time including limiting of hours that may be bought and frequency of buy backs.**

Paid Time Off – Cont.

PTO Buy Back

Years of Service	Full Time	Part Time
0 – 9 years	80 HRS/Year	40 HRS/Year
10 – 14 years	100 HRS/Year	50 HRS/Year
15+ years	120 HRS/Year	60 HRS/Year

Transfers

Employees may choose to transfer PTO to another employee who has been employed for more than 6 months of service and has a significant need as approved by VP of Human Resources. Request forms must be submitted to Human Resources by 5:00 p.m. on the Friday before payroll Monday. The transfer may not reduce the donor employee's balance below 80 hours. Catastrophic sick time may not be transferred. The hours transferred will not be included when calculating maximum PTO buy backs per year.

Holidays

In the past, Carteret General Hospital has observed seven holidays. Under the PTO program, holidays are included in the paid time off allowance. When an employee's department closes for a holiday and the employee is not scheduled to work, the employee may take PTO or take time off without pay.

Bereavement Leave/Jury Duty

Bereavement leave and jury duty are not included in PTO and will be administered under applicable Personnel policies. (See appropriate policy)

Worker's Compensation

When an employee is absent due to a work related injury, Worker's Compensation does not pay for the first seven days of absence. The employee may use PTO if they wish. If the absence continues past seven days, Worker's Compensation begins to cover lost pay, and the employee may use enough PTO to cover the cost of insurance and lost wages.

Payment of Catastrophic Leave at Retirement

If an employee has 10-24 years of service and is 59, 50% of the hours remaining in the Catastrophic Sick Bank are eligible for reimbursement upon retirement. If an employee has 25+ years of service, 100% of the catastrophic hours are eligible for reimbursement.

Resignation/Termination/Retirement Payment of PTO

Employees who have completed four or more years of service and who give and work the required resignation notice period will be paid for all unused PTO earned through the last day of work.

Employees in the first four years of employment who give and work the required resignation notice period will be paid for 75% of all PTO time. Any hours remaining in the Catastrophic Sick Bank are not eligible for reimbursement upon termination or resignation.

Employees who do not give and work proper notice will not be paid PTO time. Employees who terminate employment before completing six months of employment are not eligible for payment of their accrued PTO hours. Employees who are terminated for cause are not eligible for payment of PTO. PTO may not be bought back or transferred after a resignation has been submitted. Waiting Period

All eligible employees begin to earn PTO from the first day of employment; however, employees are generally not allowed to take PTO during the first six months of employment, except for recognized holidays (New Years, Easter, Memorial Day, Fourth of July, Labor Day, Thanksgiving and Christmas) or circumstances approved by the Manager and the VP of Human Resources.

INITIAL COBRA NOTICE

This notice is intended to summarize your rights and obligations under the group health continuation coverage provision of COBRA. You and your spouse should take the time to read this notice carefully. Should you qualify for COBRA coverage in the future, the group health plan administrator or plan sponsor will send you the appropriate notification.

Federal law requires Carteret General Hospital to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

TO QUALIFY FOR COBRA COVERAGE

Employees. As an employee of Carteret General Hospital covered by BlueCross BlueShield of North Carolina, you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Retirees. As a retiree, spouse of a retiree, or dependent child of a retiree, of Carteret General Hospital covered by BlueCross BlueShield of North Carolina you have the right to elect this continuation coverage if you lose your group health coverage because Carteret General Hospital declares Chapter 11 bankruptcy and you lose your group health care coverage within one year before or after the bankruptcy proceedings.

Spouses. As the spouse of an employee covered by BlueCross BlueShield of North Carolina, you have the right to choose continuation coverage for yourself if you lose group health coverage under BlueCross BlueShield of North Carolina for any of the following reasons:

- The death of your spouse who was an employee of Carteret General Hospital
- A termination of your spouse's employment (for reasons other than gross misconduct)
- A reduction in your spouse's hours of employment
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare

Dependent Children. In the case of a dependent child of an employee covered by BlueCross BlueShield of North Carolina, he or she has the right to continuation coverage if group health coverage under BlueCross BlueShield of North Carolina is lost for any of the following reasons:

- The death of a parent who was an employee of Carteret General Hospital
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with Carteret General Hospital
- Parent's divorce or legal separation
- A parent who was an employee of Carteret General Hospital becomes entitled to Medicare
- The dependent ceases to be a "dependent child" under BlueCross BlueShield of North Carolina.

YOUR NOTICE OBLIGATIONS

Under the law, the employee or a family member has 60 days from (1) the date of the event or (2) the date on which coverage would be lost, whichever is later, to inform the Human Resources Department at Carteret General Hospital, 3500 Arendell Street, Morehead City, NC 28557 (252-808-6030) of the employee's divorce or legal separation, or of the employee's child losing dependent status under BlueCross BlueShield of North Carolina. Please give notice in the following manner: Inform the Human Resources Department at 252-808-6030 or in writing to 3500 Arendell Street, Morehead City, NC 28557.

INITIAL COBRA NOTICE – Cont.

