Annual Notices

for Eligible Employees and Beneficiaries of
WELFARE BENEFIT PLAN
sponsored by
Macon County

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 7 for more details.

Electronic Notice Disclosure

These Annual Notices provide important information to eligible employees and beneficiaries of the various benefits offered by Macon County through the Plan. If you received these annual notices electronically, you have the right to request and obtain a paper version of such document, and you will receive a paper copy at no cost to you. Please contact Mike Decker at 828-349-2020 or Mdecker@MaconNC.org to make that request.

PREPARED BY AND PROVIDED EXCLUSIVELY TO CLIENTS OF EbenConcepts EMPLOYEE BENEFITS

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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, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid *Click on Health Insurance Premium Payment (HIPP)* Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/HCPF/Child-Health-Plan-Plus Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901- 4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
http://chfs.ky.gov/ Phone: 1-800-635-2570	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 609-631-2392 CHIP: http://www.njfamilycare.org/index.html Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
http://www.mass.gov/eohhs/gov/departments/masshealth Phone: 1-800-862-4840	http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid and CHIP**
https://dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
http://dphhs.mt.gov/MontanaHealthcarePrograms/HI Phone: 1-800-694-3084	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 - Omaha: (402) 595-1178	http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
http://dss.sd.gov Phone: 1-888-828-0059	https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
http://gethipptexas.com/ Phone: 1-800-440-0493	http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
http://www.greenmountaincare.org/ Phone: 1-800-250-8427	https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Notice of Grandfathered Group Health Plan

Name of Plan Sponsor: Macon County

Date of Notice: 7/1/2019

Grandfathered Status for Current Plan Year: NON-GRANDFATHERED

The health plan provided by the Plan Sponsor listed above for the eligible participants is Non-Grandfathered under the federal Patient Protection and Affordable Care Act (PPACA).

As such, this plan is fully compliant with all consumer protections of PPACA that apply to other plans as well as other changes to the health plan to meet the mandates required under that law at renewal.

Requests for further information or questions (such as which protections apply to a Non-Grandfathered health plan and how a change in plan status affects employees) about this notice can be directed to the individual listed below or you may also contact the Employee Benefits Security Administration, which is a part of the U.S. Department of Labor at 1-866-444-3272 or visit their website at www.dol.gov/ebsa/healthreform.

If you have any questions on these notices, please contact:

Mike Decker
828-349-2020
Mdecker@MaconNC.org

HEALTH INSURANCE MARKETPLACE NOTICE

Your Health Coverage and Coverage Options For Employees of Macon County

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

Introduction

Since key parts of the health care law went into effect in 2014, there has been a new way to buy health insurance: Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by Macon County.

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. The most recent annual open enrollment for health insurance coverage through the Marketplace ended on December 15, 2018 but will run from November 1, 2019 through December 15, 2019. However, in some situations you may be eligible to enroll in the Marketplace if there was a Special Enrollment Event.

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 9.86% for calendar year 2019 of your household income, 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. (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.)

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 of Benefits and Coverage or contact Mike Decker at 828-349-2020 or Mdecker@MaconNC.org.

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.

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		4. Employer Identification Number (EIN)
Macon County		**56-6000930**
5. Employer address		6. Employer phone number
5 West Main Street		**828-349-2000**
7. City	8. State	9. ZIP code
Franklin	**NC**	**28734**
10. Who can we contact about employee health coverage at this job?		
Mike Decker		
11. Phone number (if different from above)	12. Email address	
828-349-2020	**Mdecker@MaconNC.org**	

Here is some basic information about health coverage offered by Macon County:

As your employer, we offer a health plan to:

- ☐ All employees.
- ☑ Some employees. Eligible employees are: Those employees who work, on average, 30 or more hours per week

With respect to dependents:

- ☑ We do offer coverage. Eligible dependents are: Legally married spouse and children up to the age of 26
- ☐ We do not offer coverage to dependents.

Based on the information available at the time of preparation of this Notice, the health benefits provided by Macon County meets the minimum value standard, and the cost of this coverage to you does not exceed the maximum allowable 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.)

As a result, employees and their dependents who are eligible (whether enrolled or not) in the group health benefits sponsored by Macon County are likely not eligible for premium subsidies in the Marketplace. However the final results may vary based on additional factors such as affordability and your income.

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.

You can also contact Mike Norris of Wayah Employee Benefits / EbenConcepts at 828-524-4442 or MANorris@ebenconcepts.com to help walk you through the process to determine if you are eligible.

Medicare Part D Notice

Important Notice About Your Prescription Drug Coverage and Medicare

All employers who offer a group health plan that provides pharmacy coverage are required to send a notice to all plan participants who are eligible for Medicare about your options under Medicare's prescription drug coverage. Because we do not track which of our employees or if your dependents are eligible for Medicare, we are meeting this obligation by providing this notice to all employees who are eligible for our benefits program. This notice does not apply to you if you or your dependents are not Medicare eligible. If you or a covered dependent are Medicare eligible, or will become Medicare eligible during this Plan Year or the next calendar year, this notice is important to you and contains important, time sensitive information which could 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. Please read it carefully, keep it where you can find it and act to protect your interests.

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. Based on the standards established by CMS, we have determined that the prescription drug coverage offered as part of the Macon County group health and prescription drug plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan..

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 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	7/1/2019
Name of Entity/Sender:	Macon County
Contact--Position/Office:	Mike Decker
Address:	5 West Main Street Franklin, NC 28734
Phone Number:	828-349-2020

Annual Notices Required by Applicable Law

No Pre-Existing Condition Provisions

With the passage and implementation of the Affordable Care Act, individual and group health plans are prohibited from containing pre-existing condition limitations at renewals that occur on or after January 1, 2014. This group health plan does not restrict coverage for medical conditions present before an individual's enrollment.

Notice of Special Enrollment and Nondiscrimination Rights under HIPAA

Right to get special enrollment in another plan. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Mike Decker at 828-349-2020 or Mdecker@MaconNC.org.

- ➔ Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws, or http://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/index.html.

Newborn's and Mothers' Health Protection Act Notice

Under Federal and state law you have certain rights and protections regarding your maternity benefits under the Plan. Under the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 828-349-2000 for more information.

Michelle's Law Notice

Beginning January 1, 2010, if you have a dependent child older than age 18 who is enrolled at a post-secondary institution (e.g., college or university) on a full-time basis, he or she may be eligible to continue to be covered as a dependent if he or she loses full-time student status due to a serious injury or illness. In order to be eligible to continue coverage as a dependent under Michelle's Law:

- the dependent child must be enrolled in our group health plan based on full-time student status immediately before the first day of the medically necessary leave of absence;
- a doctor's written certification of the medically necessary leave of absence must be submitted to the health insurer; and
- proof of full-time student status before the leave of absence may also be required to be submitted to the health insurer.

Continued dependent coverage will be extended for at least one year after the first day of the leave of absence, but may end earlier if the dependent child does not meet the dependent eligibility requirements under our group health plan, such as meeting the limiting age for dependent eligibility under the plan. If dependent coverage under Michelle's Law ends, the dependent may be eligible for continuation coverage under the provisions of our group health plan.

If an eligible dependent remains enrolled in our group health plan under Michelle's Law, the dependent child will continue to be in the same medical benefit options that he or she was in prior to the medical leave of absence.

To obtain additional information about Michelle's Law, please contact:

Mike Decker, Macon County
5 West Main Street
Franklin, NC 28734
828-349-2020
Mdecker@MaconNC.org

Rescission of Coverage

Coverage may only be rescinded (meaning coverage retroactively revoked) due to fraud, intentional misrepresentation of a material fact, or due to failure to pay premiums. A 30-day advance notice is now required before coverage can be rescinded.

Notice on Dependent Child Coverage to Age 26

Name of Plan Sponsor: Macon County

Date of Notice: 7/1/2019

Under the Patient Protection and Affordable Care Act ("PPACA"), health plans are now required to offer dependent coverage for all children of enrolled employees up to age 26. This notice is being furnished to you in compliance with the requirements of the law.

- Children under age 26 who were not eligible, or whose coverage ended due to an age limitation or due to marriage, are eligible to enroll or re-enroll in the plan. Coverage begins on the first day of the plan year beginning thereafter.
- Children under age 26 are eligible for coverage without regard to student status, marital status, primary residence status, tax dependent status, or the amount of financial support from the parent.
- Coverage/premiums for children under age 26 will be the same as that offered to other dependent children.
- Coverage will end at the end of the month in which the child turns 26 years of age, or until coverage otherwise terminates as defined by the plan.

If you have any questions, or need the form to enroll a dependent child, please contact:

Mike Decker
828-349-2020
Mdecker@MaconNC.org

Patient Protection Disclosure

Macon County sponsors a Group Health Plan that may, in some situations, require or allow a beneficiary to designate a primary care provider. In the event that the ability or requirement to designate a primary care provider is a component of the benefit package:

- You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.
- For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Until you make this designation, the claims administrator will designate one for you. For information on how to select a primary care provider, and to verify that the need or the option to designate a primary care physician applies to your benefits, as well as for a list of the participating primary care providers, contact the Mike Decker at 828-349-2020 or Mdecker@MaconNC.org.

Life Insurance Conversion Rights

What is the conversion privilege? The right of an individual insured under the Macon County's Group Life Insurance policy to replace all or part of the Life Insurance Benefit with an individual policy if all or part of his coverage under the group policy terminates. No medical examination or other evidence of good health is required for a conversion policy.

The converted policy will be effective 31 days after coverage under the group policy terminates. This 31-day period is referred to as the conversion period. The group policy and your certificate may specify a different conversion period. If a person insured under the group policy dies within the conversion period, any death benefit provided by the group policy will be paid.

When can you convert? An individual eligible to convert, as described below, can convert during the conversion period, which follows immediately after the date s/he ceases to be eligible under the group policy.

Who is eligible to convert?

1. An Insured whose Life Insurance ends for any reason except for nonpayment of premiums is eligible to convert. If coverage ends because the group policy terminates, or because the class of insureds to which the insured belongs is terminated, the additional limitations, described below, apply.

2. An Insured whose Life Insurance is reduced or terminated because of age, retirement, or change in benefit amounts, is eligible to convert the amount reduced or terminated.

3. An Insured's covered dependent may convert if the dependent ceases to be eligible because the insured ceases to be eligible, or because the dependent ceases to be an eligible dependent, as defined in the Group Policy. Each dependent eligible to convert must complete an application for an individual policy.

How much can be converted?

1. An insured employee or an insured dependent, whose coverage terminates because the employee or the dependent ceases to be eligible under the group policy, may convert up to the amount of coverage terminating under the group policy.

2. If the group policy terminates, or if coverage for a class of employees terminates, insured employees and dependents who were covered under the group life insurance policy for at least three years may convert $10,000 or the amount of terminating group insurance, if less. Insurance regulations in some states require that an insured be permitted to convert after being insured under the group policy for a shorter period, or be permitted to convert a greater amount of terminating coverage. Please consult your Group Insurance Certificate or your Plan Administrator for details of your eligibility and amounts of coverage available to you.

Who receives the insurance benefits in the event of the insured's death? The beneficiary(ies) named on the application will receive the death benefit of the insured person. If one person, the Primary Beneficiary, is named, that individual will receive the entire death benefit. If two or more persons are named, they will share equally in the death benefit unless a percentage is specified for each individual. A contingent beneficiary who will receive the benefits in case the Primary Beneficiary should die before or at the same time as the insured, may also be named. This should be indicated in a manner similar to this:

Primary Beneficiary: Marilyn Smith, wife*
Contingent Beneficiary: William P. Smith, Jr., son

** If a beneficiary is a married woman, use her given name, for example, Mary J. Smith and not Mrs. William Smith. If there is no relationship between the insured and the beneficiary, the application should indicate "no relationship" and the beneficiary's address and social security number must be entered on the application.*

What type of policy can you convert to? Conversion may be to any permanent Life Insurance Policy, except term insurance. Benefits other than pure life insurance (such as Waiver of Premium, AD&D or Accelerated Benefits) are not included in the individual policy (unless specified in the group contract).

How to apply for conversion

1. Complete Notice of the Right to Covert form (included within the Life Insurance Conversion packet in the group life insurance policy – you may need to request from your employer).

2. Select the amount of insurance you want to convert and indicate this amount on the application.

3. Calculate your premium for the amount you selected.

4. Send the completed application and premium payment to the address indicated in the packet. The premium payment should be by check or money order (do not send cash) and made payable as indicated in the packet.

GINA Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law.

To comply with this law, we are asking that you not provide any genetic information when responding to any request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact than an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Further, you will not be subject to any adverse employment or benefit eligibility for failure to provide genetic information to your employer or group health plan.

USERRA Notice

The Uniformed Services Employment and Re-Employment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain Employees who are involved in the Uniformed Services (defined below). In addition to the rights that you have under COBRA (described in the section on COBRA), you are entitled under USERRA to continue the coverage you had under this Plan.

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered Spouse or Children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the COBRA section (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage. COBRA and USERRA coverage run concurrently.

"Uniformed Services" means the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training or Full-Time National

Guard duty), and the commissioned corps of the Public Health Service. Moreover, the President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

"Service in the Uniformed Services" or "Service" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, inactive duty training, Full-Time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

Duration of USERRA Coverage and Premium Payments

General rule: 24-month maximum. When a Covered Person takes a leave for Service in the Uniformed Services, USERRA coverage for the Employee (and covered Spouses and Children for whom coverage is elected) begins the day after the Employee loses coverage under the Plan, and it continues for up to twenty-four (24) months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.

