EMPLOYEE BENEFITS GUIDE

Davidson NORTH CAROLINA County

2026 - 2027
PLAN YEAR

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What's New in 2026?

Active Enrollment

All benefit-eligible employees are **strongly encouraged** to make an active plan selection during this year's Open Enrollment for the 2026-27 plan year. Failure to complete enrollment will only permit certain benefits to be carried forward. For instance, FSA accounts will **not** be automatically carried forward and contributions will be stopped if you do not complete your open enrollment.

Increased FSA Medical Account Contribution Limit & Rollover Maximum

For the 2026-2027 plan year members can contribute up to $3,400 to an FSA Medical account and rollover funds up to $680 remaining in accounts on June 30, 2027.

CVS Caremark Pharmacy

Your prescription drug coverage will be moving from Blue Cross Blue Shield to a separate (carve-out) pharmacy plan managed by CVS Caremark. This means all prescriptions will now be processed through CVS Caremark instead of your BCBS (Prime Therapeutics). CVS Caremark offers a large pharmacy network, including many retail locations and convenient mail-order options for maintenance medications. This change provides more specialized pharmacy support and may offer cost savings and improved access to medications.

Group Voluntary Benefits with Colonial

Your voluntary benefits are transitioning from individually owned policies to a group benefit program through Colonial Life. This change will allow employees to access to better rates, often for the same or better coverage compared to a current individual policy. For this initial open enrollment, evidence of insurability (EOI) will be waived, meaning you can elect coverage without answering health questions or undergoing medical review (up to plan limits).

Eligibility

Who is Eligible:

You may enroll in the Davidson County Employee Benefits Program if you are a Full-Time employee occupying a budgeted position, working at least 30 hours per week.

Eligible Dependents:

If you are eligible and enrolled in benefits, then your dependents are eligible too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children appointed through court-appointment legal guardianship.

When Coverage Begins:

Newly hired employees and their dependents will be eligible for coverage in Davidson County's benefits program the first day of the month, following a 30-day waiting period. Elections can only be changed during Open Enrollment unless you experience a qualifying life event.

Qualifying Life Events:

A qualifying life event (QLE) is an event or change in your personal life that may impact your eligibility and/or dependent's eligibility for benefits.

Examples of a Qualifying Life Event include:

- Change of legal marital status, separation is not a QLE (i.e., marriage, divorce, death of spouse)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

Open Enrollment

Davidson County employees have three choices for completing their enrollment:

1. Meet with an onsite benefit counselor (by scheduled appointment)

   Schedule a time to enroll with an onsite benefits counselor May 11 – May 22

   - Government Center (4th Floor, Conference Room D)
     - Monday - Thursday
     - 8:30am – 12pm and 1pm –4pm
   - Sheriff's Dept Conference Room
     - Monday - Thursday
     - 8:30am – 4:00pm
   - Colonial Drive – Thomasville
     - May 19 (8:30am – 12pm and 1pm – 4pm)

2. Meet/Enroll by telephone with a benefit counselor

   Contact a benefits counselor by phone at 833-703-1967 (May 11 – May 22):

   Available Monday through Friday from 8:00 a.m. to 8:00 p.m. EST

   Employer Code: **2150324**

3. Self-Enroll via your Davidson County Workday Account

   Enroll Yourself: (May 11 - May 22):

   You will receive a notification and task in Workday when Open Enrollment begins

If a QLE occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

MEDICAL COVERAGE

Blue Cross Blue Shield of North Carolina

Davidson County offers medical coverage through Blue Cross Blue Shield. This coverage allows you to see any provider without a physician referral. The level of benefits you receive is dependent upon your choice of an in-network PPO provider or an out-of-network provider. Lower costs and greater benefits are available to you when you obtain care from an in-network provider. To find a provider, visit www.bluecrossnc.com. Please also see your Booklet or Carrier Benefit Summary for more information.

Blue Cross Blue Shield Base Plan with HRA

	Your Cost for Provider Services	
Benefit Coverage Summary	In-Network	Out-of-Network
Annual Deductible		
Individual	$1,250	$2,500
Family	$2,500	$5,000
Coinsurance	30%	50%
Maximum Out-of-Pocket		
Individual	$3,750	$7,500
Family	$7,150	$14,300
Physician Office Visit		
Primary Care	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Specialty Care	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Teladoc (includes Behavioral Health)	$0 Copay	Not Covered
Preventive Care		
Adult Periodic Exams	100% Covered by Plan	50% after deductible (Plan pays 50%)
Well-Child Care	100% Covered by Plan	50% after deductible (Plan pays 50%)
Diagnostic Services		
X-ray and Lab Tests	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Complex Radiology	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Urgent Care Facility	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Emergency Room Facility Charges*	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Inpatient Facility Charges	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Outpatient Facility and Surgical Charges	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Mental Health		
Inpatient	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Outpatient	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Substance Abuse		
Inpatient	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Outpatient	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Other Services		
Chiropractic (30 visits per year)	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)

Blue Cross Blue Shield Buy-Up PPO

Benefit Coverage Summary	**Your Cost** for Provider Services	
	In-Network	Out-of-Network
Annual Deductible		
Individual	$750	$1,500
Family	$1,500	$3,000
Coinsurance	30% (Plan Pays 70%)	50% (Plan Pays 50%)
Maximum Out-of-Pocket		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Physician Office Visit		
Primary Care	$30 copay	50% after deductible (Plan pays 50%)
Specialty Care	$45 copay	50% after deductible (Plan pays 50%)
Teladoc (includes Behavioral Health)	$0 Copay	Not Covered
Preventive Care		
Adult Periodic Exams	100% Covered by Plan	50% after deductible (Plan pays 50%)
Well-Child Care	100% Covered by Plan	50% after deductible (Plan pays 50%)
Diagnostic Services		
X-ray and Lab Tests	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Complex Radiology	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Urgent Care Facility	$45 copay	$45 copay
Emergency Room Facility Charges*	$150 copay for first visit; $300 for all subsequent visits	$150 copay for first visit; $300 for all subsequent visits
Inpatient Facility Charges	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Outpatient Facility and Surgical Charges	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Mental Health		
Inpatient	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Outpatient	30% after deductible ($30 office visit)	50% after deductible (Plan pays 50%)
Substance Abuse		
Inpatient	30% after deductible (Plan Pays 70%)	50% after deductible (Plan pays 50%)
Outpatient	30% after deductible ($30 office visit)	50% after deductible (Plan pays 50%)
Other Services		
Chiropractic (30 visits per year)	$30 copay	50% after deductible (Plan pays 50%)

Pharmacy Plan (Applies to both Base/HRA Plan & Buy-Up PPO Plan)

Pharmacy/Rx Coverage		
Prescription Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Tier 1	$10 copay	Not Covered
Tier 2	$30 copay	Not Covered
Tier 3	25% up to $75 maximum	Not Covered
Tier 4	25% up to $100 maximum	Not Covered
Tier 5	25%; min. $100; max. $150	Not Covered

One (1) copayment for up to a 30-day supply. 31–60-day supply is two (2) copayments, and 61-90 is three (3) copayments.