Failure to give notice within the time limits can result in COBRA coverage being forfeited. Carteret General Hospital has the responsibility to notify ADP Benefit Services-Cobra of the employee's death, termination of employment, reduction in hours, or Medicare entitlement.

TO ELECT COVERAGE

When ADP Benefit Services-Cobra is notified that one of these events has happened, ADP Benefit Services-Cobra will in turn notify the employee, spouse and dependents that they have the right to choose COBRA continuation coverage. The employee and spouse have independent election rights. The employee, spouse and dependents have 60 days from either (1) the date coverage is lost under BlueCross BlueShield of North Carolina or (2) the date of the notice, whichever is later, to respond informing ADP Benefit Services-Cobra that they want to elect continuation coverage. There is no extension of the election period.

If an employee, spouse or dependent does not elect continuation coverage within this election period, then rights to continue group health insurance will end.

If an employee, spouse or dependent chooses continuation coverage and pays the applicable premium, Carteret General Hospital is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated active employees or family members. If Carteret General Hospital changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

DURATION OF COBRA COVERAGE

Termination or Reduction in Hours. If group health coverage was lost because of a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, the continuation coverage period is 18 months from the date of the qualifying event, if elected.

Employees, Spouses or Dependents with Disabilities. The 18 months of continuation coverage can be extended to 29 months if the Social Security Administration determines that the employee, spouse or dependent child was disabled on the date of the qualifying event according to Title II (Old Age Survivors and Disability Insurance) or XVI (Supplemental Security Income) of the Social Security Act. Disabilities that occur after the qualifying event do not meet the criteria for the extended COBRA coverage period.

The employee, spouse or dependent must obtain the disability determination from the Social Security Administration and notify ADP Benefit Services-Cobra of the result within 60 days of the date of disability determination and before the close of the initial 18-month period. The employee, spouse or dependent has 30 days to notify ADP Benefit Services-Cobra from the date of a final determination that he or she is no longer disabled.

Multiple Events. The 18-month continuation period can also be extended, if during the 18 months of continuation coverage, a second event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent). The 18 months of continuation coverage will be extended to 36 months from the date of the original qualifying event. Upon the occurrence of a second event, it is the employee's, spouse's or dependent's responsibility to notify ADP Benefit Services-Cobra within 60 days of the event and within the original 18-month COBRA period. COBRA coverage does not last beyond 36 months from the original qualifying event, no matter how many events occur.

INITIAL COBRA NOTICE – Cont.

DURATION OF COBRA COVERAGE

Other Qualifying Events. If group health coverage was lost because of the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under BlueCross BlueShield of North Carolina, then the continuation coverage period is 36 months from the date of the qualifying event, if elected.

COBRA CANCELLATION

The law provides that continuation coverage may be cut short for any of the following reasons:

- Carteret General Hospital no longer provides group health coverage to any of its employees
- The premium for continuation coverage is not paid in a timely manner
- The employee, spouse or dependent becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition
- The employee or spouse becomes entitled to Medicare
- The employee, spouse or dependent extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that he or she is no longer disabled
- The employee, spouse or dependent notifies ADP Benefit Services-Cobra that they wish to cancel continuation coverage.

PREMIUMS

An employee, spouse or dependent does not have to show that they are insurable in order to choose continuation coverage. But an employee, spouse or dependent must have been actually covered by the group health plan the day before the qualifying event in order to elect COBRA coverage.

An employee, spouse or dependent may have to pay all of the applicable premium, which generally can not exceed 102% of the plan costs for a 12-month period. An exception exists for coverage of employees with disabilities during the extension from the 19th month to the 29th month. During that time, 150% of the plan cost may be charged. The group health plan may increase the cost that must be paid for COBRA coverage if the applicable premium increases.

The period for paying the initial COBRA premium following the election of coverage is 45 days. The first payment made is to be applied retroactively toward coverage for the period beginning after the date on which coverage would have been lost as a result of the qualifying event.

There is a 30-day grace period following the date regularly scheduled monthly premiums are due. Only in the case of mental incapacity is any further extension permitted, since the group health plan does not permit extensions.

CONVERSION PRIVILEGES

At the end of the continuation coverage period, the employee, spouse or dependent must be allowed the option to enroll in an individual conversion health plan provided under BlueCross BlueShield of North Carolina if such conversion plan is available.

FURTHER INFORMATION

If you have any questions about the law or your obligations, please contact:

Brenda A. Waugh
Benefits Coordinator
Carteret General Hospital
3500 Arendell Street
Morehead City, NC 28557
252-808-6033

CARTERET GENERAL HOSPITAL

POLICY MANUAL

DEPARTMENT: **HUMAN RESOURCES**

PAGE 34 OF 2

SUBJECT: **Family Medical Leave**

The **Family Medical Leave Act of 1993 (FMLA)** requires covered employers to provide up to 12 weeks of job protected leave to “eligible” employees for certain family and medical reasons. Employees may be granted Family or Medical leave in accordance with this Act. The leave may be paid or unpaid.

1. *Eligibility:*

Employees are eligible if they have worked for the Hospital for at least one year and have worked 1,250 hours over the previous 12 months. Employees must request leave through their Manager as well as contact FMLASource at 1-888-365-7242. Employees are eligible for up to 12 weeks during any given 12-month period. If the employee is not eligible for FML, the employee may be eligible for personal leave of absence.