COBRA and USERRA coverage are concurrent. This means that both COBRA coverage and USERRA coverage begin upon commencement of the Employee's leave, and COBRA coverage continues for up to eighteen (18) months while USERRA coverage continues for up to twenty-four (24) months, up to six (6) months longer than COBRA. COBRA coverage (but not USERRA coverage) may continue for longer, as described in the COBRA section. For example, George takes a Leave of Absence for service in the Uniformed Services beginning on August 1, 2006. George elects COBRA/USERRA continuation coverage and pays the required one hundred two percent (102%) of the premium each month for the next eighteen (18) months. Although George's COBRA coverage would terminate at the end of this eighteen (18) month period, USERRA coverage could continue for another six (6) months, unless coverage is terminated earlier due to non-payment of premiums or other permitted event.

If you elect to continue your health coverage (or your Spouse or Children's coverage) pursuant to USERRA, you will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if your Uniformed Service Leave of Absence is less than thirty-one (31) days, you are not required to pay more than the amount that you pay as an active Employee for that coverage.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement

Discrimination is Against the Law. Macon County complies with applicable Federal civil rights laws and does not discriminate and does not exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex. Macon County provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact Mike Decker at Mdecker@MaconNC.org or 828-349-2020.

If you believe that Macon County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email with:

Mike Decker
Macon County
5 West Main Street
Franklin, NC 28734
Mdecker@MaconNC.org
828-349-2020

If you need help filing a grievance, Mike Decker is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-868-1019
800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Statement on Designation as a Hybrid Entity under HIPAA Regulations

Introduction: The Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations apply to individuals and organizations designated in the law/regulations as covered entities. These covered entities include: (1) group health plans; (2) health care providers who conduct certain transactions electronically, including but not limited to transmission of health care claims, health care payments, enrollment in a health plan, and referral authorizations; and (3) health care clearinghouses. Although Macon County ("Employer") does not primarily engage in any of these activities, some departments or employees of Employer may perform functions that bring them within the definition of a covered entity under HIPAA.

Organizations such as Employer that have both covered entity departments and non-covered entity departments may choose to be designated as hybrid entities. In this case, Employer must designate and include in its HIPAA "health care component" those departments that would meet the definition of a covered entity if they were separate legal entities. In this case, although Employer as a hybrid entity remains responsible for oversight, compliance, and enforcement obligations, the HIPPAA requirements apply only to the health care component.

Designation of Health Care Components

Employer has designated certain units as constituting its healthcare components based on one or more of the following criteria:

- A department that would meet the definition of a covered entity if it were a separate legal entity.
- A department that performs covered functions or transactions under HIPAA.
- A department that performs activities that would make it a business associate if it were a separate legal entity.

Note: A business associate is a person or organization that performs or assists a covered entity in the performance of a function that involves the use or disclosure of protected health information on behalf of a covered entity.

The following department(s) have been designated as its health care components and are required to comply with any applicable HIPAA regulations:

- Schools & Universities:

  - Student Health Center, if its health care providers conduct any standard HIPAA transactions electronically, directly or through a vendor
  - Counseling Center, if its health care providers conduct any standard HIPAA transactions electronically, directly or through a vendor
  - Athletic Training Staff, if its health care providers conduct any standard HIPAA transactions electronically, directly or through a vendor
- Information Technology Services, to the extent any personnel use and disclose individually identifiable health information in providing administrative and support services to named departments.
- Business/Finance/Accounting Office, to the extent any personnel use and disclose individually identifiable health information in providing administrative and support services to named departments.
- Human Resources maintains employee health records (in its capacity as an employer which are excluded from the definitions of PHI under HIPAA) and various employee health insurance records (in its capacity as employer sponsor of a group health plan). Human Resources is not one of the employer's health care components. The group health plans offered to those eligible to participate are separate legal entities covered by HIPAA, and have HIPAA compliance obligations separate and apart from Employer and are not health care components.

Designation of Privacy and Security Officers

Employer designates the following as the Privacy & Security Officer for its health care components:

Mike Decker
828-349-2020
Mdecker@MaconNC.org

Employer has designated the Privacy & Security Officer for its Group Health Plans, which is contained in the HIPAA Notice of Privacy Practices found in this Annual Notice Packet. Please refer to that document for details. For any questions about Employer's compliance with applicable HIPAA or state privacy and security laws and regulations regarding individually identifiable health information, please contact one of these officers.

Non-Retaliation Policy

Employer, its health care components and personnel shall not intimidate, threaten, coerce, discrimination against, or take other retaliatory action against anyone for exercising his/her right under the privacy regulations or participating in any process established by the privacy regulations; nor for filing a complaint, participating in an investigation or audit or review proceeding conducted by Employer or a government agency under the privacy regulations, or opposing any act or practice made unlawful by the privacy regulations. Any individual who believes that some form of retaliation under the privacy regulations has occurred or is occurring should report such concern to the relevant privacy officer designated above. The privacy officer will then conduct an investigation and, if the retaliation is substantiated, will impose sanctions in accordance with Employer's confidentiality and information security policies.

Notice Regarding Wellness Program

Macon County sponsors a voluntary wellness program available to eligible employees. The program is administered in accordance with federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, you may be asked to complete a voluntary health risk assessment ("HRA") that asks a series of questions about your health-related activities and behaviors and whether

you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which will include a blood test for various medical conditions that may impact your long-term health. The specific list of conditions will be provided when you are asked to complete the biometric screening. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive for satisfying certain criteria, including some related to your specific health status compared to a goal or objective set through the wellness plan. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Mike Decker at 828-349-2020. Please do not email sensitive medical information.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program (additional details on the wellness plan are available where you can access other benefit information, or from your benefits department). You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Macon County may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program administrator will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the wellness plan administrator or its affiliates in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Mike Decker at 828-349-2020 or by email at Mdecker@MaconNC.org. Please do not email sensitive medical information.

HIPAA Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN A COPY FOR YOUR RECORDS.

Dear Employee:

This is your Notice of Privacy Practices from Macon County Welfare Benefits Plan ("Plan"). Please read it carefully. The Plan strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to the Plan as "us", "we", or "our".

This notice describes how we protect the protected health information we have about you which relates to your the Plan's benefits and how we may use and disclose this information. Protected Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to your Protected Health Information and how you can exercise those rights.

NOTICE OF PRIVACY PRACTICES

Under applicable law, the Plan is required to protect the privacy of your individual health information (which we refer to in this notice as "Protected Health Information" or "PHI"). PHI includes all information that relates to the past, present, or future physical or mental health of an individual; the provision of health care to an individual; and the past, present, or future payment for the provision of health care to an individual. We are required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information, and to abide by the terms of this notice, as it may be updated from time to time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes without obtaining your authorization.

For treatment purposes, we may use and disclose your PHI for the purpose of providing, coordinating, or managing the delivery of healthcare services to you by one or more healthcare providers, including doctors, nurses, technicians, medical students or other hospital personnel who are involved in taking care of you. For example, your primary care physician may consult with us regarding your condition or treatment. We do not limit the use or disclosure of your PHI for purposes of your care or treatment. Otherwise, we limit use and disclosure of PHI to that which is reasonably necessary for a permitted purpose. Disclosure for the work-related purposes (such as job-specific purposes permitted by the ADA, workplace safety and drug testing, or under the Family Medical Leave Act, if applicable), or for claims for benefits under workers' compensation or disability are not protected by HIPAA or this notice.

For payment purposes, we may use and disclose your PHI to obtain payment or reimbursement for providing healthcare services, such as when we request payment from your insurer, health plan, or a government benefit program.

For healthcare operations purposes, we may use and disclose your PHI internally in a number of ways, including for quality assessment and improvement, for planning and development, management, and administration. Your information could be used, for example, to assist in the evaluation of the quality of services that you were provided. Healthcare operations also includes conducting training programs in which students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills.

- In addition, we may contact you to provide reminders or information about health-related benefits and services that may be of interest to you.
- Where applicable, we may disclose your health information to your health plan sponsor. This applies to a group health plan, a health insurance issuer, or a Health Maintenance Organization (HMO) with respect to a group health plan, and solely for the plan administration purposes and then only to those individuals who been designated to have access to the information, and who are aware of their special responsibilities to protect your PHI.

We may use and disclose your PHI, without your authorization, for treatment, payment, and health care operations purposes, with health care providers, health plans, and those that process health care claims, benefits and related information. We are also permitted to share your PHI, without your authorization, in the other limited instances.

We may also use or disclosure your PHI as permitted or required by law, including, for example:

- To public health authorities for the purposes of preventing or controlling disease or other public health needs;
- To appropriate government authorities to report incidents of suspected abuse, neglect, or domestic violence;
- To the Food and Drug Administration to report quality, safety, or effectiveness of the FDA-regulated products or activities;
- To qualified health authorities for purposes of conducting health oversight activities;
- In response to subpoenas, discovery requests, or other lawful legal processes in the course of a judicial or administrative proceeding;
- To law enforcement authorities as required or permitted by law such as, for example, to report a death, to report a crime on our premises, or if it appears necessary to alert law enforcement to respond to an emergency;
- To persons involved with respect to matters pertaining to a decedent, or relating to cadaveric organ, eye or tissue donation;
- In certain instances, for research purposes;
- We may disclose your PHI if we believe, in good faith, that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
- We may disclose your PHI for certain specialized government functions such as, for example, to Armed Forces Authorities with reference to military personnel or for national security purposes.

Unless you object, we may also disclose to a member of your family or other relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to that person's involvement with your care or payment related to your care. In addition, unless you object, orally or in writing, to another employee or our Privacy Officer, we may use or disclose the PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick up filled prescriptions, medical supplies, test results, or other similar actions involving disclosure of PHI.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization by notifying us by contacting our Privacy Officer as described below. We may not sell your protected health information.

Contact Information. We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act (HIPAA). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please contact Mike Decker, or you may submit questions in writing directly to:

Macon County Welfare Benefit Plan
Mike Decker
5 West Main Street
Franklin, NC 28734

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any PHI we receive in the future. You will receive a copy of any revised notice from the Plan by mail, email, hand delivery or other appropriate means.

Macon County Welfare Benefits Plan
Summary Plan Description

Amended and Restated Effective
7/1/2019

1. Definitions

Capitalized terms used in the Plan have the following meanings:

"Code" means the Internal Revenue Code of 1986, as amended.

"Employee" means any common-law employee of the Plan Sponsor who satisfies the eligibility provisions of Section 4 and who is not excluded from participation by the terms of an applicable component benefit program.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Plan" means Macon County Welfare Benefits Plan.

"Plan Administrator" means Macon County.

"Plan Sponsor" means Macon County, or any successor thereto.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

2. Introduction

The Plan Sponsor maintains the Plan for the exclusive benefit of its eligible employees and eligible dependents. The Plan provides benefits through the following component benefit programs:

Benefit	Included in Wrap Plan?	How Funded?	Vendor
Premium Only Conversion (POP) Plan	Yes	N/A	EbenConcepts
Group Health Benefits	Yes	Self-Funded	BCBSNC
Group Dental Benefits	Voluntary	Fully-Insured	Companion Life
Group Term Life Benefits	Group	Fully-Insured	USAble Life
Vision Benefits	Voluntary	Fully-Insured	CEC Vision
Group Long-Term Disability Benefits	No	Fully-Insured	Lincoln Financial
Flexible Spending Accounts	Yes	Self-Funded	TASC
Dependent Care Flexible Spending Accounts	Yes	Self-Funded	TASC
Cancer, Hospital Indemnity, Critical Illness	Voluntary	Fully-Insured	Aflac
Cancer, Hospital Indemnity, Critical Illness	Voluntary	Fully-Insured	Colonial Life
Cancer, Hospital Indemnity, Critical Illness	Voluntary	Fully-Insured	TransAmerica

Each of the component benefit programs is summarized by a certificate of insurance booklet issued by an insurer, a summary plan description (SPD) prepared specifically for that component benefit program, or another written governing document prepared by the Plan Sponsor. Some of these component benefit programs require completion of application forms, annual elections, and/or other administrative forms. A copy of each booklet, summary, or other governing document is available upon request.

Note: Not all of the component benefit programs are subject to ERISA. They are described as part of the Plan for purposes of convenience and because there may be other applicable laws (for example, the Internal Revenue Code) that require a written document.

Purpose of This Wrap SPD Document

You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in Documents contained in the above URL. This document, together with the documents contained in the URL, is the SPD required by ERISA §102, but you must read the Documents and this Wrap SPD together to understand your benefits. This document is not intended to give you any substantive rights to benefits that are not already provided by the Documents. If you want to receive paper copies of the Documents contained in the above URL, contact the Human Resources Manager of Macon County.

Electronic Forms

To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

3. General Information About the Plan

Plan Name

Macon County Welfare Benefits Plan

Type of Plan

The Plan is a welfare plan that provides those benefits identified in Section 2. Note: The Plan may also include benefits under other tax code sections (e.g. premium only conversion under Code §125), which are not subject to ERISA.

Plan Year

The Plan Year begins 7/1/2019 and ends June 30, 2020, and for each twelve month period thereafter.

Plan Number

The Plan number is 501.