The lowest cost prescription drugs, such as generics, are generally located on the lowest tiers (Tier 1 and Tier 2). Higher cost prescription drugs, such as brand-name prescription drugs are generally located on the higher tiers (Tier 3 and Tier 4). All tiers of the formulary may contain generic and brand name prescription drugs.

Specialty drugs are located on the highest tiers of the Plan, even though they may be classified as generic, brand-name, biologic, or biosimilar prescription drugs.

Comparing Medical Plans – Which one is Right for You?

	Base HRA Plan	Buy-Up Plan
Deductible	The employee deductible applies if you selected employee-only coverage; otherwise, the family deductible applies. If one or more dependents are covered, all covered family members contribute to the same family deductible. Once the family deductible is reached, it is met for all covered family members.	The plan has an embedded deductible which means you have an individual deductible and if dependents are covered, you also have a combined family deductible. You must meet your individual deductible before benefits are payable under the plan. However, once the family deductible is met, it is met for all
Coinsurance	Your share of the costs of a covered health service, after you have met your benefit period	
Out-of-Pocket Limit	The out-of-pocket limit includes your deductible, coinsurance, and copayments. The employee out-of-pocket limit applies if you selected employee-only coverage; otherwise, the family out-of-pocket limit applies. If one or more dependents are covered under the HRA plan, all covered family members contribute to the same family out-of-pocket limit.	The out-of-pocket limit includes your deductible, coinsurance, and copayments. The plan has an individual out-of-pocket limit and if dependents are covered, you also have a combined family out-of-pocket limit. Once the family out-of-pocket limit is met, it is met for all members.
Copays for	Prescriptions & Teladoc	Physicians, Prescriptions & Teladoc

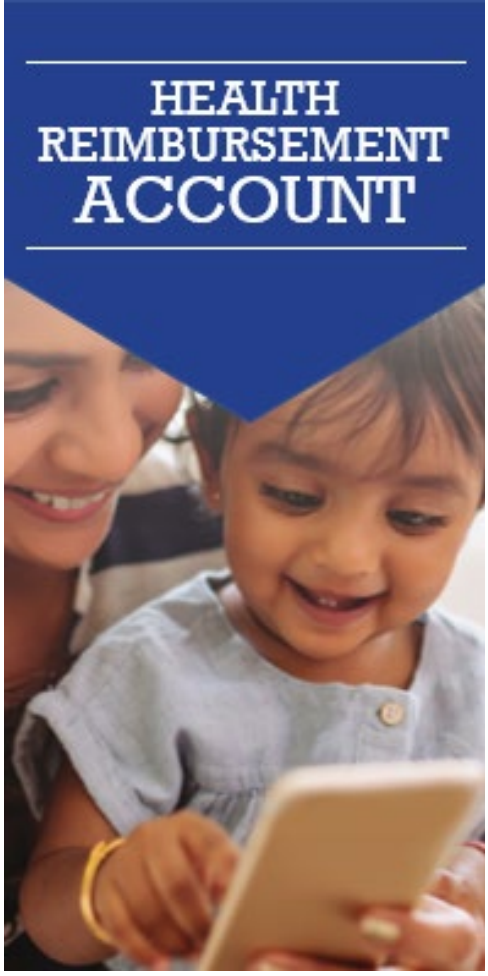
Employee Premiums

Base / HRA Plan (Bi-Weekly Deductions)	
With Wellness Discount	
Employee	$10.00
Employee & Spouse	$135.64
Employee & Child(ren)	$68.23
Employee & Family (Spouse & Child/ren)	$157.55
Without Wellness Discount	
Employee	$22.48
Employee & Spouse	$149.49
Employee & Child(ren)	$82.08
Employee & Family (Spouse & Child/ren)	$171.26

Buy-Up PPO Plan (Bi-Weekly Deductions)	
With Wellness Discount	
Employee	$49.48
Employee & Spouse	$362.58
Employee & Child(ren)	$216.14
Employee & Family (Spouse & Child/ren)	$403.94
Without Wellness Discount	
Employee	$63.32
Employee & Spouse	$376.42
Employee & Child(ren)	$229.99
Employee & Family (Spouse & Child/ren)	$417.79

How do I get the discounted rate?

All you have to do is have an annual physical with your Primary Care Physician and submit a one-page form to earn the discount on your premium. That's it! Having a PCP and checking in with them at least once per year has been shown to help diagnose conditions more accurately and sooner leading to lower costs and better health. You can learn more about how to submit the required information to earn this discount on page **8** of this benefits guide.



Health Reimbursement Account (HRA)

HealthEquity

Davidson County offers a Health Reimbursement Account in conjunction with the Blue Cross Blue Shield Base Plan. The HRA Plan is managed by Health Equity. Each employee enrolled in the Base Plan has an account that will reimburse up to $500 for individual or $1,000 for family medical deductible expenses after you have paid the first $500 or $1,000 for individual or family coverage respectively.

After you've satisfied your portion of the deductible, Blue Cross Blue Shield of North Carolina will automatically deduct funds from your Davidson County funded HRA account and send you funds to pay for eligible service expenses that will apply to the middle portion of your deductible. Copayments for Teladoc and prescription drugs are creditable towards your annual maximum out-of-pocket, but not your annual deductible, therefore those expenses are **NOT** reimbursable.

- Funds run according to the plan year (July 1st – June 30th)

HRA Contribution and Payment Overview				
	Employee pays	**HRA reimburses**	**Employee pays**	**Deductible is reached**
Individual Coverage	First $500	The next $500	Last $250	$1,250 deductible is met
Family Coverage (Employee & 1 or more dependents)	First $1,000	The next $1,000	Last $500	$2,500 deductible is met

What happens to the County funded Health Reimbursement Account in the Base Plan if I do not use it all?

Davidson County provides the Health Reimbursement Account (HRA) in the amount of $500 ($1,000 for family) for employees on the Base Plan. The employee pays the first $500 of the deductible ($1,000 for family) and then Davidson County funds the next $500 of the deductible ($1,000 for family). The employee pays the remaining portion of the deductible. Any funds remaining in the Health Reimbursement Account after June 30th will roll forward. Each year, unused HRA funds will be rolled over until you reach the maximum balance or cap of $3,750 - individual and $7,150 – family which is the Base Plan's annual Out of Pocket Maximum.

Taking Care of Your Health Just Got Easier

Complete an annual physical and submit the one-page Doctor Verification Form to earn the Wellness Discount on your Medical Insurance Premium.

Physicals completed between May 1, 2026, and April 30, 2027 earn the wellness discount for the plan year beginning on July 1, 2027. Discount varies from $324 - $360 depending on plan and enrollment.

Log in to your **IncentFit Recharge app** or visit **app.incentfit.com/login** to stay on top of your wellness goals.

Your member ID card

Your health insurance card is also known as your member ID card. It's your proof of insurance when you visit the doctor's office, hospital, or pharmacy. A provider can use it to verify your benefits and coverage so you don't overpay by mistake.

Access your member ID card

The Blue Cross and Blue Shield of North Carolina (Blue Cross NC) member portal gives you convenient access to all the things you need to feel confident in your health care decisions – including your member ID card.

Click "Register" and take a few minutes to set up your account to start getting on-the-go access tools and resources for your health journey.