2. *Scope:*

Leave must be granted for any of the following reasons:

- ✓ For the birth or adoption of a new child,
- ✓ For an employee's own serious medical condition
- ✓ To provide care for a family member (child, spouse or parent) with a serious medical condition
- ✓ In situations of qualifying exigency to be with an employee's spouse, parent or child if they are an active service member or have an impending call to active duty in support of a contingency operation.
- ✓ In addition, up to 26 weeks of leave can be granted in a single one year time period for the care of an injured service member, if the service member is the employee's spouse, child, parent, or "next of kin".

The Hospital requires employees to utilize accumulated Paid Time Off (PTO) or Catastrophic Sick Leave while on FML. Catastrophic Sick Leave may only be used for the employee's own illness and must be used after 40 hours of PTO has been used. Once all PTO and Catastrophic Sick Leave is exhausted, the remaining FML will be unpaid.

3. *Notice and Certification:*

Employees are required to provide a 30-day advance notice when the leave is “foreseeable”. Employees requesting leave may be required to have a medical certification form completed and have it returned in 15 calendar days. An employee's leave request may be denied if the employee fails to return the form in 15 days (unless it is not practicable for the employee to do so despite the employee's diligent, good faith efforts). The Hospital may also require a return to work certification, prior to an employee being allowed to return to work. Any charges incurred for completing certification is the responsibility of the employee. The Hospital retains the right to seek a second or third opinion for either the employee's need to be out of work or return to work. If the Hospital exercises its rights to second and third opinions, it will be at the Hospital's expense.

4. *Job Benefits and Protection:*

- For the duration of the leave, the Hospital will maintain the employee's health coverage under the group health plan, as long as premiums are paid timely.
- Any portion of premium payments paid by the employee must be maintained while on leave. If payment is not made on time, group health insurance and other benefits will be cancelled.

- Upon return from FML, the employee will be restored to his or her original or equivalent position with equivalent pay, benefits, and other employment terms.
- The use of FML cannot result in loss of any employment benefits that accrued prior to the start of an employee's leave; unless the employee fails to make timely payments on insurance premiums.
- The Hospital may recover all health care premiums paid during a period of leave if the employee fails to return to work after the leave expires, unless the reason the employee fails to return is due to a: (1) continuation, recurrence, or onset of a serious health condition of disability which would entitle the employee to leave under this policy, or (2) other circumstances beyond the employee's control.

5. *Intermittent and Reduced Schedule Leave:*

An employee may take Family Medical Leave intermittently or on a reduced schedule. The employee and the Hospital must agree on these variations if the employee is taking leave for the birth, adoption or foster care of a child. However, for leave relating to a serious health condition, the employee may take intermittent leave or work a reduced schedule without the employer's approval if it is "medically necessary". If the Department Manager feels reduced or intermittent leave would create a hardship on the department, they may temporarily transfer the employee to an equivalent position that would better accommodate the hours. The Hospital will request medical certification.

6. *Service Member FMLA Leave Eligibility and Duration*

Eligible employees may take Servicemember leave for either (or both) of the following reasons:

- A "qualifying exigency" arising out of a covered family member's active duty or call to active duty in the Armed Forces in support of a contingency operation.
 - Leave Duration: Up to 12 workweeks of leave during any 12-month period.
- To care for a covered family member ("next of kin") who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces provided that such injury or illness may render the family member medically unfit to perform duties of the member's office, grad, rank or rating.
 - Leave Duration: Up to 26 workweeks of leave during any 12-month period. (Leave may not exceed 26 weeks in a single 12-month period when it is combined with other FMLA-qualifying leave).

Family Medical Leave.doc
 Original Date: 01/15/2001
 Revised Dates: 02/01/2004
 Revised Dates: 01/16/2009

ORIGINATOR'S SIGNATURE _____ DATE: _____

MANAGER'S APPROVAL: _____ DATE: _____

ADMINISTRATIVE APPROVAL: Beth Beswick _____ DATE: 01/14/05

DISTRIBUTION DATE: 01/14/05 _____ DATE: _____

How to Access to your plan:

Health Insurance

Blue Cross Blue Shield of North Carolina

1-877-258-3334 or www.bcbsnc.com

Health Savings Account

ACS|BNY Mellon

1-877-HSA-4200 or www.hsamember.com

Dental Insurance

CIGNA

1-800-244-6224 or www.myCIGNA.com

Vision Insurance

Community Eye Care

1-888-254-4290 or www.communityeyecare.net

Life Insurance

Unum

1-800-445-0402 or www.unum.com

Long Term Disability

Unum

1-800-633-7479 or www.unum.com

Accident/Cancer Insurance

AFLAC

252-726-5356 or www.aflac.com

Short Term Disability/Critical Illness

Unum

1-800-635-5597 or www.unum.com

Flexible Spending Account

ADP Flex Direct

1-866-469-4910 or www.flexdirect.adp.com

Retirement Savings Account

Prudential Retirement Services

1-800-458-6333 or www.prudential.com