Effective Date

The effective date of the Plan amendment/restatement is 7/1/2019. The Plan has been amended several times since its original effective date of 7/1/1998.

Plan Sponsor

Macon County
5 West Main Street
Franklin, NC 28734
828-349-2000

Employer Identification Number: 56-6000930

Funding Medium and Type of Plan Administration

Some benefits under the Plan are self-funded, and other benefits are fully insured (as listed in Section 2 of this Wrap Plan SPD). The Plan Sponsor and the insurers (as indicated) share responsibility for administering the component benefit programs under the Plan.

The Plan Sponsor is responsible for paying claims with respect to the self-funded component benefit programs. The insurers, not the Plan Sponsor, are responsible for paying claims with respect to the insured component benefit programs.

Insurance premiums for employees and their eligible family members are paid in part by the Plan Sponsor out of

its general assets and in part by employees on a pre-tax basis. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the component benefit programs, as applicable. Contributions for the self-funded component benefit programs are also made by employees on a pre-tax basis through the cafeteria plan component benefit program under the Plan. Neither the Plan nor any of the component benefit programs offered through it have a trust.

Service Providers

Benefits are provided through third party administration for the following lines of coverage

Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, North Carolina 27702
Phone: 800.291.6315
Website: www.bluecrossnc.com

Lines of Coverage: Health Plan Administration (including pharmacy benefit)

TASC
2302 International Lane
Madison, Wisconsin 53704-3140
Phone: 800.422.4661
Website: www.tasconline.com

Administration of Flexible Spending Account & Dependent Care Flexible Spending

Insurers

Benefits are provided through insurance contracts with the Insurers listed below.

Companion Life Insurance Company
PO Box 100102
Columbia, South Carolina 29202-3102
Phone: 800.753.0404
Website: www.companionlife.com

Lines of Coverage: Voluntary Dental

USAble Life
PO Box 1650
Little Rock, Arkansas 72203
Phone: 800.370.5856
Website: www.usablelife.com

Lines of Coverage: Term Life/AD&D, Supplemental Life/AD&D, Dependent Life

CEC Vision
2359 Perimeter Pointe Parkway
Suite 150
Charlotte, North Carolina 28208
Phone: 888.254.4290
Website: www.cecvision.com

Lines of Coverage: Voluntary Vision

Lincoln Financial Group
PO Box 2616
Omaha, Nebraska 68103-2616
Phone: 800.423.2765
Website: www.lfg.com

Lines of Coverage: Voluntary Long Term Disability

Aflac, Inc.
1932 Wynnton Road
Columbus, Georgia 31999
Phone: 800-992-3522
Website: www.aflac.com

Lines of Coverage: Voluntary Cancer, Accident & Critical Illness

Colonial Life & Accident Insurance Company
PO Box 1365
Columbia, South Carolina 29202-1365
Phone: 800.325.4368
Website: www.coloniallife.com

Lines of Coverage: Voluntary Cancer, Accident & Critical Illness

TransAmerica Insurance Company
4333 Edgewood Road NE
Cedar Rapids, Iowa 52499
Phone: 800.797.2643
Website: www.transamerica.com

Lines of Coverage: Voluntary Cancer, Accident & Critical Illness

Plan Administrator and Named Fiduciary

Macon County
5 West Main Street
Franklin, NC 28734
Attention: Human Resources Manager
828-349-2020
Mdecker@MaconNC.org

Named Fiduciary (for Insured Benefit Claims)

For each of the insured component benefit programs, the applicable Insurer is a Named Fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

Agent for Service of Legal Process

President
Macon County
5 West Main Street
Franklin, NC 28734
828-349-2020

Service for legal process may also be made on the Plan Administrator.

Important Disclaimer

Benefits hereunder are provided pursuant to an insurance contract or governing written plan document adopted by the Plan Sponsor. If the terms of this Wrap SPD document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this Wrap SPD document, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible employee with respect to the Plan is any common-law employee of the Plan Sponsor who is eligible to participate in and receive benefits under one or more of the component benefit programs. The eligibility and participation requirements may vary depending on the particular component program and are described in the Plan Documents. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program (including completing any waiting period as noted in the Plan Documents). To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Plan Documents for the applicable component benefit programs.

Eligibility to enroll on our group health plan may be impacted by your ACA Benefit Status, which is reflected in our counting policy. These rules, based on regulations adopted under the Affordable Care Act, are integrated into this Summary Plan Description to determine eligibility for full-time and other non-seasonal positions. Seasonal employees, if any, are not eligible to participate on the group health plan.

Application of Counting Policy Rules (ACA Eligibility for Health Plan)

Plan Sponsor has adopted a Counting Policy and Procedure to determine when a newly hired variable hour employee would become eligible, and also to adopt a measurement period to determine on a regular basis when each employee would either be determined to be eligible, to lose their eligibility or to continue their eligibility based on the 30 hour per week/130 hours per month thresholds mandated by the Affordable Care Act. Please refer to Plan Sponsor's Counting Policy to determine if you are subject to special eligibility determination.

Need for Enrollment: Time Limits

In general, eligible employees must complete an application form (available through the Human Resources Manager of Macon County) to enroll themselves and/or their eligible dependents. New employees must generally enroll within certain time periods after being hired, as described in the Plan Documents. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before the beginning of each plan year.

Special Enrollment Rights

In certain circumstances and with respect to particular component benefit programs, enrollment may occur at times outside the open enrollment period (this is referred to as "special enrollment"), as explained in the Plan Documents. The Plan's Special Enrollment Notice also contains important information about your potential special enrollment rights. Contact the Human Resources Manager of Macon County if you need another copy.

When Participation Begins

Once you, as an eligible employee, have completed the necessary enrollment paperwork, your coverage under the Plan may begin. Requirements may vary depending on the component benefit program. For information about when coverage begins, please read the eligibility and participation information contained in the Plan Documents.

Termination of Participation

In general, your coverage under this Plan ends on the day on which you terminate employment with the Plan Sponsor (but this day may be different based on the benefit plans and administrative rules). Coverage also terminates if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, lose eligibility and for certain other reasons described in the Plan Documents. Coverage for your eligible and enrolled dependents stops when your coverage stops and for other reasons

specified in the Plan Documents (for example, divorce or a dependent's attaining age limit). Coverage also ceases for participants upon termination of the Plan.

Coverage under a particular component benefit program stops according to the terms and conditions reflected in the Plan Documents. Note that termination of coverage under a particular component benefit program does not necessarily mean your coverage under the Plan in general terminates. You may still have coverage under another component benefit program.

5. Summary of Plan Benefits

Available Benefits and Contributions

In general, the cost of the benefits provided through the component benefit programs will be funded in part by Company contributions and in part by pre-tax employee contributions. The Plan Sponsor will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and the Plan Sponsor may change that determination at any time.

The Plan Sponsor will make its contributions in an amount that (in the Plan Sponsor's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. With respect to the insured component benefit programs, the Plan Sponsor will remit its contribution and your contributions to the insurer. With respect to benefits that are self-funded, the Plan Sponsor will use these contributions to pay benefits directly to (or on behalf of) you or your eligible family members from the Plan Sponsor's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

What you pay toward the cost of your benefits, if applicable, are included as an Appendix to this Wrap Plan Summary Plan Description (SPD).

Qualified Medical Child Support Orders

With respect to the component benefit programs, the Plan extends benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA §609(a). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Human Resources Manager of Macon County.

Administrative Requirements and Timelines

As described in the Plan Documents, there may be other reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. In this regard, please consult the benefit materials referenced above.

6. How the Plan Is Administered

Plan Operations

Because benefits under the Plan are provided both through insurance contracts and on a self-funded basis, the Plan is administered by Macon County and, where applicable, the insurers.

Plan Administration

Macon County is the Plan Administrator. As the Plan Administrator, Macon County responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs). The Human Resources Manager of Macon County is the person who acts on behalf of the Plan Administrator. Macon County has agreed to indemnify the Human Resources Manager for any liability that he or she incurs as a result of acting on behalf of the Plan Administrator, unless such liability is due to his or her gross negligence or misconduct.

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms, and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering

the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Plan Sponsor will bear its incidental costs of administering the Plan.

Power and Authority of Insurer(s)

Certain benefits under the Plan are fully insured. Benefits are provided under a group insurance contract entered into between Macon County and the applicable Insurer. For those benefits, claims are sent to the applicable Insurer, who is responsible for determining and paying claims, not Macon County. The applicable Insurer is responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan. As Named Fiduciary for benefit determinations, the applicable Insurer has the discretionary authority to interpret the Plan in order to make benefit determinations. The Insurer also has the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular component benefit program offered through the Plan, or the amount of any benefit payable under the self-funded component benefit plans), please contact the Human Resources Manager, who acts on behalf of the Plan Administrator. If you have any question regarding your eligibility for, or the amount of, any benefit payable under the fully insured component benefit plans, please contact the appropriate Insurer.

7. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 4. Your benefits will also cease upon termination of the Plan.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied if you have a preexisting condition (but not health benefits) or must incur costs within the exclusionary period under the certain benefit programs. See the referenced documents for additional details.

8. Amendment or Termination of the Plan

Amendment or Termination

Macon County, as the sponsor of the Plan, has the general right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the Macon County President or the Human Resources Manager, both of whom are authorized to amend or terminate the Plan and to sign insurance contracts with the insurers, including amendments to those contracts. Note, for this purpose, that an insurance contract is not necessarily the same as the Plan. (An insurance contract is how benefits under a particular component program offered through the Plan are provided.) Consequently, termination of an insurance contract does not necessarily terminate the Plan.

Macon County, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by Plan Sponsor or any of its delegates.

The Human Resources Manager of Macon County may sign insurance contracts for the Plan on behalf of the Plan Sponsor, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable in order to comply with applicable law.

9. No Contract of Employment

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Plan Sponsor to the effect that you will be employed for any specific period of time.

10. Claims Procedures

Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form. (See the Plan Documents for more information.)

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan). (See the Plan Documents for more information.)

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Plan Sponsor's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent review and to require such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial. (See the Plan Documents for more information.)

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

See the referenced materials for information about how to appeal a denied claim and for details regarding the insurer's appeals procedures.

11. Statement of ERISA Rights

Note that certain benefits are not covered by ERISA and this Statement of ERISA Rights does not apply to those benefit programs under this Plan.

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series, if required) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual 5500 report (if required) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Macon County, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500, for plans with 100 or more participating employees), from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Macon County, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 10), you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your Premium Conversion Plan—A Brief Description

Macon County has established a Premium Conversion Plan, which lets you pay for your employer-sponsored benefits with pre-tax dollars. This is a tax benefit, the effect of which is to lower the cost to you of your premiums for employer-sponsored medical insurance.

This is a brief description of the Premium Conversion Plan. The Premium Conversion Plan is governed by an official plan document. If there are any differences between this description and the official plan document, the official plan document will govern.

What is the Premium Conversion Plan and how does it work?

The Premium Conversion Plan is set up under Section 125 of the Internal Revenue Code and provides you with a tax benefit. This is how it works: A portion of your pay is withheld by Macon County for the purpose of paying your share of your medical premium. The money withheld for premiums is not subject to federal income, Medicare, or Social Security (FICA) taxes, and in most cases, state and local taxes. Accordingly, you will save on most federal, state, and local taxes (the exact savings depends upon your tax bracket and your state of residence). Here's an example:

John earns $2500 each month. His federal income tax bracket is 15%, his FICA tax rate is 7.65%, and his state income tax rate is 4.75%, for a total tax rate of 27.4%. His employer sponsors a medical plan, and employees must contribute $300 per month for employee only coverage. By paying for his portion of the premiums with pre-tax dollars, John's take-home pay only decreases by $217.80 each month. John saves $82.20 by paying for his share of the premiums with pre-tax dollars.

	If John pays for his share of his coverage with after-tax dollars	**If John participates in the premium conversion plan and pays with pre-tax dollars**
Gross monthly income	$2,500	$2,500
Pre-tax deduction for employee share of medical premiums	0	$300
Taxable income for the month	$2,500	$2,200
Taxes (taxable income multiplied by total tax rate of 27.4%)	$685	$602.80
Net pay for the month	$1,815	$1,597.20
After-tax payment of employee share of medical premiums	$300	0
Take-home pay after employee contribution for medical coverage	$1,515	$1,597.20 (savings of $82.20)

Am I eligible to participate?

You are eligible to participate in the Premium Conversion Plan if you are a common law employee of Macon County and satisfy the minimum hour requirements and waiting period for new employees. You are not eligible to participate if your employer determines that you are:

- Self-employed
- An independent contractor
- A consultant or advisor

May premiums for my family's coverage be paid by Premium Conversion?

Generally, yes—but there is an exception. Under IRS rules, pre-tax dollars may only be used to pay for the premiums of someone who is your dependent, as defined under the Internal Revenue Code. If an individual is a dependent for purposes of your medical coverage but not a dependent as defined by the Internal Revenue Code, your payments toward that individual's coverage may not be paid with pre-tax dollars through this Premium Conversion Plan but must be paid instead on an after-tax basis. You may want to consult your tax advisor for information about whether someone is your tax dependent. Macon County may ask for information about the tax status of your dependents to ensure that you comply with the terms of the Premium Conversion Plan.

How do I enroll?

You are automatically enrolled in the Premium Conversion Plan as of the day the Premium Conversion Plan is established, or your date of hire if you are hired after the Premium Conversion Plan is established. Your participation will continue automatically unless you elect not to participate.