If you're already registered, log in and choose "ID Card" from the account menu in the top right corner. There you can view, download, or print your card. If you have selected paperless communications but would still like to receive a hard-copy in the mail, you can request one by selecting "Request New ID Card." This won't change your communication preferences. It simply allows you to have both a physical AND digital member ID card.

If you don't have your member ID card

At the doctor's office:

- Providers can use your Social Security number and/or your date of birth to access your information.

At the pharmacy:

- If your plan includes pharmacy benefits, pharmacists can use your Social Security number, your date of birth, and the Blue Cross NC Rx Bin Number: **015905**.

On your phone:

- Your digital member ID card is accessible through the mobile app. You can also use the app to add your member ID card to your mobile wallet, that way you have access to your insurance information whenever you might need it, with or without internet access.

  If a provider is unable to verify coverage, they can call the Blue Cross NC provider line at 800-214-4844.

Learn more about member ID cards, download our app, and register for an account.

Questions?

Call the Customer Service number on the back of your member ID card

Member ID cards are for identification purposes only. They do not guarantee eligibility or payment of your claim.

Blue Cross NC offers several decision support tools to aid you in making decisions around your health care experience. These tools are offered for your convenience and should be used only as reference tools. You should consult your own legal counsel, tax advisor, or personal physician as applicable throughout your health care experience.

Make the most of your preventive care benefits

Preventive care[1] includes medical tests (sometimes called screenings), checkups and counseling to help prevent illnesses, disease or other health problems. It's important because it can reveal a health problem before you have any signs or symptoms – and when it can be more easily treated.

Your health plan covers the cost

To be covered at 100% with no out-of-pocket costs to you,[2] the service must be:

- Provided by an in-network doctor or facility
- Billed by your doctor as a preventive care visit
- Done in a doctor's office, urgent care facility, outpatient clinic or ambulatory surgery center

What's covered?

Here are some services that are usually covered as preventive care (see page 2 for details):

- Adult screening tests[3]
- Well-baby and well-child care[4]
- Immunizations (adult and child)[5]
- Mammograms
- Colon cancer screenings

What's not covered as preventive?

Here are some services your doctor may do that are not considered preventive care. If your doctor files them as preventive, they will be denied as "not covered." These services should be filed as diagnostic and will be covered under your diagnostic benefit.

- Chest X-rays
- EKGs (electrocardiograms)
- Hormone tests
- Iron level tests
- Thyroid tests
- Urine tests
- Vitamin B tests
- Vitamin D tests

How to avoid extra costs

When you make your appointment, say that you want preventive care screenings and tests:

- Ask if any tests or treatments done might not be considered preventive care
- Ask if discussing other topics that are not considered preventive care will lead to extra out-of-pocket costs
- Ask if any lab work can be sent to an in-network lab to lower any out-of-pocket costs

Know before you go

Learn more about your preventive care coverage. Check your benefit booklet, visit **BlueCrossNC.com/Preventive** or call the Customer Service number on the back of your member ID card.

Service	In-network[6]	
	In office	Outpatient facility
Mammograms	**Covered at 100% if billed as preventive** If billed as diagnostic, may be subject to deductible and cost share or covered at 100%	
Women's health services • Breastfeeding support and counseling • Contraceptive methods and counseling • Gestational diabetes screening (pregnant women) • Interpersonal and domestic violence screening and counseling • Postpartum depression screening • Sexually transmitted infections counseling • Well-woman visits	**Covered at 100% if billed as preventive** If billed as diagnostic, may be subject to deductible and cost share or covered at 100%	
Colorectal cancer screenings (colonoscopies) – includes pathology charges associated with polyp removal	**Covered at 100% if billed as preventive** If billed as diagnostic, may be subject to deductible and cost share or covered at 100%	
Adult preventive care (routine exams)	**Covered at 100% if billed as preventive** If billed as diagnostic, may be subject to deductible and cost share or covered at 100%	
Immunizations • Chicken Pox • COVID-19 • Diphtheria-Tetanus-Acellular Pertussis (DTaP) • Flu (influenza) • Haemophilus Influenzae Type B (Hib) • Hepatitis A and B • Human Papillomavirus (HPV) • Measles-Mumps-Rubella (MMR) • Meningococcal vaccine • Pneumonia • Polio (IPV) • Rotavirus • Tetanus-Diphtheria (Td) Tetanus-Diphtheria-Acellular Pertussis (Tdap) • Zoster (shingles) (Immunizations required for occupational hazard or international travel are not covered)	**Covered at 100% if billed as preventive** If billed as diagnostic, may be subject to deductible and cost share or covered at 100%	
Well-baby/well-child care • Developmental/behavioral assessments • Newborn bilirubin screening • Oral health • Physical exams • Vision and hearing tests	**Covered at 100% if billed as preventive** If billed as diagnostic, may be subject to deductible and cost share or covered at 100%	
Adult & child (age 6+) obesity services • Behavioral intervention • Nutritional counseling • Obesity screening	**Covered at 100%** Visits covered at 100% are limited to a set number, which is defined in the member benefit booklet	
Adult tests[7] • Cervical cancer (Pap test and/or HPV test) • Chlamydia • Cholesterol (lipid) • Depression • Diabetes • High blood pressure • HIV screening and counseling • Latent tuberculosis • Lung cancer • Osteoporosis	**Covered at 100% if billed as preventive** If billed as diagnostic, may be subject to deductible and cost share or covered at 100%	

1 Preventive care services, as defined by federal regulations, are covered at no charge in-network. Federally- and state-mandated preventive services are available out-of-network, for which members will pay deductible and coinsurance, plus charges over the allowed amount. Visit BlueCrossNC.com/Preventive for more details.

2 This is a summary of preventive care benefits for non-grandfathered plans that went into effect on or after March 24, 2010. Final interpretation and a complete listing of benefits and what is not covered are in and governed by the group contract and benefit booklet. Your benefit booklet can be accessed on BlueConnectNC.com or by requesting a copy from Blue Cross NC Customer Service.

3 Based on the guidelines published by the United States Preventive Services Task Force.

4 Based on the guidelines published by the Health Resources & Services Administration.

5 Based on the full series of standard immunizations recommended by the Centers for Disease Control and Prevention's Guidelines and Recommendations for Adults and Children.

6 Chart outlines coverage for in-network services only received through non-grandfathered plans. If these services are rendered by an out-of-network (OON) provider, member liability will be no more than 30% coinsurance after the OON deductible. Refer to your benefit booklet for details.

7 Screening tests that involve additional services may result in higher out-of-pocket costs.

TELEHEALTH

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

Your Blue Cross and Blue Shield of North Carolina (Blue Cross NC) health plan includes telehealth services from Teladoc®. Because telehealth is such a convenient and effective option, Blue Cross NC encourages you to set up your account today.

Convenient care for your total health

- **Range of services.** Your telehealth offering includes acute care as well as behavioral health services and substance use support.[1]
- **Affordable care.** Costs vary depending on your benefits. If you are enrolled in a copay plan, you can expect to pay no more than your no more than your primary care provider (PCP) copay. For deductible and coinsurance plans, you will pay no more than the cost of the service.[2]
- Available 24 hours a day, seven days a week (even holidays) for acute care.
- Low wait times.[3]
- Prescriptions sent electronically to your local pharmacy if needed.[4]
- On the couch, at work or traveling – you can use Teladoc anywhere in the U.S.[5]
- Pediatricians available if your child gets sick.[6]
- Teladoc doctors are board-certified with an average of 20 years' experience.[7] Specialties range from primary care and internal medicine, to pediatrics and family medicine.

Acute/non-emergency health problems

- Allergies
- Cough, cold and flu
- Diarrhea
- Ear problems
- Fever[6]
- Headaches
- Insect bites
- Nausea and vomiting
- Sinus problems
- Sore throat
- Urinary problems[6]
- And more

Behavioral health[1]

- Addictions
- Anxiety
- Depression
- Grief and loss
- Relationship issues
- And more

Learn more at **Teladoc.com** or by calling **1-855-549-2214**.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.

3 ways to sign up today

So it's ready when you need it!

Download the Teladoc mobile app
(iOS- / Android™-supported)

Go to Teladoc.com and click **"Log in/Register"**

Call 1-855-549-2214

Please Note:

You must wait until your health plan effective date before registering for telehealth services.

Happy customers

Teladoc has a >95% satisfaction rate with 92% of issues resolved after the first visit.[8]

1 Behavioral health telehealth is currently only available to members ages 13 or older.

2 www.teladoc.com/health-talk/time-and-money/ (Accessed January 2024).

3 www.teladoc.com/start (Accessed December 2023).

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

5 Consults can only be held within the United States.

6 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. Teladoc 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 Teladoc doctor.

7 Member.teladoc.com/ih (Accessed January 2024).

8 Teladoc Health General Medicine brochure. (19 April 2021). assets.ctfassets.net/l3v9j0ltz3yi/73VhGDN96SJh2DTdtZs0XV/42ec6017429167ea0645ad2b8b183c04/General_Medical_Sell_Sheet.pdf (Accessed December 2023).

Teladoc interactive consultations are available 24 hours a day, 7 days a week. 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. Teladoc does not replace your primary care doctor and is not an insurance product. Teladoc is subject to state regulations. Teladoc does not prescribe DEA-controlled substances and may not prescribe nontherapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc 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. Teladoc and the Teladoc logo are registered trademarks of Teladoc, Inc. and may not be used without written permission. For complete terms of use, visit member.teladoc.com/terms/terms_of_use.

Teladoc is an independent company that is solely responsible for the telehealth services it is providing. Teladoc does not offer Blue Cross or Blue Shield products or services.

North Carolina

Nurse support program

Condition Care

The care you need, when you need it most

When you're managing a chronic condition, things can get complicated and overwhelming. That's why Blue Cross and Blue Shield of North Carolina (Blue Cross NC) wants to help you manage your condition with the Nurse Support Program Condition Care. As you work with your primary care provider, the Nurse Support Program Condition Care also connects you to more tools, resources, and care. **And this program is available to you as a benefit of your health plan at no additional cost.**

The Nurse Support Program Condition Care is available to members with conditions such as:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- Hypertension

A Nurse Advocate or Health Coach may call you to provide one-on-one support. Be sure to take the call as it's the first step to a healthier you! During your conversations on the phone, these registered nurses will be your care companion – working alongside you to create personalized plans to manage your condition. They're with you every step of the way.

The care team

Your coordinated care team is led by your Nurse Advocate and includes:

- Registered nurses
- Certified diabetes care and education specialists
- Behavioral health professionals
- Pharmacists
- Social workers
- Registered dietitian
- Physicians (available to consult with Nurse Advocate)
- Support staff
- All staff have access to translation services

The Nurse Support Program Condition Care is available to you as a benefit of your health plan at no additional cost, so you can get the resources you need to manage your conditions and avoid future medical problems.

What our members have to say:

"This was very helpful. If I didn't understand what the physicians recommended, I could ask the nurse, and she explained things very well."

"Sherri was absolutely a pleasure to work with. She was very instrumental in my recovery process."

"Thank you for this service. It was a great help to us!

To learn more:

Log into your Member Portal at **BlueCrossNC.com**, visit the Wellness section and click on 'Nurse Support Program.

If you have not already been contacted by the Nurse Advocate, you can call **888-229-8510**.

Monday – Thursday: 8 AM — 7 PM ET
Friday: 8 AM — 5 PM ET

Blue Distinction® Specialty Care

Better care, better value

The Blue Distinction program helps you find hospitals that deliver superior specialty care. Hospitals earn the distinction by meeting objective quality standards for patient safety and outcomes – standards that have been developed with input from the medical community.

Blue Distinction Centers (BDC) are hospitals recognized for their specialty care expertise. Blue Distinction Centers+ (BDC+) go a step further. They not only meet all the Blue Distinction quality standards, they also deliver care at lower costs.

Both BDC and BDC+ have proven results in quality care, treatment expertise, and overall patient outcomes:[1]

- Care teams are experienced experts in their specialties
- Patients receive the highest level of support at all stages of treatment
- Patients have fewer complications

In other words, you can get higher quality care and lower costs.

When you turn to a BDC or BDC+ for one of the following specialty procedures or treatments, you can feel confident about getting back to health faster.

Hospitals can earn the BDC or BDC+ designation in the following specialties:

- Bariatric surgery
- Cardiac care
- Knee and hip replacement
- Maternity care
- Spine surgery
- Substance use treatment and recovery
- Transplants, including eleven programs*

* Adult Heart, Adult Lung, Adult Liver, Pediatric Heart, Pediatric Liver, Adult Kidney, Pediatric Kidney, Adult Bone Marrow/Stem Cell and Pediatric Bone Marrow/Stem Cell.

Nationwide, Blue Distinction Centers+ average a medical cost savings of 20% for specialty procedures or treatment.[2]

Higher quality, lower cost.

In addition to better outcomes and lower costs, you may receive better health plan benefits when you use Blue Distinction-designated facilities.** Depending on your plan, you can save $250-$500 via a copayment reduction, OR reduce your coinsurance by 10% simply by utilizing an outpatient or inpatient Blue Distinction Center.[3]

**Benefits may vary by health plan.

Learn more

To find a BDC or BDC+ near you: Call the Customer Service number on the back of your member ID card. Or visit the Blue Distinction Center finder at **BlueCrossNC.com/members/find-care/blue-distinction.**

1 Blue Cross and Blue Shield Association (BCBSA). (June 2023). "Blue Distinction Specialty Care: Facts and Figures of the Program" (Accessed October 2023).

2 BCBSA and registry data, BDC+ eligible facilities vs. relevant comparison group. Results based on most recent designation cycle for each specialty. Savings based on BDC+ total episode cost. Blue Cross and Blue Shield Association. (June 2023). Centers of Excellence: Blue Distinction Specialty Care [Sell Sheet]. (Accessed October 2023).

3 Standard 10 percent coinsurance and copay reduction will apply to both inpatient and outpatient settings.

Blue Distinction Centers (BDC) met overall quality measures for patient safety and outcomes, developed with input from the medical community. A Local Blue Plan may require additional criteria for facilities located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare.