Can I choose not to participate in the Premium Conversion Plan?

Yes. To opt-out of the Premium Conversion Plan, you need to complete a written waiver/election form and return it to Macon County's Human Resources Department. If you do not pay federal income tax, you should consider waiving participation in the Premium Conversion Plan (but your contributions will still be treated as post-tax for the purpose of FICA obligations).

How does participation in the Premium Conversion Plan affect my other benefits, such as Social Security?

Participating in the Premium Conversion Plan could slightly lower your Social Security benefit. This is because your Social Security benefit is calculated based on your taxable earnings. Participating in the Premium Conversion Plan will reduce your taxable earnings and accordingly affect your Social Security benefit calculation. You may experience a similar effect on other benefits such as life insurance, disability, or pension benefits, depending upon how these other benefits define compensation. If these benefits, like Social Security, are calculated based on your taxable earnings, your participation in the Premium Conversion Plan could result in lower benefits.

May I change my Premium Conversion Plan participation?

Each year, we will have an open enrollment period during which you may change your participation in the Premium Conversion Plan. During open enrollment, you may elect to participate if you haven't been doing so, you may cancel your participation, or you may make a change to your election—such as increasing your participation level to add a dependent to your medical coverage.

Except for annual open enrollment, you cannot change your Premium Conversion Plan participation unless you experience a "change in status" as defined by the Internal Revenue Service. If you experience a change in status, you may only change your participation status within 30 days of the event, and your requested change must be consistent with the change in status that you experience.

The following is a list of changes in status that may allow you to make a change to your elections.

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment.
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption.
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or ending employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances.
- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan's network service area.
- **Loss of Other Coverage**: If you decline enrollment for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Premium Conversion Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage).
- **Government coverage:** If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.)

What happens if I take a leave of absence or terminate employment?

If you take a leave of absence, you may be able to revoke your election. See your employer about information about your rights. If you stop working for your employer, whatever the reason, your participation in the Premium Conversion Plan will automatically terminate. This means that any premiums for medical coverage after you stop working must be paid with after-tax dollars.

Continuation Coverage Rights Under COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

A spouse of an employee will become a qualified beneficiary if they lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Mike Decker, Macon County, 828-349-2020 or Mdecker@MaconNC.org.

How is COBRA Coverage Provided?

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

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

- ***Disability extension of 18-month period of continuation coverage.*** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
- ***Second qualifying event extension of 18-month period of continuation coverage.*** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under

the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Macon County
Mike Decker
828-349-2020
Mdecker@MaconNC.org

NOTICE OF PRIVACY PRACTICES

WAYAH EMPLOYEE BENEFITS

EbenConcepts

This provides notice of the privacy practices and policies of EbenConcepts Company, Inc. These protections have been adopted to ensure that the information that we obtain and maintain for our clients and customers, which may also include information about the employees, dependents, former employees and dependents, and other eligible participants on a group health plan for which we are providing services ("Protected Parties"), is protected in accordance with relevant state and federal rules. The Notice outlines our practices, policies, and legal duties to maintain and protect against prohibited disclosure of personally-identifiable financial information (as required by the federal Gramm-Leach-Bliley Financial Modernization Act ("GLB Act"), and the various state laws implementing those requirements), Protected Health Information of those Protected Parties (under the privacy regulations mandated by the Health Insurance Portability and Accountability Act and further expanded by the Health Information Technology for Economic and Clinical Health Act provisions in Title XIII of the American Recovery and Reinvestment Act ("HITECH") and the regulations related to these laws and mandates), and the protection of personally-identifiable information under 45 CFR § 155.260 (collectively referred herein as "Privacy Rules").

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

PROTECTING THE PRIVACY AND SECURITY OF INFORMATION WE ARE ENTRUSTED WITH IS VERY IMPORTANT TO US.

1. Statement of Our Duties. We are required by law to maintain the privacy of non-public personal information ("NPPI"), protected health information ("PHI"), and personally-identifiable information ("PII") (collectively referred herein as "Protected Information") of Protected Parties and to provide our clients with this notice of our privacy practices and legal duties. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to adopt any new provisions regarding the Protected Information that we maintain about the Protected Parties. If we revise this notice, we will provide each client or customer with whom there is a current and direct business relationship with a revised notice by mail, email (or any other electronic means), fax, or hand-delivery.

2. Statement of the Client's Rights under Privacy Rules. As a client or potential customer, you have a right to know how we may use or disclose the Protected Information we maintain on those Protected Parties with whom there is a direct relationship. When our client is an employer sponsoring a group health plan, our duty to protect information is to the client and not to their employees, dependents, former employees or dependents or other eligible participants on the group health plan. Our obligations to not disclose Protected Information we maintain about those individuals may arise due to our contractual obligations as a Business Associate of our client, as well as to any other third party who is a Covered Entity under the Privacy Rules, but does not create a special legal duty to provide notice to those individuals of their rights through a Notice of Privacy Practices. When our client is an individual or family purchasing an insurance policy, then our duty is to those individuals.

Primary Uses and Disclosures of Protected Information. We use and disclose Protected Information about Protected Parties for payment and health care operations. Privacy Rules does not generally "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the Privacy Rules, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the Protected Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights.

In addition to these legal requirements, we also may use or disclose Protected Information in the following situations:

Payment: We might use and disclose your Protected Information for all activities that are included within the definition of "payment" within the Privacy Rules. For example, we might use and disclose a Protected Party's Protected Information to assist with the payment of claims for services provided to that Protected Party by doctors, hospitals, pharmacies and others for services that are covered by a group health plan. We might also use your information to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations: We might use and disclose a Protected Party's Protected Information for all activities that are included within the definition of "health care operations" within the Privacy Rules. For example, we might use and disclose the Protected Information of a Protected Party to an insurer to determine the premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to manage our business.

Business Associate Subcontractors: In connection with our payment and health care operations activities, we contract with individuals and entities (called "subcontractors") to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our subcontractors will receive, have access to, create, maintain, use, or disclose Protected Information, but only after we require the subcontractor to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities: In addition, we might use or disclose your Protected Information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we might disclose a Protected Party's Protected Information to a health care provider when needed by the provider to render treatment to that party, and we might disclose Protected Information to another covered entity or subcontractor to conduct health care operations related to billing, claims payment or enrollment.

For all other uses and disclosures, we first must obtain your permission.

In addition, you have the following rights:

- The right to request that we place additional restrictions on our uses and disclosures of the Protected Information of Protected Parties. However, we are not obligated to agree to impose any such additional restrictions.
- The right to access, inspect, and copy the protected information pertaining to Protected Parties that we maintain in our files, and the right to have us correct or amend any information that we create in error. Requests to access or amend your health information should be sent to the contact person and address provided below.
- The right to receive an accounting of the disclosures of the Protected Information we maintain on Protected Parties that we make for purposes other than activities related to payment functions or other health care operations.
- The right to request that communications containing a protected party's Protected Information are sent in a confidential manner.

- If you received this notice electronically, you also have the right to obtain a paper copy of this notice from us on request.

3. Information We Collect About You. We collect the following categories of information for group and/or individual policies from the following sources:

a) Information that we obtain directly from you, in conversations or on applications or other forms that you or a Protected Party completes.
b) Information regarding current or prospective plan participants we obtain about them on applications or other forms.
c) Information about the plan's transactions with our affiliates, others or us.
d) Information that we obtain as a result of our transactions with you.

4. Permissible Uses and Disclosures of Protected Information. We disclose the information we receive regarding current or prospective clients only in accordance with the terms and conditions of the various Business Associate contracts we have entered to with Covered Entities under Privacy Rules and as permitted under state and federal laws concerning the privacy of your insurance and financial information. Those include:

- Situations Permitted or Required by Law. We also may use or disclose your Protected Information without your written permission for other purposes permitted or required by law, including, but not limited to the following:
  a) As authorized by and to the extent necessary to comply with workers' compensation or other no-fault laws;
  b) To an oversight or insurance regulatory agency for activities including audits or civil, criminal or administrative actions;
  c) To a public health authority for purposes of public health activities (such as to the Federal Food and Drug Administration to report consumer product defects);
  d) To a law enforcement official for law enforcement purposes or in response to a court order or in the course of any judicial or administrative proceeding;
  e) To organ procurement organizations or other entities for approved research; or
  f) To a governmental authority, including a social service or protective services agency, authorized to receive reports of abuse, neglect or domestic violence.
- For any Purposes to Which you have Not Objected. In certain limited circumstances, we may use or disclose your Protected Information after we have given you an opportunity to object and you have not objected. For example, if you do not object, we may use limited information about you to maintain an office directory, to notify family members or any other person identified by you regarding issues directly related to such person's involvement with your care or payment for that care, or in emergency circumstances.
- For Purposes for Which We Have Obtained your Written Permission. All other uses or disclosures of your Protected Information will be made only with your written permission, and you may revoke any permission that you give us at any time.

5. Complaints About Misuse of Health Information. You may complain either directly to us or to the Secretary of Health and Human Services if you believe that your rights with respect to our protection of your health information have been violated. To file a complaint with us, you may send a written statement outlining your complaint, the facts and circumstances surrounding your complaint, including the names, dates and as many details as possible. You will not be retaliated against in any way for filing a complaint.

6. Our Practices Regarding Confidentiality and Security. We restrict access to Protected Information about you to those employees and its subcontractors who need to know that information in order to provide products and services to you. We maintain physical, electronic and procedural safeguards that comply with state & federal regulations to guard your Protected Information.

7. Our Duties. We are required by law to maintain the privacy of Protected Information and to provide individuals with notice of its legal duties and privacy practices with respect to Protected Information. If unsecured Protected Information is acquired, used or disclosed in a manner that is not permitted under the Privacy Rules that compromises the security or privacy of that Protected Information, (referred to as a "Breach"), We are required to provide appropriate Notice as defined by law without unreasonable delay and in no case later than 60 days after the discovery of the Breach or the receipt of information of the Breach. We may delegate this duty to a subcontractor. We are required to abide by the terms of the Notice that is currently in effect. We will provide a paper copy of this Notice to you upon your request.

8. Our Policy Regarding Dispute Resolution. Any controversy or claim arising out of or relating to our privacy policy, or the breach thereof, shall be settled by arbitration in accordance with the rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

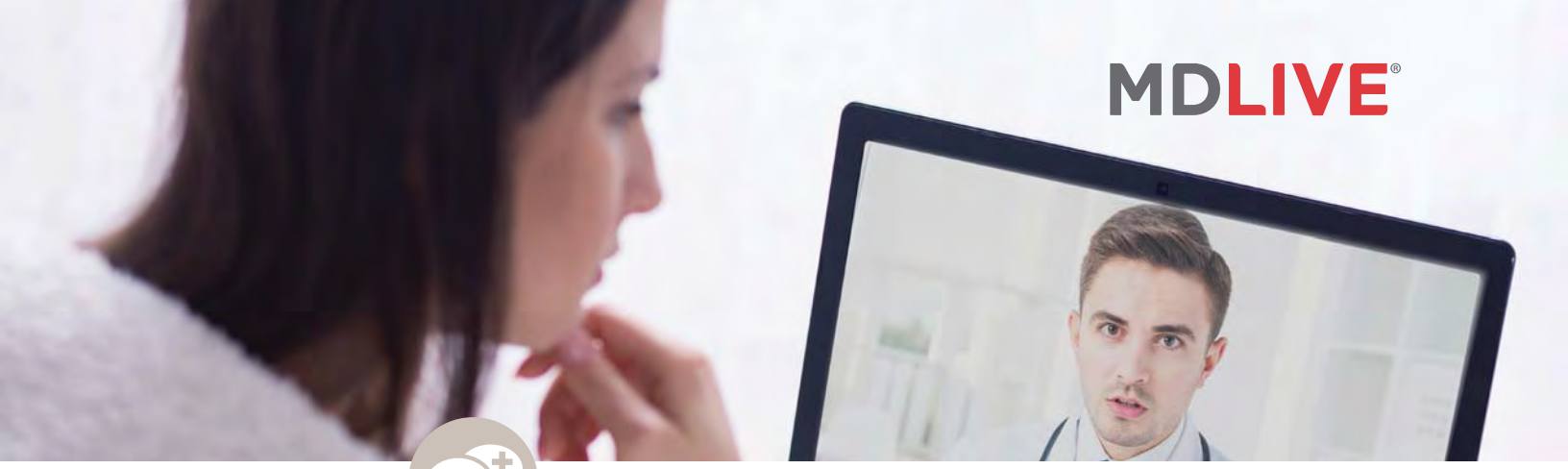
9. Revisions to this Notice. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all Protected Information we maintain, regardless of whether the Protected Information was created or received prior to issuing the revised Notice. Whenever there is a material change to our use and disclosure of Protected Information, individual rights, our duties, or other privacy practices stated in this Notice, we will promptly revise and distribute the new Notice.

Contact Person for Filing Complaint or Obtaining Other Information. If you believe your privacy rights have been violated, you may file a written complaint with our Privacy Officer at the following address:

David C. Smith
Vice President
EbenConcepts Company, Inc.
921-C S. McPherson Church Road
Fayetteville, NC 28303
(910) 401-9455
dcsmith@ebenconcepts.com

BENEFIT SUMMARIES

MDLive



TELEHEALTH

See a doctor from home, at work or on the go

Sunburn at the beach? Stomach bug on Thanksgiving? In a rural area with no doctors nearby? Think you've got the flu but don't feel up to driving to your doctor's office? These are just a few of the reasons people use telehealth. And you can too!