Each facility's cost of care is evaluated using data from its Local Blue Plan. Facilities in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. National criteria for BDC and BDC+ are displayed onwww.bcbs.com. Individual outcomes may vary. For details on a provider's in-network status or your own policy's coverage, contact your Local Blue Plan and ask your provider before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for non-covered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

Behavioral Health

Care for your whole self

It's normal to experience ups and downs in life, but when your emotions or behaviors start to impact your relationships or your health, it's time to take action. Behavioral health conditions – like depression, anxiety, ADHD, trauma or overuse of drugs or alcohol – can strain your family, your job, even your finances.[1]

You don't have to go through it alone. Your primary care provider (PCP), behavioral health specialists in your community and our nurse advocates are here to help. Behavioral health is part of your total health, so take good care of yourself. And please reach out if you need support. Your team is ready and waiting.

How do I get help?

Need help finding an outpatient behavioral health provider? Use our Care Navigation services. **Complete this referral form to get started.** You can also make a referral request by calling **1-800-755-0798** for one of our Behavioral Health Care Navigators to assist you.

Talk to your PCP. They can address your concerns in the office or refer you to a behavioral health provider.*

Access our Blue Connect℠ member site to find an in-network provider. Search for keywords like: *Psychologist, Psychiatrist, Social Worker, Therapist, Substance Use* or *Counselor.*

Call the Blue Cross NC Customer Service number on the back of your member ID card. We will help connect you to a high-quality behavioral health provider or program.

Use your Employee Assistance Program (EAP), if available.[2]

Access therapy or psychiatry through your telehealth benefit, if available.[3]

Note: Check your benefit booklet or go to **BlueConnectNC.com** for more information on your coverage and costs.

Possible Signs of a Problem

Physical signs:

- Feeling tired, low energy
- Difficulty sleeping/sleep changes
- Appetite changes
- Decline in personal care/hygiene
- Odd or uncharacteristic behavior

Emotional signs:

- Feeling sad
- Excessive fears or worries
- Withdrawal from friends or previously enjoyed activities
- Difficulty with regular tasks, changes in grades/work performance
- Anger or irritability

* You don't need a referral from your PCP to see a behavioral health specialist, but it helps to have your team connected and sharing information to get the best care for your total health.

1 Money and mental health facts and statistics - A money and Mental Health Policy Institute factsheet. Money and Mental Health Policy Institute. (2022, August 10). www.moneyandmentalhealth.org/money-and-mental-healthfacts/ (Accessed May 2023).
2 EAP is a confidential, voluntary, work-based program that offers free counseling for work related and/or personal problems. Ask your employer if there's an EAP program where you work.
3 Telehealth offers virtual consults with doctors, counselors, psychiatrists or other health professionals via video, phone or mobile app. Ask your employer if this program is available through your plan.

CVS caremark®

Prescription benefits

Convenient and cost-effective medication options

Welcome to CVS Caremark® – we manage your prescription benefit on behalf of your new plan. We're here to help you get the medication you need and learn how to keep costs low.

Know how to get your medication

Find out where to fill your prescriptions. Use the *Pharmacy Locator* tool to find a pharmacy that's covered under your prescription benefit plan. Some plans offer home delivery. Review your plan summary to see your options.

Tap into savings with digital tools

Save time, compare costs and stay connected. Do it all at **Caremark.com** and the CVS Health® mobile app.*

- Using a pharmacy that's covered by your plan can help keep your costs low. Locate one that's convenient through our *Pharmacy Locator* tool.
- Check and compare drug costs across in-network pharmacies to find possible savings through our *Check Drug Cost* tool.
- Stay connected for benefit plan updates. Sign up for email or text alerts to easily get important updates, including status alerts on any changes to your covered medications.

Access everything you need, all in one place

Scan this code to download the CVS Health app today.*

To scan the QR code:
Open the camera on your smart phone
Focus on the QR code
Tap the link that appears

*Some app functions are not available yet, but coming soon.

Davidson NORTH CAROLINA County

Teladoc® HEALTH

Live healthier at no cost to you

With the Diabetes Management program, get tools and support to track blood sugar levels, prioritize your mental health and develop a healthier lifestyle.

The Diabetes Management program includes:

- A blood glucose meter that seamlessly connects to your mobile device
- Unlimited strips and lancets
- One-on-one coaching to manage nutrition activity and health goals
- Real-time support for out-of-range readings
- Digital tools that support your mental health

You may also be eligible for additional tools and devices to help you live healthier, including:

- Connected blood pressure monitor to help track your numbers
- Smart scale to help achieve your weight goals and track progress over time

Get started

Join by visiting **TeladocHealth.com/Happy**
or call **800-835-2362**

To enroll in Teladoc Health you must opt in to at least one program that your plan sponsor offers as a health benefit. You must also meet the health criteria for each program you wish to enroll in. If a Teladoc Health program is not offered by your plan sponsor, or if you do not meet the specific health criteria of that program, you will not be able to enroll.

DENTAL COVERAGE

Delta Dental of North Carolina

DELTA DENTAL®

Taking care of your oral health is a necessary component of long-term health and Davidson County is proud to partner with Delta Dental as we continue to offer you and your family a comprehensive dental and orthodontia program. With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Preventative services are covered at no cost to you and includes routine exams and cleanings, with in network providers. You will only pay a small deductible and coinsurance for basic and major services.

When you visit a dentist in the Delta Dental PPO or Premier network, you will maximize your savings. These dentists have agreed to reduced fees, which means you will not get charged more than your expected share of the bill.

Dental Benefits	Low Plan	High Plan
Annual Deductible (Individual/Family)	$50/$150	$50/$150
Annual Maximum *(All services except Orthodontia)*	$1,500	$1,500
Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	Not Covered	50%
Orthodontia (adult and child)	Not Covered	$2,000 lifetime maximum

Employee Contributions (Biweekly 26 per year)	
Low Plan	
Employee	$10.63
Employee & Spouse	$20.32
Employee & Child(ren)	$27.68
Employee & Spouse & Child(ren) (Family)	$37.37
High Plan	
Employee	$24.64
Employee & Spouse	$47.32
Employee & Child(ren)	$58.94
Employee & Spouse & Child(ren) (Family)	$81.63

DELTA DENTAL®

Stay in network and save

As a Delta Dental PPO plus Premier™ member, you may see any dentist you like. However, there are advantages to choosing a dentist who belongs to one of Delta Dental's two dentist networks.

Delta Dental PPO™ dentists	• No balance billing on covered services • Most significant network discounts with more than 3,137 dentists in North Carolina[1] • Dentists file claims for member
Delta Dental Premier® dentists	• No balance billing on covered services • Significant network discounts with more than 4,356 dentists in North Carolina*[1] • Dentists file claims for member
Out-of-network dentists	• May be balance billed • No network discounts • May need to file own claims

1 Delta Dental of North Carolina internal data, Dec. 2025.

How it works—As shown below, your lowest out-of-pocket costs result from going to a Delta Dental PPO™ dentist.

Example savings for a crown by network	Estimated charge	Maximum allowed fees	Percentage paid by Delta Dental	Amount Delta Dental pays	Amount dentist can balance bill	Total amount you pay	Your total cost savings
Delta Dental PPO™	$1,500	$900	50%	$450	$0	$450	**$600** ✓
Delta Dental Premier®	$1,500	$1,000	50%	$500	$0	$500	$500
Out-of-network	$1,500	$1,200	50%	$600	$300	$900	$0

Delta Dental PPO™ dentists

Delta Dental PPO™ dentists have **agreed to charge $900 for the $1,500 service, a savings of $600.** Your **Delta Dental plan covers 50 percent** of the cost. Assuming you've already met your deductible for the year, **Delta Dental will pay $450** and **you'll pay $450.**

Delta Dental Premier® dentists

Delta Dental Premier dentists have **agreed to charge $1,000—a savings of $500** compared to the fee the dentist usually charges. Assuming you've met your deductible, **Delta Dental will cover 50 percent** of that $1,000, **paying $500. You'll also pay $500.** That's an extra **$50 tacked on to your share of the bill** when compared to what you would have paid with a Delta Dental PPO™ dentist.

Out-of-network dentists

Out-of-network dentists **have not agreed to charge lower fees and can bill the full $1,500.** Delta Dental has set a limit on the accepted amount at $1,200, which means **Delta Dental's share of the tab is $600.** The dentist can bill you the difference between Delta Dental's payment and what they charge. This leaves **you with a bill of $900, which includes the $300 the out-of-network dentist can "balance bill."**

* This number is inclusive of the PPO network.
NOTE: Payment examples above are illustrative only. Fees and reimbursements can vary by location and dentist. They do however represent how payment is determined.

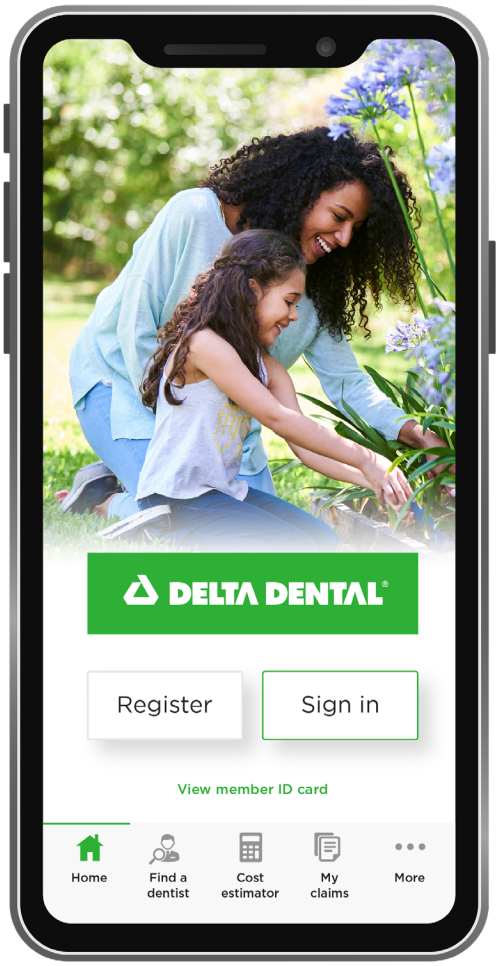
Find Delta Dental participating dentists near you by using the search feature on our website at www.deltadentalnc.com/findadentist, or by calling Delta Dental toll-free at 800-662-8856.

DELTA DENTAL

Delta Dental Mobile App

Manage your oral health anytime, anywhere

Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, view ID cards and more, right on your mobile device.



Getting started

The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental Mobile App. Or, scan the QR code below. You will need an internet connection in order to download and use most features of our free app.

Logging in to view benefits

Delta Dental members can sign in using the username and password they use to sign in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental Mobile App.

SCAN TO DOWNLOAD
DELTA DENTAL MOBILE APP

VISION COVERAGE

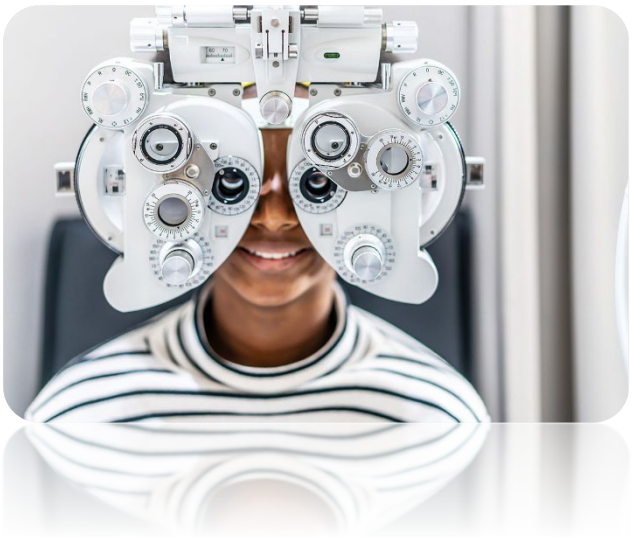
Eyemed

Sight, it is a beautiful thing and not to be taken for granted. Whether you want to be incognito by wearing contact lenses or stand out in the crowd with stylish frames, our vision plan has you covered. *If you are covered by either Davidson County medical plan and visit an in-network vision provider with BCBS you may be able to get your annual Basic Vision Exam covered at 100% as a preventative screening and avoid the $10 Vision Exam copay.*

Participants have the can use either the contacts and frame, or frame and lens benefits in a 12 month period. Separate contact lens fit and follow-up coverage (leave the entire allowance for materials).

Benefit	
Vision Exam (every 12 months)	$10 Copay
Contact Lens Fit & Follow-up	Up to $55 Allowance
Frames (every 12 Months) or Contacts (every 12 months)	$140 Allowance
Standard Plastic Lenses	$25 Copay

Employee Contributions (Biweekly 26 per year)	
Employee	$2.84
Employee & Spouse	$5.35
Employee & Child(ren)	$5.63
Employee & Spouse & Child(ren) (Family)	$8.25



HOW TO: enjoy your own eye site

MEMBER WEB ON EYEMED.COM

Your vision plan is like a friendly smile – it doesn't do any good if it's hidden away. Member Web at eyemed.com is here, there and everywhere. It's your vision plan control center. A place to manage the details of every visit and every claim. Instantly. Easily. Smile-ly.

START MANAGING YOUR BENEFITS IN A FEW EASY STEPS:

1. Visit eyemed.com and click on Member Login.
2. If you're a new user, click on Create an Account.
3. Register using your member ID or the last four digits of your social security number (You'll get an email asking to confirm your account.).*
4. Finish setting up your new account with your email address and a password (To keep it secure, we list some password "musts.").
5. Come back anytime to change your password, email address and billing preferences (It's all under Manage Profiles.).

LOG IN 24/7 TO:

- View your benefit details
- Confirm eligibility
- Check claim status
- Print replacement ID cards
- Locate a provider
- Schedule an appointment online**
- View health and wellness information
- Get special offers

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now

* Depends on how your benefit administrator entered you into the system.

** Most, but not all, network providers offer this.

This information is available broadly and is not plan or state specific. Offers are not valid in the state of Texas.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

PDF-1801-M-134

There's more to love when you enroll in EyeMed

Got EyeMed on your mind? Can't blame you. Whether you're a vision benefits veteran or a newbie, get ready for an unrivaled experience.