Your Blue Cross and Blue Shield of North Carolina (Blue Cross NC) health plan includes telehealth services from MDLIVE.* It's a good option for minor health problems when you can't see your regular doctor. Plus, it's often more convenient and cost effective than urgent care.

Get started.

Don't wait until you're sick – activate your MDLIVE account now so you're prepared. There are three ways to activate: mobile app, online or by phone (see graphic).

Once your account is set up, you can see a board-certified doctor via secure online video from the MDLIVE app or your computer. MDLIVE's doctors can diagnose symptoms, prescribe non-narcotic medication[1] and send prescriptions to your pharmacy.

Skip the waiting room.

Seventy percent of consumers say they're interested in telehealth – and convenience is the top reason.[2] MDLIVE offers these time-saving benefits:

+ Video consults available from 7 a.m. to 9 p.m. every day (even holidays)
+ Takes just minutes to connect with an MDLIVE doctor
+ No appointment needed (though you can make one to see a specific doctor)
+ Pediatricians available if your child gets sick
+ If you need a prescription, your MDLIVE doctor can electronically send it to the pharmacy that's close to you
+ On the couch, at work, travelling – you can use MDLIVE just about anywhere[3]

*MDLIVE is an independent company that is solely responsible for the telehealth services it is providing.

3 ways to activate today

So it's ready when you need it!

Download the MDLIVE app on your smartphone or tablet.

Go to ***mdlive.com/ncvideodoc*** and click **"Activate Now."**

Call 888-657-9982

Why wait?

Average time it takes to see a doctor:

+ **Less than 10 minutes to start an MDLIVE video consult[4]**
+ 19 minutes at a doctor's office[5] (40 minutes for total visit)[6]
+ 30 minutes at an urgent care (60 minutes for total visit)[7]
+ 28 minutes at the ER (153 minutes for total visit)[8]

Save money.

Extra convenience doesn't mean extra cost. In fact, telehealth runs less than the typical urgent care visit. And if you go to the ER for a non-emergency? Your cost can skyrocket more than 1,300%![9]

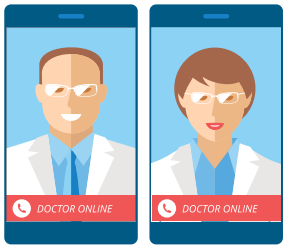
With MDLIVE, **your copay will be waived for a video consult**.

Dollars to dollars

Compare the average member cost for:[9]

Get quality care.

MDLIVE doctors are board certified with an average of 15 years' experience. Specialties range from primary care and internal medicine, to pediatrics and family medicine. So, they can treat a wide range of conditions.



Trust is also important. MDLIVE has a 97% satisfaction rating – and 97% would recommend it.[4] You're only shown doctors who are licensed to practice in your state. It's HIPAA-compliant and your personal health information is never shared with your employer.

Keep in mind that telehealth isn't meant to replace your primary care doctor. Instead, think of it as an easy way to get care when common health problems hit. And of course, you should always call 911 for any life-threatening emergencies.

MDLIVE can handle many non-emergency health problems:

- Acne
- Cough, cold and flu
- Fever[10]
- Joint aches and pains
- Rash
- Sunburn
- Allergies
- Diarrhea
- Headache
- Nausea and vomiting
- Sinus problems
- Urinary problems and UTIs[10]
- Constipation
- Ear problems
- Insect bites
- Pink eye
- Sore throat
- And more

Learn more at ***mdlive.com/ncvideodoc*** or by calling **888-657-9982.**

1 In some states, laws require that a doctor only prescribe medication in certain situations and subject to certain limitations.

2 "2017 Consumer Survey on Virtual Health." Accenture. Online: *www.accenture.com/us-en/insight-voting-virtual-health-survey* (accessed May 2017).

3 MDLIVE services currently not available in Arkansas.

4 *Quality of Care Management System*. MDLIVE: 2017.

5 Based on national average wait time of 18 minutes and 35 seconds. Source: 8th Annual Vitals Index. Online: *www.vitals.com/about/posts/press-center/press-releases/vitals-index-reveals-wait-times-decreasing* (accessed May 2017).

6 Shaw, Meredith K., et al. "The duration of office visits in the United States, 1993 to 2010." *The American Journal of Managed Care* 20.10 (2014): 820-826.

7 "2016 Benchmarking Report Summary." Urgent Care Association of America. Online: *www.ucaoa.org/resource/resmgr/benchmarking/2016BenchmarkReport.pdf* (accessed May 2017).

8 Average times shown are for emergency departments in North Carolina. Source: *https://projects.propublica.org/emergency/* (accessed May 2017).

9 Urgent care and ER figures are the average cost to Blue Cross NC members across commercial group plans.Based on Blue Cross NC internal data for 12 months ending December 2016. ER costs include both facility and professional charges—and combine copayment, deductible and coinsurance.

10 Children under 36 months who present with fever must be referred to their pediatrician (medical home), child-friendly urgent care center or emergency department for clinical evaluation and care. MDLIVE doctors may not treat any children with urinary symptoms. Parent/guardian will be required to complete a different medical history disclosure form for children under the age of 36 months prior to making an appointment with an MDLIVE doctor.

MDLIVE is an independent company that is solely responsible for the telehealth services it is providing. MDLIVE does not offer Blue Cross or Blue Shield products or services. MDLIVE interactive video consultations are available 7 days a week during the hours of 7 a.m. to 9 p.m. Availability depends on location at the time of consultation; services are not available when a member is physically located in Arkansas. Telehealth services are subject to the terms and conditions of the member's health plan, including benefits, limitations and exclusions. Telehealth services are not a substitute for emergency care.

MDLIVE does not replace your primary care doctor and is not an insurance product. MDLIVE may not be available in certain states and is subject to state regulations. MDLIVE does not prescribe DEA-controlled substances and may not prescribe non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE does not guarantee patients will receive a prescription. Health care professionals using the platform have the right to deny care if based on professional judgment a case is inappropriate for telehealth or for misuse of services. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use, visit *https://welcome.mdlive.com/terms-of-use*.

BLUE CROSS®, BLUE SHIELD®, and the Cross and Shield symbols are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other marks are the property of their respective owners. Blue Cross NC is an independent licensee of the Blue Cross and Blue Shield Association. U13145b, 6/17

FAQs

MDLIVE Telehealth Services

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) is excited to offer telehealth services from MDLIVE. With telehealth, you can see a board-certified doctor via secure online video from the MDLIVE app or your computer. MDLIVE's doctors can diagnose symptoms, prescribe non-narcotic medication (if needed) and send e-prescriptions to your local pharmacy.[1]

Telehealth is a good care option for minor health problems when you can't see your regular doctor. Plus, it's often more convenient and cost effective than urgent care. Below, you'll find answers to questions you may have about this benefit.

GETTING STARTED

Should I wait until I'm sick to create an MDLIVE account?

No. It's best to activate your account now. That way, it's ready when you need it. (There's no charge for signing up.) Be sure to fill out your medical history profile, too.

Does this replace my primary care doctor?

Not at all. In fact, we encourage you to list your primary care doctor when activating your MDLIVE account. That way, you can share the results of your video consult with them – and your medical records stay up-to-date.

Is it private and secure?

Absolutely. MDLIVE complies with the Health Insurance Portability and Accountability Act (HIPAA). It uses secure video through your computer, tablet or the MDLIVE mobile app. Your personal health information is never shared with your employer.

What devices are supported?

You can access MDLIVE on most Apple and Android mobile devices by downloading the MDLIVE app. On a desktop or laptop, you'll need a high-speed internet connection, a webcam with a resolution of at least 1.3 megapixels and a microphone (most webcams have a built-in microphone). After activating your account, you can test that your computer setup will work.

How do I activate my MDLIVE account?

Setting up your free account is quick and easy. **You can use any of these methods:**

Download the MDLIVE app on your smartphone or tablet.

Go to *mdlive.com/ncvideodoc* and click **"Activate Now."**

Call 888-657-9982

WHEN TO USE IT

When can I use MDLIVE?

Video consults are available from 7 a.m. to 9 p.m., seven days a week (including holidays).

Do I need an appointment?

No, unless you want to see a specific doctor. After logging in, you can select a doctor who is currently available, make an appointment with a particular doctor or talk to the next available doctor on call. MDLIVE's average wait time is less than 10 minutes.

Is it right for any medical problem?

Not everything. MDLIVE is designed to handle non-emergency medical conditions like the flu or pink eye. It's not intended to replace your primary care doctor. And it should not be used in medical emergencies. If you have a life-threatening emergency, call 911 right away.

What conditions can MDLIVE treat?

MDLIVE's doctors can diagnose and treat many non-emergency health problems:

- Acne
- Constipation
- Diarrhea
- Fever[2]
- Insect bites
- Nausea and vomiting
- Rash
- Sore throat
- Urinary problems and UTIs[3]
- Allergies
- Cough, cold and flu
- Ear problems
- Headache
- Joint aches and pains
- Pink eye
- Sinus problems
- Sunburn
- And more

Can I use MDLIVE when I travel?

Yes. Video consultations are available in every state except for Arkansas. MDLIVE ensures the doctor you see is fully licensed to practice medicine in the state you're in.

HOW TO USE IT

What does it cost?

Your copay will be waived for a telehealth visit.

Who are the MDLIVE doctors?

All MDLIVE doctors are U.S. board certified with 15 years of experience, on average. Their specialties include primary care, pediatrics and family medicine. So, they can treat a wide range of conditions. When you log in, you'll only be shown doctors licensed to practice in your state.

Can a doctor prescribe medication from a video consult?

If the MDLIVE doctor believes it's needed, he or she can write a prescription for non-narcotic medicines. It's sent electronically to your pharmacy of choice. If that pharmacy doesn't take e-prescriptions, a traditional prescription is created for the doctor to sign and fax to the pharmacy.

Can I use this for my child?

Yes. MDLIVE has pediatricians on call. When you register, set up your child's record under your account. Parents must be present on any video consult for children under age 18.[2,3]

Can I give feedback on the MDLIVE doctors I see?

We encourage it! After a video consult, you'll get a survey to rate the doctor you saw. The results are reviewed for quality as part of MDLIVE's continuous improvement process. MDLIVE's internal medical board also reviews randomly-selected appointments.

I have a question that isn't listed here. What should I do?

For questions about MDLIVE, call 888-657-9982. MDLIVE's health service specialists will be happy to help you. For questions about your insurance, please call the phone number on your Blue Cross NC member ID card.

1 Some state laws require that a doctor only prescribe medication in certain situations and subject to certain limitations.
2 Children under 36 months who present with fever must be referred to their pediatrician (medical home), child-friendly urgent care center or emergency department for clinical evaluation and care.
3 MDLIVE doctors may not treat any children with urinary symptoms. Parent/guardian will be required to complete a different medical history disclosure form for children under the age of 36 months prior to making an appointment with an MDLIVE doctor.

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BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

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BlueCross BlueShield of North Carolina

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY 1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્કુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。

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HEALTH PLAN
BASE
BCBSNC

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bluecrossnc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-877-275-9787 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network- $2,500 Individual/$5,000 Family Total. Out-of-Network- $5,000 Individual/$10,000 Family Total. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services.	For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $200 prescription drug coverage. There are no other specific deductibles	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network- $6,600 Individual/$13,200 Family Total. Out-of-Network- Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsnc.com/FindADoctor or call 1-877-275-9787 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35/visit	50% coinsurance	None
	Specialist visit	$70/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	50% coinsurance	-You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay for.- Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnc.com/rxinfo	Tier 1 Drugs	$10/prescription	Not Covered	- * See Prescription Drug section. - For Infertility dosage limits apply -Up to $100 max for each 30 day supply for tier 2-3 drugs -Minimum of $0 in coinsurance but no more than $250 for tier 4 drugs
	Tier 2 Drugs	25% coinsurance	Not Covered	
	Tier 3 Drugs	25% coinsurance	Not Covered	
	Tier 4 Drugs	50% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$500/visit	$500/visit	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$70/visit	$70/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$70/office visit; 30% coinsurance / outpatient	50% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Inpatient services	30% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered
If you are pregnant	Office visits	$35/visit	50% coinsurance	-*See Family planning section. -Cost sharing does not apply for preventive services.