MORE CHOICE

Our more than 55 million members get to pick from a huge network of eye doctors, so you get the quality care you deserve with the convenience you want. Choose a traditional brick-and-mortar location or use your in-network benefits online—anytime, anywhere. Instantly apply your in-network benefits at checkout, with free shipping, free returns and no paperwork at these participating providers: lenscrafters.com, targetoptical.com, ray-ban.com, glasses.com and contactsdirect.com.

MORE GUIDANCE

We go out of our way to make your benefits easy to understand—and even easier to use with tools that help you find an eye doctor near you, schedule an appointment and manage your vision benefits.

MORE EXTRAS

We're out to wow you with members-only savings and an eye-opening experience. In addition to your vision benefits, EyeMed members get a mix of special offers and discounts that give your benefits a boost - so you can keep your eyes healthy and save some cash while you're at it. That's just how life is for an EyeMed member.

Learn more about enrolling in EyeMed vision benefits at enroll.eyemed.com

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

PDF-1905-M-522

FlexibleBenefit ADMINISTRATORS

Davidson County Government

Get reimbursed for out-of-pocket healthcare and expenses with tax-free dollars!

MAXIMIZE YOUR INCOME!

Flexible Spending Accounts (FSAs) allow you to pay certain healthcare and dependent care expenses with pre-tax money. (The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars.) You will not pay any federal, state or Social Security taxes on funds placed in the Plan. You will save between, $27.65 and $37.65 on every $100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

ELIGIBILITY

Participation in the Plan begins on July 1, 2026 and ends on June 30, 2027. You are eligible to participate in the Flexible Spending Accounts on the first of the month following your first 30 days of employment if you work at least 30 hours or more per week. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions will begin on the first pay period following your Plan start date. You must complete your enrollment during the open enrollment period to participate in the Flexible Spending Accounts each year. If your enrollment is not completed during the open enrollment period, you will not be enrolled in the Plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

ELECTION CHANGES

Once you have enrolled in an FSA, you may NOT make any changes to your election unless you have a change in status such as:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in Dependent Care Providers

REIMBURSEMENT SCHEDULE

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for healthcare expenses. Please refer to the Benefits Card section for details.

ONLINE ACCESS

Flexible Benefit Administrators, Inc. provides online account access for all FSA participants. Please visit their website at https//fba.wealthcareportal.com/ to view the following features:

- View account history & balances
- Submit & track claims
- Sign-up for email/text messages
- Use the FSA calculator to estimate how much you can save by utilizing an FSA

THE HEALTHCARE ACCOUNT IS A PRE-FUNDED ACCOUNT

This means that you can submit a claim for healthcare expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions are deposited into your account throughout the Plan Year.

Contribution Limits: The maximum you may place in this account for the Plan Year is $3,400.

HEALTHCARE REIMBURSEMENT

With this account, you can pay for your out of pocket healthcare expenses for yourself, your spouse and all of your tax dependents for healthcare services that are incurred during the plan year and while an active participant. Eligible expenses are those incurred "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or the purpose of affecting any structure or function of the body." This is a broad definition that lends itself to creativity.

EXAMPLES OF ELIGIBLE HEALTHCARE EXPENSES

Fees/Co-Pays/Deductibles For:

- Acupuncture
- Prescription eyeglasses/ reading glasses/ Contact lens and supplies/ Eye exams/ Laser eye surgery
- Physician
- Ambulance
- Psychiatrist
- Psychologist
- Anesthetist
- Hospital
- Chiropractor
- Laboratory/ diagnostic
- Fertility treatments
- Surgery
- Dental/ Orthodontic fees
- Obstetrician
- X-Rays
- Eye exams
- Prescription drugs
- Artificial limbs & teeth
- Orthopedic shoes/ inserts
- Therapeutic care for drug and alcohol addiction
- Vaccinations & immunizations
- Mileage
- Take-home screening kits
- Diabetic supplies
- Routine physicals
- Oxygen
- Physical therapy
- Hearing aids and batteries
- Medical equipment
- Antacids
- Pain relivers
- Allergy & Sinus Medication

OVER-THE-COUNTER EXPENSES

Examples of medications and drugs that may be purchased in reasonable quantities with a prescription:

- Acne Treatment
- Humidifiers
- Multivitamins
- Baby Formula
- Fiber Supplements
- Herbal Supplements

DAY CARE/AGED ADULT CARE REIMBURSEMENT

The Day Care/Aged Adult Care FSA allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars. Eligible Day Care/Aged Adult Care expenses are those you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives. This can include stepchildren, grandchildren, adopted or foster children; refer to the Employee Guide for more details. Eligible dependents are further defined as:

- Under age 13
- Physically or mentally unable to care for themselves such as:
  - Disabled spouse
  - Disabled child
  - Elderly parents that live with you

Contribution Limits: The annual maximum contribution may not exceed the lesser of the following:

- $7,500 ($3,750 if married filing separately)
- Your wages for the year or your spouse's if less
- Maximum is reduced by spouse's contribution to a Day Care/Aged Adult Care FSA

HOW THE FLEXIBLE BENEFIT PLAN WORKS

	Without Flex Benefits	With Flex Benefits
Gross Monthly Income	$ 2,500.00	$ 2,500.00
Eligible Pre-Tax employer medical insurance	$ 0.00	$ 200.00
Eligible Pre-Tax Medical Expenses	$ 0.00	$ 100.00
Eligible Pre-Tax Dependent Child Care Expenses	$ 0.00	$ 300.00
Taxable Income	$ 2500.00	$ 1900.00
Federal Tax (15%)	$ 375.00	$ 285.00
State Tax (5.75%)	$ 143.75	$ 109.25
FICA Tax (7.65%)	$ 191.25	$ 145.35
After-Tax employer medical insurance	$ 200.00	$ 0.00
After-Tax medical expenses	$ 100.00	$ 0.00
After-Tax dependent child care expenses	$ 300.00	$ 0.00
Monthly Spendable Income	$ 1190.00	$ 1360.40

By taking advantage of the Flexible Benefit Plan this employee was able to increase his/her spendable income by $170.40 every month! This means an annual tax savings of $2,044.80. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

HOW TO RECEIVE REIMBURSEMENT

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

FORFEITING FUNDS

Plan carefully! Unused funds will be forfeited as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to add the $680 rollover provision to the Medical FSA. Please see the Employee Guide for more information.

ELIGIBLE DAY CARE/AGED ADULT CARE EXPENSES

- Au Pair
- Nannies
- Before and After Care
- Day Camps
- Babysitters
- Daycare for an Elderly Dependent
- Daycare for a Disabled Dependent
- Nursery School
- Private Pre School
- Sick Child Center
- Licensed Day Care Centers

Ineligible Expenses

- Overnight Camps
- Babysitting for Social Events
- Tuition Expenses Including Kindergarten
- Food Expenses (if separate from dependent care expenses)
- Care Provided By Children Under 19 (or by anyone you claim as a dependent)
- Days Your Spouse Doesn't Work (though you may still have to pay the provider)
- Kindergarten expenses are ineligible as an expense because it is primarily educational, regardless if it is half or full day, private, public, state-mandated or voluntary
- Transportation, books, clothing, food, and entertainment are ineligible if these expenses are shown separately on your bill.
- Expenses incurred while on a Leave of Absence or Vacation.