*For more information about limitations and exceptions, see plan or policy document at www.bluecrossnc.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	-No coverage for maternity for dependent children.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	-Precertification may be required
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Rehabilitation services	$70/visit	50% coinsurance	-*See Therapies section -30 visits/ benefit period includes PT/OT- 30 visits/benefit period Chiropractic care - $40,000 max/benefit period for Adaptive Behavior Treatment (18 and younger)
	Habilitation services	$70/visit	50% coinsurance	-Habilitation services are combined with the Rehabilitation service limits listed above.
	Skilled nursing care	30% coinsurance	50% coinsurance	-Coverage is limited to 60 days per benefit period. -Prior review and certification of services may be required or services will not be covered
	Durable medical equipment	30% coinsurance	50% coinsurance	-Prior review and certification of services may be required or services will not be covered -Limits may apply
	Hospice services	30% coinsurance	50% coinsurance	-Precertification may be required

*For more information about limitations and exceptions, see plan or policy document at www.bluecrossnc.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded Service
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See www.bluecrossnc.com
- Chiropractic care
- Private duty nursing
- Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross NC at 1-877-275-9787 or **www.BlueConnectNC.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, if applicable.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.
Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.
Chinese (中文):如需國語或廣東話協助，請致電您保險卡背面的電話號碼。
Navajo (Dine):Diné bizaad bee shíká'adoowoł nínzingo kwojí' hólne', naaltsoos áłts'ísí nantinígíí bine'dęę' binámboo bikáá'.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist copayment	$70
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$30
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,300**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist copayment	$70
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$700
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,500**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist copayment	$70
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

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BlueCross BlueShield of North Carolina

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY：1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્કુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。

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HEALTH PLAN ENHANCED BCBSNC

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network- $1,500 Individual/$3,000 Family Total. Out-of-Network- $3,000 Individual/$6,000 Family Total. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services.	For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network- $4,000 Individual/$8,000 Family Total. Out-of-Network- $8,000 Individual/$16,000 Family Total.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsnc.com/FindADoctor or call 1-877-275-9787 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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	Specialist visit	$50/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge	40% coinsurance	-You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay for.- Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnc.com/rxinfo	Tier 1 Drugs	$10/prescription	Not Covered	- * See Prescription Drug section. - For Infertility dosage limits apply -Up to $100 max for each 30 day supply for tier 2-3 drugs -Minimum of $0 in coinsurance but no more than $250 for tier 4 drugs
	Tier 2 Drugs	25% coinsurance	Not Covered	
	Tier 3 Drugs	25% coinsurance	Not Covered	
	Tier 4 Drugs	50% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$300/visit	$300/visit	-$500/visit for subsequent visits during the benefit year
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50/visit	$50/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50/office visit; 20% coinsurance / outpatient	40% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Inpatient services	20% coinsurance	40% coinsurance	-Prior review and certification of services may be required or services will not be covered
If you are pregnant	Office visits	$25/visit	40% coinsurance	-*See Family planning section. -Cost sharing does not apply for preventive services.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	-No coverage for maternity for dependent children.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	-Precertification may be required
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	-Prior review and certification of services may be required or services will not be covered
	Rehabilitation services	$50/visit	40% coinsurance	-*See Therapies section -30 visits/ benefit period includes PT/OT- 30 visits/benefit period Chiropractic care - $40,000 max/benefit period for Adaptive Behavior Treatment (18 and younger)
	Habilitation services	$50/visit	40% coinsurance	-Habilitation services are combined with the Rehabilitation service limits listed above.
	Skilled nursing care	20% coinsurance	40% coinsurance	-Coverage is limited to 60 days per benefit period. -Prior review and certification of services may be required or services will not be covered
	Durable medical equipment	20% coinsurance	40% coinsurance	-Prior review and certification of services may be required or services will not be covered -Limits may apply
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded Service
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See www.bluecrossnc.com
- Chiropractic care
- Private duty nursing
- Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross NC at 1-877-275-9787 or **www.BlueConnectNC.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, if applicable.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.
Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.
Chinese (中文):如需國語或廣東話協助，請致電您保險卡背面的電話號碼。
Navajo (Dine):Diné bizaad bee shíká'adoowoł nínzingo kwojí' hólne', naaltsoos áłts'ísí nantinígíí bine'dęę' binámboo bikáá'.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,600**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

® Marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

BlueCross BlueShield of North Carolina

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY：1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્કુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。

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FLEXIBLE SPENDING ACCOUNT AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

TASC

Save up to 30% on eligible expenses

Enroll in a TASC Flexible Spending Account (FSA) so you can use pretax dollars to pay for common, everyday expenses and reduce your taxable income.

Below is a partial list of reimbursable expenses that may be incurred by you, your spouse, or qualified dependents.

Eligible Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductibles and co-insurance
- Diabetic supplies
- Eye exams
- Eyeglasses, contacts, or safety glasses (prescription)
- Flu shots
- Hearing aids and hearing aid batteries
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Nasal strips
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- Physical exams
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy test
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Sales tax on eligible expenses
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Vaccinations
- Wrist supports, elastic wraps
- X-ray fees

Eligible OTC Medicines and Drugs

Over-the-counter (OTC) medicines and drugs, except for insulin, require a prescription from your physician to be reimbursable.

- Bengay, Flexall, pain relieving creams or gels
- Calamine lotion
- Canker/cold sore relievers
- Cold medicines
- Corn removal
- Diaper rash ointment
- GasX, baby gas drops
- Hemorrhoid creams and treatments
- Hydrogen peroxide or rubbing alcohol
- Indigestion or anti-acid relievers
- Laxatives
- Nicotine patch
- Pain relievers (Tylenol, Advil, Aspirin, etc.)
- Sinus medicines
- Suppositories
- Teething gel
- Wart removal medication

Continued on next page...

Use your TASC Card to pay for eligible expenses at the point of purchase instead of paying out-of-pocket and requesting a reimbursement.

Eligible Dental Expenses

- Braces and orthodontic services
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

Eligible Dependent Care Expenses

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature
- Late pick-up fees
- Does not cover medical costs; use Healthcare FSA for medical expenses incurred by you or your dependents

For more information regarding eligible expenses, please review IRS Publication 502/503 at **irs.gov** or ask your employer for a copy of your Summary Plan Description (SPD).

Eligible Disability Expenses

- Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile
- Braille books/magazines in excess of cost of regular editions
- Note-taker for a hearing impaired child in school
- Seeing eye dog (buying, training, and maintaining)
- Special devices, such as a tape recorder or typewriter for a visually impaired person
- Visual alert system in the home or other items such as a special phone required for a hearing impaired person
- Wheelchair or autoette (cost of operating/ maintaining)

Requiring Additional Documentation

The following expenses are eligible only when incurred to treat a diagnosed medical condition. Such expenses require a ***Letter of Medical Necessity*** from your physician, containing the medical necessity of the expense, diagnosed condition, onset of condition, and physician's signature.

- Ear plugs
- Massage treatments
- Nursing services for care of a special medical ailment
- Orthopedic shoes (excess cost of ordinary shoes)
- Oxygen equipment and oxygen
- Support hose
- Varicose vein treatment
- Veneers
- Vitamins and supplements
- Wigs (for mental health condition of individual who loses hair because of a disease)

TASC®

Save money with FSA pretax benefit accounts.

A Flexible Spending Account (FSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for common expenses like these:

HEALTHCARE

- Medical/dental office visit co-pays
- Dental/orthodontic care services
- Prescriptions and vaccinations
- Eye exams; prescription glasses/lenses

DEPENDENT CARE

- Daycare expenses
- Before & after school care
- Nanny/nursery school
- Elder care

TIPS

- You can choose to enroll in a Healthcare FSA, Dependent Care FSA, and more
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at **irs.gov**

Increase your take-home pay by reducing your taxable income.

Each $1 you contribute to your FSA reduces your taxable income by $1.
With less tax taken, your take-home pay increases!

Consider this example:
(For illustration only)

Richard has:

- Gross monthly pay of $3,500
- $600 per month in eligible expenses

Here is his net monthly take-home pay:

Without FSA	With FSA
($600 spent using post-tax dollars)	($600 spent using pretax dollars)
$1,932	$2,098

That's a net increase in take-home pay of $166 every month!

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at www.tasconline.com/tasc-calculators/tasc-flexsystem-calculator/

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

How to participate.

It's easy to start saving with a TASC FSA.

Just follow 3 simple steps:

1. DECIDE how much you want contribute for the upcoming plan year

The more you contribute, the lower your taxable income will be. In spite of this, it's important be conservative when choosing your annual contribution based on your anticipated qualified expenses since:

- The money you contribute to your benefit account can only be used for eligible FSA expenses.
- Any unused FSA funds at the close of the plan year are not refundable to you. (Note: If your employer offers a Carryover option, up to $500 in unused contributions to a Healthcare FSA can carry over to the next year.)

PLANNING TIPS

START by making a conservative estimate of how much you expect to spend on eligible out-of-pocket expenses for the year.

COMPARE your estimate to the IRS limits at **www.tasconline.com/benefits-limits.** If your estimate is higher than these annual contribution limits, consider making the maximum contribution allowed.

2. ENROLL by completing the enrollment process each year

Your contribution will be deducted in equal amounts from each paycheck, pretax, throughout the plan year.

Your total annual contribution to a **Healthcare FSA** will be available to you immediately at the start of the plan year. Alternatively, your **Dependent Care FSA** funds are only available as payroll contributions are made.

SPECIAL FEATURES

Individual Giving Account: Every participant receives a complimentary TASC giving account.

Identify Theft Protection: All active participants receive TASC Identity Theft Protection.

3. ACCESS your funds easily using the TASC Card

This convenient card automatically approves and deducts most eligible purchases from your benefit account with no paperwork required. Plus, for purchases made without the card, you can request reimbursement online, by mobile app, or using a paper form.

Reimbursements happen fast — within 12 hours — when you request to have them added to the MyCash balance on your TASC Card. You can use the MyCash balance on your card to get cash at ATMs or to buy anything you want anywhere Mastercard is accepted!

Track and manage all TASC benefits and access numerous helpful tools, anywhere and anytime—with just one app!

GET IT ON Google Play | Download on the App Store | Search for "TASC" (green icon)

Questions? Ask your employer or contact your Plan Administrator:
Total Administration Services Corporation • www.tasconline.com • 1-800-422-4661

FX-4245-041619

MOBILE EXPERIENCE

Track and manage all TASC benefits and access helpful tools, anywhere and anytime—with just one app!

The TASC mobile app includes special features that make it easy to keep TASC accounts safe and secure. We've made it even faster and easier to manage benefits on the go.

TASC Card Lock. Misplace a TASC Card? No worries. With a swipe of a finger, participants can lock access until they've located the card, then swipe it back on when found.

Fingerprint (Touch ID) and Facial Recognition. These capabilities protect participants' account information without the hassle of remembering another password.

Picture to Pay. Take a picture of an eligible benefit expense then submit it via the TASC mobile app. There are no forms to fill out and no need to sign in to a website. Just click and submit and we'll take care of the rest.

Expense Eligibility Check. Not sure an item is eligible for reimbursement? Find out in seconds on the app. It's the quickest way to make sure benefits are being spent correctly.

Mobile Alerts[1]. Participants are notified when we've received a request and when it's been paid, making it easy to stay on top of account activity and available funds.

Seamless Account Management. Our website, mobile app, and customer care call center make it easy for participants to manage their account and get the support they need, anytime and anywhere! Plus, account information is connected across all platforms, which means participants don't have to re-enter data or restart a process between devices.

GET IT ON Google Play | Download on the App Store

Search for "TASC" (green icon)

TASC Wallet. These user-friendly features make benefits management simple and fast:

- ATM Locator. Finds the nearest ATM to withdraw cash from MyCash account via TASC Card.
- Card Management. Stores image of TASC Card; lets participants lock a card, report lost/stolen cards, or request more cards.
- Card Holder. Stores digital images of other important cards (insurance cards, rewards cards – even a gym membership card).
- Receipt Repository. Keeps benefits-related receipts in one convenient place.

The TASC mobile app. Just one more way we're making benefits smart, easy, and connected.

[1] *Standard message and data rates may apply.*

WEB EXPERIENCE

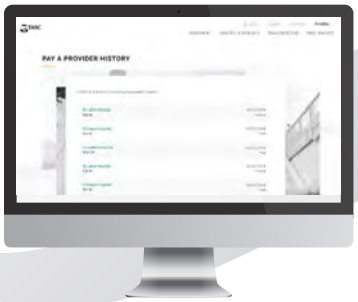
Make benefits feel like benefits again with TASC Universal Benefit Account™ — one-stop, online access to all enrolled accounts.

TASC's web and mobile tools ensure easy access, account management, and benefit fund security for our customers.

TASC Card Lock. All participants receive a TASC Card to access their benefit funds. If a card is lost or stolen, TASC Card Lock lets them disable a card in seconds from the TASC website or mobile app—and unlock it once it's found.

Pay the Provider. Instead of paying out of pocket and waiting to be reimbursed, participants can use their TASC Card to pay for eligible expenses, or they can use our convenient web payment feature. Simply scan or take a picture of the provider bill and upload it. TASC will then pay the bill directly from the appropriate benefit account.

Email Alerts. Participants are notified when requests are received and paid, making it easy to stay on top of account activity and available funds.



Seamless Account Management. Our website, mobile app, and customer care call center make it easy for participants to manage their account and get the support they need, anytime and anywhere! Plus, account information is connected across all platforms, which means participants don't have to re-enter data or restart a process between devices.

Access to Individual Giving Accounts. TASC believes in giving back to the community and that's why every participant receives a complimentary giving account. They can designate a regular payroll deduction or do one-time transfers from their bank or MyCash account and select favorite charities to allocate donations to – all via the TASC website or mobile app. And with no fees to use the giving account, 100% of donations go to designated causes.

TASC Wallet. These user-friendly features make benefits management simple and fast:

- ATM Locator. Finds the nearest ATM to withdraw cash from MyCash account via TASC Card.
- Card Management. Stores image of TASC Card; lets participants lock a card, report lost/stolen cards, or request more cards.
- Card Holder. Stores digital images of other important cards (insurance cards, rewards cards – even a gym membership card).
- Receipt Repository. Keeps benefits-related receipts in one convenient place.

The TASC web. Just one more way we're making benefits smart, easy, and connected.

Determine if your Dependent Care expenses qualify for reimbursement from FSA

The TASC Dependent Care FSA allows you to use pretax dollars to pay for eligible expenses related to care for your child, disabled spouse, elderly parent, or other dependent who is physically or mentally incapable of self-care, so you (or your spouse) can work, look for work, or attend school full time. **Medical expenses for your dependent are not eligible for reimbursement under the TASC Dependent Care FSA.**

Eligibility for the dependent care benefit requires that certain criteria be met, which is outlined in this document.

A) **The dependent care expenses must be work-related.** The care must be necessary for the employee and/or the employee's spouse to work, to look for work, or to attend school full-time, or if they are physically unable to care for their children.

B) **The dependent care expenses provided during a calendar year cannot exceed $5,000.** In the case of a separate return by a married individual, the limit is $2,500. This amount may be less if the employee's earned income or spouse's earned income is less than $5,000.

Dependent care expenses must be for the care of one or more qualifying persons.

A "Qualifying Person" is defined as one of the following:

- A dependent child who was under age 13 when care was provided and for whom a tax exemption can be claimed.
- A spouse who was physically or mentally not able to care for him/herself and lived with you for more than half the year.
- A dependent who was physically or mentally not able to care for him/herself and for whom an exemption can be claimed, and lived with you for more than half the year.

Eligible and Ineligible Expenses for Dependent Care FSA Reimbursement (partial list)

Allowed for Reimbursement:

- ☑ Fees for licensed day care or adult care facilities
- ☑ Before and after school care programs for dependents under age 13
- ☑ Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- ☑ Nanny expenses attributed to dependent care
- ☑ Nursery school (preschool) fees
- ☑ Summer Day Camp – primary purpose must be custodial care and not educational in nature
- ☑ Late pick-up fees

NOT Allowed for Reimbursement:

- ⊘ Medical expenses
- ⊘ Baby-sitter in or out of your home for reasons other than to enable you to work
- ⊘ Activity fees/ educational supplies
- ⊘ Food, clothing, and entertainment
- ⊘ Transportation expenses
- ⊘ Child support payments
- ⊘ Kindergarten fees
- ⊘ Overnight camp
- ⊘ Late payment charges

Continued on next page...

For more information regarding eligible Dependent Care expenses, please review IRS Publication 503 or ask your employer for a copy of your Summary Plan Description (SPD).

You can also find current contribution limits on our resource page at:

www.tasconline.com/benefits-limits

To receive the dependent care benefit, one must follow these procedures:

A) All persons and organizations that provide dependent care for a qualified person must be identified. This information is requested on IRS Form 2441. The name, address, and taxpayer identification number of the provider must be included. Under certain circumstances, the taxpayer identification number will be a social security number.

B) If the care is being provided by a center that cares for more than six persons, the center must comply with all state and local regulations.

C) Payments made to relatives who are not dependents can be included. However, do not include amounts paid to a dependent for whom you can claim an exemption or for your child who is under age 19 at the end of the year, regardless of whether he or she is your dependent.

D) Use Form W-10 to request the required information from the care provider.

Special rules apply to children of divorced or separated parents:

Even if you cannot claim your child as a dependent, he or she is treated as your qualifying person if all of the following are true:

- The child was under age 13 or was not physically or mentally able to care for himself or herself.
- One or both parents provided more than half of the child's support for the year and are divorced, legally separated, or lived apart at all times during the last 6 months of the calendar year.
- One or both parents had custody of the child for more than half of the year.
- You were the child's custodial parent. The custodial parent is the parent having custody for the greater portion of the calendar year. If the child was with both parents for an equal number of nights the parent with the higher adjusted gross income is the custodial parent.

A non-custodial parent that is entitled to claim the child as a dependent on their tax return may not treat the child as a qualifying individual for the dependent care benefit even when that parent is financially responsible for providing the care. Only one parent (the custodial parent) may qualify for the dependent care benefit for a taxable year. The regulations do not provide any relief for a non-custodial parent that incurs dependent care expenses for the portion of the year in which they have custody of the child to enable the non-custodial parent to work.

DENTAL PLAN COMPANION

dental by design®

Modified Dental Essentials

Region: 907
State: North Carolina
Rates Effective: 07/01/17

Macon County
Group Number 907-14-38113-

Dual Option	BASIC (Low Option) 001	ENHANCED (High Option) 000
Program Deductible Per Individual Family Limit Waived for Type I Services	$50 Contract Year 3 Yes	$50 Contract Year 3 Yes
Type I **Preventive Services**	**100%** oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)	**100%** oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)
Type II **Basic Services** **Benefit Waiting Period**	**80%** space maintainers, fillings, pain treatment, sealants, full mouth X-rays, anesthesia, simple and surgical extractions, oral surgery None	**80%** space maintainers, fillings, pain treatment, sealants, full mouth X-rays, anesthesia, simple and surgical extractions, oral surgery None
Type III **Major Services** **Benefit Waiting Period**	**0%**	**50%** endodontics, periodontics, crowns, inlays, onlays, dentures, bridges, implants 12 months
Contract Year Maximum	$1,000	$1,000
Type IV Orthodontia **Child(ren) Under 19 Only** Lifetime Maximum Deductible **Benefit Waiting Period**	*Not Selected*	**50%** Child(ren) Only $1,000 None 12 months
Semi-monthly Rates Employee Only Employee + 1 Employee + 2 Employee + 3 or more	**(24 pay periods)** $11.19 $22.01 $32.46 $43.28	**(24 pay periods)** $15.43 $33.09 $52.59 $70.11

Rates are guaranteed for 24 months.

Disclaimer: This is a summary of benefits only. Please refer to the policy for comprehensive benefit details. Payment is based upon allowable charges in the area in which service is rendered. Any dentist charge above the allowable charge is not a covered expense.

These amount may change if the cost for coverage changes mid-year due to a change in federal or state law.

Companion Life

P.O. Box 100102 • Columbia, SC 29202-3102 • 800-753-0404 • 800-836-5433 Fax • CompanionLife.com

TERM LIFE/AD&D, SUPPLEMENTAL LIFE/AD&D, DEPENDENT LIFE USAble LIFE

USAble Life
Live life. You're covered.℠

Macon County

Class 1: All Full Time Active Employees Earning at least $20,000.

USAble Life is proud to make the following insurance products available to you as an employee of Macon County.

Group Term Life/ Accidental Death & Dismemberment **Employer Paid**	$30,000 *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Dependent Life **Employee Paid**	**Spouse:** You may purchase coverage for your eligible spouse, in the amount of $5,000. **Children:** You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of $ 5,000.
Supplemental Life **Employee Paid**	Purchased in equal amounts, life and AD&D benefit available is $5,000 increments to a maximum of $50,000. *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Important Note: If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a policy or certificate of insurance. Please read your insurance documents carefully.	

Group Term Life Insurance is designed to provide benefits to your designated beneficiary for loss of life.

Group Term Life coverage also includes the following benefits:

Right of Conversion, Accelerated Benefit
Extended Life Insurance Benefit (Waiver of Premium)

Accidental Death and Dismemberment (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

AD&D coverage also includes the following benefits:

Seat Belt/ Air Bag Rider Benefit
Coma Benefit
Exposure & Disappearance Benefit
Repatriation Benefit

Supplemental Life and Accidental Death and Dismemberment (AD&D) is available to eligible employees of County of Macon.

Supplemental Life & AD&D includes the following benefits:

Coverage is Portable

Additional Services from USAble Life

With Group Term Life Coverage:

Assist America is a global emergency medical travel assistance company. Anytime you, your spouse and/or minor dependent children are traveling 100 miles or more away from home or in another country—with or without you present, they are protected by Assist America's vast assistance resources. A single phone call is all it takes to put Assist America in motion on your behalf.

Identity Theft Resource Center provides you with an online resource for information regarding identity theft including victim support and education. Go to www.usablelife.com and click on "Individuals"/"Products"/"Value Added Services" to obtain prevention tips, a consumer guide to identity theft, victim resources, and scam alerts.

USAble Life
Live life. You're covered.℠

Macon County

Class 2: All Full Time Active Employees Earning at least $15,000 but Less than $20,000.
USAble Life is proud to make the following insurance products available to you as an employee of Macon County.

Group Term Life/ Accidental Death & Dismemberment **Employer Paid**	$25,000 *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Dependent Life **Employee Paid**	**Spouse:** You may purchase coverage for your eligible spouse, in the amount of $5,000. **Children:** You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of $ 5,000.
Supplemental Life **Employee Paid**	Purchased in equal amounts, life and AD&D benefit available is $5,000 increments to a maximum of $50,000. *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Important Note: If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a policy or certificate of insurance. Please read your insurance documents carefully.	

Group Term Life Insurance is designed to provide benefits to your designated beneficiary for loss of life.

Group Term Life coverage also includes the following benefits:
Right of Conversion, Accelerated Benefit
Extended Life Insurance Benefit (Waiver of Premium)

Accidental Death and Dismemberment (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

AD&D coverage also includes the following benefits:
Seat Belt/ Air Bag Rider Benefit
Coma Benefit
Exposure & Disappearance Benefit
Repatriation Benefit

Supplemental Life and Accidental Death and Dismemberment (AD&D) is available to eligible employees of County of Macon.

Supplemental Life & AD&D includes the following benefits:
Coverage is Portable

Additional Services from USAble Life

With Group Term Life Coverage:

Assist America is a global emergency medical travel assistance company. Anytime you, your spouse and/or minor dependent children are traveling 100 miles or more away from home or in another country—with or without you present, they are protected by Assist America's vast assistance resources. A single phone call is all it takes to put Assist America in motion on your behalf.

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USAble Life
Live life. You're covered.℠

Macon County

Class 3: All Full Time Active Employees Earning at least $10,000 but less than $15,000.
USAble Life is proud to make the following insurance products available to you as an employee of Macon County.

Group Term Life/ Accidental Death & Dismemberment **Employer Paid**	$20,000 *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Dependent Life **Employee Paid**	**Spouse:** You may purchase coverage for your eligible spouse, in the amount of $5,000. **Children:** You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of $ 5,000.
Supplemental Life **Employee Paid**	Purchased in equal amounts, life and AD&D benefit available is $5,000 increments to a maximum of $50,000. *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Important Note: If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a policy or certificate of insurance. Please read your insurance documents carefully.	

Group Term Life Insurance is designed to provide benefits to your designated beneficiary for loss of life.

Group Term Life coverage also includes the following benefits:
Right of Conversion, Accelerated Benefit
Extended Life Insurance Benefit (Waiver of Premium)

Accidental Death and Dismemberment (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

AD&D coverage also includes the following benefits:
Seat Belt/ Air Bag Rider Benefit
Coma Benefit
Exposure & Disappearance Benefit
Repatriation Benefit

Supplemental Life and Accidental Death and Dismemberment (AD&D) is available to eligible employees of County of Macon.

Supplemental Life & AD&D includes the following benefits:
Coverage is Portable

Additional Services from USAble Life

With Group Term Life Coverage:

Assist America is a global emergency medical travel assistance company. Anytime you, your spouse and/or minor dependent children are traveling 100 miles or more away from home or in another country—with or without you present, they are protected by Assist America's vast assistance resources. A single phone call is all it takes to put Assist America in motion on your behalf.

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USAble Life
Live life. You're covered.℠

Macon County

Class 4: All Full Time Active Employees Earning at less than $10,000.

USAble Life is proud to make the following insurance products available to you as an employee of Macon County.

Group Term Life/ Accidental Death & Dismemberment **Employer Paid**	$15,000 *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Dependent Life **Employee Paid**	**Spouse:** You may purchase coverage for your eligible spouse, in the amount of $5,000. **Children:** You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of $ 5,000.
Supplemental Life **Employee Paid**	Purchased in equal amounts, life and AD&D benefit available is $5,000 increments to a maximum of $50,000. *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Important Note: If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a policy or certificate of insurance. Please read your insurance documents carefully.	

Group Term Life Insurance is designed to provide benefits to your designated beneficiary for loss of life.

Group Term Life coverage also includes the following benefits:

Right of Conversion, Accelerated Benefit
Extended Life Insurance Benefit (Waiver of Premium)

Accidental Death and Dismemberment (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

AD&D coverage also includes the following benefits:

Seat Belt/ Air Bag Rider Benefit
Coma Benefit
Exposure & Disappearance Benefit
Repatriation Benefit

Supplemental Life and Accidental Death and Dismemberment (AD&D) is available to eligible employees of County of Macon.

Supplemental Life & AD&D includes the following benefits:

Coverage is Portable

Additional Services from USAble Life

With Group Term Life Coverage:

Assist America is a global emergency medical travel assistance company. Anytime you, your spouse and/or minor dependent children are traveling 100 miles or more away from home or in another country—with or without you present, they are protected by Assist America's vast assistance resources. A single phone call is all it takes to put Assist America in motion on your behalf.

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USAble Life
Live life. You're covered.℠

Macon County

Class 5: County Commissioners

USAble Life is proud to make the following insurance products available to you as an employee of Macon County.

Group Term Life/ Accidental Death & Dismemberment **Employer Paid**	$30,000 *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Dependent Life **Employee Paid**	**Spouse:** You may purchase coverage for your eligible spouse, in the amount of $5,000. **Children:** You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of $ 5,000.
Supplemental Life **Employee Paid**	Purchased in equal amounts, life and AD&D benefit available is $5,000 increments to a maximum of $50,000. *Benefits reduce by 50% at age 70, and terminate when you are no longer eligible or your retirement whichever occurs first.*
Important Note: If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a policy or certificate of insurance. Please read your insurance documents carefully.	

Group Term Life Insurance is designed to provide benefits to your designated beneficiary for loss of life.

Group Term Life coverage also includes the following benefits:

Right of Conversion, Accelerated Benefit
Extended Life Insurance Benefit (Waiver of Premium)

Accidental Death and Dismemberment (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

AD&D coverage also includes the following benefits:

Seat Belt/ Air Bag Rider Benefit
Coma Benefit
Exposure & Disappearance Benefit
Repatriation Benefit

Supplemental Life and Accidental Death and Dismemberment (AD&D) is available to eligible employees of County of Macon.

Supplemental Life & AD&D includes the following benefits:

Coverage is Portable

Additional Services from USAble Life

With Group Term Life Coverage:

Assist America is a global emergency medical travel assistance company. Anytime you, your spouse and/or minor dependent children are traveling 100 miles or more away from home or in another country—with or without you present, they are protected by Assist America's vast assistance resources. A single phone call is all it takes to put Assist America in motion on your behalf.

Identity Theft Resource Center provides you with an online resource for information regarding identity theft including victim support and education. Go to www.usablelife.com and click on "Individuals"/"Products"/"Value Added Services" to obtain prevention tips, a consumer guide to identity theft, victim resources, and scam alerts.

MACON COUNTY

Supplemental Life and AD&D Rates

Premium Per Month

Benefit Amount	Rate
$5,000.00	$2.00
$10,000.00	$4.00
$15,000.00	$6.00
$20,000.00	$8.00
$25,000.00	$10.00
$30,000.00	$12.00
$35,000.00	$14.00
$40,000.00	$16.00
$45,000.00	$18.00
$50,000.00	$20.00

VISION PLAN
CEC VISION

Macon County Government

Vision Plan

Enjoy the Simplicity of CEC!

Enrolling in CEC gives you the vision services you need and the ability to select the eyewear you want. With CEC, there's never any confusion about what's covered. It's that simple!

Why enroll in CEC? Here are a few simple reasons:

Simplicity

The CEC benefit is the simplest vision plan ever designed. It's easy-to-understand and easy-to-use.

Savings

CEC's vision benefits can save you up to 70% on routine eye care.

Network

CEC's national provider network includes private practices and major retail chains.

	The Benefit	Semi-Monthly Rates
150 Plan	■ **An eye exam once a year** ($0 co-pay) ■ **A $150 allowance for eyewear annually** ($xx co-pay) ■ **A contact lens fitting, re-fit, or evaluation once a year** ($15 co-pay)	Employee Only ..... $5.69 Employee + One .....$10.78 Employee + Family $15.93
200 Plan	■ **An eye exam once a year** ($0 co-pay) ■ **A $200 allowance for eyewear annually** ($0 co-pay) ■ **A contact lens fitting, re-fit, or evaluation once a year** ($15 co-pay)	Employee Only ..... $7.53 Employee + One .....$14.30 Employee + Family $21.07

Plan Features

Your Allowance. Your Decision.

Your eyewear allowance is completely flexible. That means you can get frames, lenses, contact lenses and/or special lens options. You can even purchase non-prescription eyewear!

Eyewear Discounts

Members who exceed their allowance are eligible for discounts on the coverage when seeing a network provider — a 20% discount for glasses and a 10% discount for contact lenses.

Members Portal

CEC's website, cecvision.com, gives you 24/7 access to find a provider, view your benefit information, check your current eligibility, print a temporary ID card and more.

CEC community eye care

Questions about your benefits?

Our customer service team is available at 888-254-4290, Monday - Friday, 8:30 AM-7:00 PM, and Saturday, 10:00 AM-4:00 PM.

Additional Plan Features

Out-of-Network Benefit

Members who obtain exams and eyewear from a non-credentialed provider still receive their full covered benefit. The member simply submits a claim to CEC and is reimbursed for the cost of their exam (minus the co-pay) and for the cost of their eyewear, up to the amount of their eyewear allowance (minus the co-pay).

Portability Benefit

Existing CEC members who terminate employment will be able to enroll in the portability plan within 60 days of their termination date. Coverage will commence on the first day of the month following receipt of the member's completed form. New membership cards will be mailed to the member prior to their new effective date.

LASIK Discounts

Members receive up to a 50%* discount on LASIK from participating providers.

Coverage for Fittings & Evaluations

Maximum coverage for contact lens fittings is $100, and maximum coverage for contact lens evaluations is $80.

The Importance of Vision

Routine eye care is more than just reading a chart on the wall. At your visit, your doctor will check the health of your eyes, which is important to your overall health and well-being. Undiagnosed diseases, such as diabetes, high blood pressure and glaucoma, can be detected during an annual eye exam. And as a CEC member, you can even purchase non-prescription sunglasses to protect your eyes from the sun.

of Americans need glasses or contact lenses

Studies show that eye strain and other bothersome visual symptoms occur in 50-90% of computer workers.

Visit CECVision.com to find a provider

**Relative to national averages*

VOLUNTARY LONG TERM DISABILITY

LINCOLN FINANCIAL GROUP

Macon County Open Enrollment – July 2019

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

YOU CHOOSE FROM TWO WAITING PERIODS!

Long Term Disability Insurance

- Benefit - 60% of Gross Pay
- Progressive Income Benefit - (qualification requirements apply) - 10%
- Total Available Benefit - 70%
- Maximum Monthly Benefit - $6,500
- Social Security Integration - Primary & Family
- Minimum Monthly Benefit - $50
- Elimination Period

90 Days or 180 Days - YOU CHOOSE!

- Maximum Benefit Period - Later of Age 65 or SS Normal Retirement Age
  - Benefit of up to 24 months if actively working past age 65
  - Keep your coverage for up to one year after you leave employment at the same rates that were in effect at the time of termination. (Coverage must be in force at least 12 months prior to termination and you must not be disabled, on a leave of absence, or retired.)
  - Pre-existing Condition Exclusion - 3 months prior/12 month wait
  - Mental/Nervous & Substance Abuse - 24 months Benefit Limit
- Premium payments are waived during any period for which disability benefits are payable

Definition of Disability

- Own (regular) Occupation Coverage Period - 24 Months
- Following Own Occupation Period - Any Occupation which your training, education, or experience will reasonably allow

90 waiting period

Age	Rate, as a Percent of Your Pay	Per Pay Rates Sample Annual Salary $35,000
<30	0.20%	$ 2.92
30-34	0.33%	$ 4.81
35-39	0.55%	$ 8.02
40-44	0.85%	$ 12.40
45-49	1.18%	$ 17.21
50-54	1.52%	$ 22.17
55-59	1.94%	$ 28.29
60-64	1.62%	$ 23.63
65-69	1.28%	$ 18.67
70-99	1.11%	$ 16.19

Calculate your rate!	Mthly Sal /100 x rate x 12 /24	_____

180 waiting period

Age	Rate, as a Percent of Your Pay	Per Pay Rates Sample Annual Salary $35,000
<30	0.15%	$ 2.19
30-34	0.26%	$ 3.79
35-39	0.43%	$ 6.27
40-44	0.67%	$ 9.77
45-49	0.93%	$ 13.56
50-54	1.20%	$ 17.50
55-59	1.53%	$ 22.31
60-64	1.28%	$ 18.67
65-69	1.01%	$ 14.73
70-99	0.87%	$ 12.69

Lincoln Financial Group®
You're In Charge®

Group Long-Term Disability Insurance
Specialty Worksite

SUMMARY OF BENEFITS

Sponsored by: **Macon County Government**

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

LTD Benefit

	Monthly Benefit	Maximum Benefit Duration	Own Occupation Period	Elimination Period
Employee Paid Plan	60% of monthly salary up to $6,500 per month	Later of Age 65 or Social Security Normal Retirement Age	24 Months	90 Days

Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.
Benefit Limitations	Mental Illness: 24 Months Substance Abuse: 24 Months Specified Illness: No Limit

Enrolling for Coverage

Eligibility: All employees in an eligible class.
You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again until your annual open enrollment.

Semi-Monthly Premium Calculation**

		EXAMPLE Age 35
List your monthly earnings (*Maximum covered payroll is $10,833 Monthly)	$_____	$2,643
Multiply by your premium factor	_____	0.00275
Your Estimated Semi-Monthly Premium**	$_____	$7.27

**This is an estimate of premium cost.
Actual deductions may vary slightly due to rounding and payroll frequency.

Attained Age	Premium Factor
0 - 24	0.00100
25 - 29	0.00100
30 - 34	0.00165
35 - 39	0.00275
40 - 44	0.00425
45 - 49	0.00590
50 - 54	0.00760
55 - 59	0.00970
60 - 64	0.00810
65 - 69	0.00640
70 - 74	0.00555
75 - 99	0.00555

Understanding Your Benefits	
Elimination Period	The number of days you must be disabled prior to collecting disability benefits.
Own Occupation	The occupation, trade, or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.
Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your own occupation on a full-time basis. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training. See Certificate of Coverage for details.
Partial Disability	Due to an injury or illness, you are unable to perform one or more of the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer and continue to receive benefits, which may enable you to receive 100% of your income during your time of disability. See Certificate of Coverage for details.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 6 months of returning to work, you will begin receiving benefits again immediately with no new Elimination Period.
Benefit Duration Reduction	Your benefit duration may be reduced if you become disabled after age 65.
Pre-Existing Condition	Any sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to your coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • You were involved in a felony commission, act of war, or participation in a riot. • You were residing outside of the United States or Canada for more than 12 consecutive months for purposes other than employment with your Employer.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any compulsory benefit act or law (such as state disability plans); • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings from any form of employment; • Workers compensation; • Salary continuance or employer contributions to an employer sponsored retirement plan.
Coverage Termination	Coverage will terminate when you terminate employment with this policyholder, or at your retirement.
Additional Benefits	

Progressive Income Benefit, Family Care Expense Benefit, Survivor Income Benefit, EmployeeConnect - Employee Assistance Program and Waiver of Premium

See your Schedule of Benefits on your Certificate for more information

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **MACONGOV2**	www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Insurance products are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply. **Not for use in New York**.

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Lincoln Financial Group®
You're In Charge®

Group Long-Term Disability Insurance
Specialty Worksite

SUMMARY OF BENEFITS

Sponsored by: **Macon County Government**

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

LTD Benefit

	Monthly Benefit	Maximum Benefit Duration	Own Occupation Period	Elimination Period
Employee Paid Plan	60% of monthly salary up to $6,500 per month	Later of Age 65 or Social Security Normal Retirement Age	24 Months	180 Days

Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.
Benefit Limitations	Mental Illness: 24 Months Substance Abuse: 24 Months Specified Illness: No Limit

Enrolling for Coverage

Eligibility:	All employees in an eligible class. You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again until your annual open enrollment.

Semi-Monthly Premium Calculation**

		EXAMPLE Age 35
List your monthly earnings (*Maximum covered payroll is $10,833 Monthly)	$_____	$2,643
Multiply by your premium factor	_____	0.00215
Your Estimated Semi-Monthly Premium**	$_____	$5.68

**This is an estimate of premium cost.
Actual deductions may vary slightly due to rounding and payroll frequency.

Attained Age	Premium Factor
0 - 24	0.00075
25 - 29	0.00075
30 - 34	0.00130
35 - 39	0.00215
40 - 44	0.00335
45 - 49	0.00465
50 - 54	0.00600
55 - 59	0.00765
60 - 64	0.00640
65 - 69	0.00505
70 - 74	0.00435
75 - 99	0.00435

Understanding Your Benefits	
Elimination Period	The number of days you must be disabled prior to collecting disability benefits.
Own Occupation	The occupation, trade, or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.
Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your own occupation on a full-time basis. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training. See Certificate of Coverage for details.
Partial Disability	Due to an injury or illness, you are unable to perform one or more of the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer and continue to receive benefits, which may enable you to receive 100% of your income during your time of disability. See Certificate of Coverage for details.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 6 months of returning to work, you will begin receiving benefits again immediately with no new Elimination Period.
Benefit Duration Reduction	Your benefit duration may be reduced if you become disabled after age 65.
Pre-Existing Condition	Any sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to your coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • You were involved in a felony commission, act of war, or participation in a riot. • You were residing outside of the United States or Canada for more than 12 consecutive months for purposes other than employment with your Employer.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any compulsory benefit act or law (such as state disability plans); • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings from any form of employment; • Workers compensation; • Salary continuance or employer contributions to an employer sponsored retirement plan.
Coverage Termination	Coverage will terminate when you terminate employment with this policyholder, or at your retirement.
Additional Benefits	

Progressive Income Benefit, Family Care Expense Benefit, Survivor Income Benefit, EmployeeConnect - Employee Assistance Program and Waiver of Premium

See your Schedule of Benefits on your Certificate for more information

For assistance or additional information Contact Lincoln Financial Group at	
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Annual Notice and Privacy Notice Acknowledgment

I acknowledge receipt of the Wayah Employee Benefits, a Division of EbenConcepts Notice of Privacy Practices AND the Annual Notice Packet provided for Macon County Government.

_____

Client Signature

_____

Client Name

_____

Date