HOW TO ENROLL IN OUR FSA PLAN

Step 1

Carefully estimate your eligible HealthCare and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at https//fba.wealthcareportal.com/ to help you determine your total expenses for the Plan Year.

Step 2

Complete your enrollment during your enrollment time frame which instructs payroll to deduct a certian amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, Social Security, and state taxes are calculated.

BENEFITS CARD (MEDICAL FSA ONLY)

You must use your Benefits Card to pay for eligible healthcare expenses at approved service providers and merchants. Using your card allows you instant access to your funds with no out-of-pocket expense. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. You may also elect to have an additional Benefits Card for your dependent(s) over the age of 18. Please contact Flexible Benefit Administrators, Inc. to order additional cards.

Voluntary Long-Term Disability

Long-Term Disability Insurance

Davidson County offers all full-time employees Long Term Disability Insurance (subject to underwriting criteria). In the event you become disabled, disability income benefits are provided as a source of income.

The monthly benefit is 60% of your insured pre-disability earnings reduced by deductible income. When you enroll or are approved to enroll, in this benefit, you pay the full cost through bi-weekly payroll deductions. **During Open Enrollment, Workday will calculate your rate for new/continuing coverage.**

Pre-existing condition exclusion and waiting periods apply.

The rates for your voluntary Long-Term Disability depend on your age and income and are subject to change each year as the enrollees age increases and income changes.

Elimination period of 180 days, benefit 60% of salary up to $10,000 per month with a minimum benefit of $100 per month if there is other deductible income.

Basic Life and Accidental Death & Dismemberment

Colonial Life®

Basic Life and AD&D

Davidson County provides all full-time benefit eligible employees under age 70, with $15,000 group life and $15,000 accidental death and dismemberment (AD&D) insurance. Full time employees over the age of 70 are provided with a reduced life insurance benefit. Employees aged 70 – 74 receive 65% of the regular amount or $9,750. Employees aged 75 and above receive 50% of the regular amount or $7,500. Davidson County pays the full premium for this insurance for all eligible employees.

Coverage takes effect on the first of the calendar month following a 30 day waiting period following the employees first eligibility date or hire date.

Accidental Death and Dismemberment Benefits

Full Benefit Payable for the loss or loss of use of any of the following:

- Life
- Both hands or both feet or sight of both eyes
- One hand and one foot
- One hand and sight of one eye
- One foot and sight of one eye
- Speech and hearing

Half Benefit Payable for the loss or loss of use of any of the following:

- One hand or foot
- Sight of one eye
- Speech or hearing loss

One Quarter Benefit Payable for the loss or loss of use of thumb and index finger on the same hand.

Legal Insurance from ARAG

WHAT IS LEGAL INSURANCE?

Legal coverage isn't just for the serious issues, it's for your everyday needs, too. Legal insurance helps you address common situations like creating wills, transferring property or dealing with a traffic ticket.

WHAT DOES LEGAL INSURANCE COVER?

A legal insurance plan from ARAG® covers a wide range of legal needs like the examples shown below – and many more – to help you address life's legal situations.

Consumer Protection Matters
- Auto repair
- Buying or selling a car
- Consumer fraud
- Consumer protection for goods or services
- Home improvement
- Personal property disputes
- Small claims court

Criminal Situations
- Juvenile
- Parental responsibility

Family Law Events
- Adoption
- Domestic partnership
- Guardianship/conservatorship
- Name change
- Pet-related matters and damages
- Pre-marital agreements
- Divorce

General Needs
- Document review
- Credit records correction
- Document preparation

Finance, Tax & Debt-Related Matters
- Debt collection
- Garnishments
- IRS tax audit
- Personal bankruptcy
- Student loan debt

Home Ownership or Renter Matters
- Buying and selling a home
- Contracts/lease agreements
- Contractor issues
- Deeds
- Foreclosures or evictions
- Disputes with a landlord
- Neighbor disputes
- Real estate disputes

Traffic Troubles
- License suspension/revocation
- Traffic tickets

Wills & Estate Planning Needs
- Funeral directives
- Powers of attorney
- Wills
- Trusts

WANT MORE INFORMATION?

For specific details about your plan, and to view a complete list of coverages, visit **ARAGlegal.com/myinfo** and enter Access Code: **19190dcg**

To talk with someone, call ARAG at **800-247-4184**

WHAT DOES IT COST?

UltimateAdvisor®
$10.82 biweekly

USING YOUR LEGAL PLAN IS EASY

1. When you have a legal need, you can go online, use the ARAG Legal app or call Customer Care.
2. Answer a few questions to confirm your coverage and receive information on local network attorneys who can help with your legal matter.
3. Then, meet with a network attorney virtually, over the phone or in person.

HOW LEGAL SHOWS UP IN YOUR LIFE

Most consumers believe legal events are rare, once-in-a-lifetime events. But they're far more common than you think.

85%

of individuals experienced a legal event in the past three years.[1]

These events often have a considerable impact on one's finances or family.

WHY SHOULD YOU GET LEGAL INSURANCE?

Work with a network attorney and attorney fees are **100% paid in full** for most covered matters.

Save thousands of dollars on average, for legal matters by avoiding costly legal fees.

We help you easily find local attorneys in ARAG's network – many who average 20+ years of experience.

Address your covered legal situations with a network attorney for **legal help and representation.**

ARAG Members rated network attorneys **9.4 out of 10** for **accessibility, responsiveness** and **professionalism.**[2]

9.4/10

Use DIY Docs® to create a variety of **legally valid documents,** including state-specific templates.

See What a Network Attorney Can Do for You

Whenever you face legal needs throughout life, your ARAG legal coverage is there for you. Network attorneys are available to answer your legal questions in person, virtually or over the phone for your immediate needs.

Connect with a network attorney who will:

- Review or prepare documents.
- Make follow-up calls or write letters on your behalf.
- Advise you on legal issues.
- Represent you – including if you go to court.

[1]ARAG Stress Research Study, October 2022.

[2]2022 ARAG Customer Satisfaction Survey.

Rev 6/23 200333dcg

The following Colonial Life voluntary benefits will be offered during enrollment

Colonial Life®

This year's enrollment will include a new Colonial Life benefits offering, with a chance for you to enroll without any health questions. The new plans from Colonial Life are generally lower in cost. To take advantage of these benefits, and continue payroll deduction, you MUST make an election under the new offering during annual enrollment. In most cases, enrolling in the new version of your current plan will be the best option.

We strongly recommend speaking with a benefits counselor during annual enrollment. Your benefits counselor will help you make the best election for your situation by reviewing the new plan and explaining any differences compared to your current plan. You will need to enroll in the new version of your current plan, or you will have your old plan converted to direct bill.

Disability insurance replaces a portion of your income to help make ends meet if you become disabled from a covered accident or sickness.

Accident insurance helps offset unexpected medical expenses that can result from a covered accidental injury.

Term life insurance offers a predictable way to provide more coverage at more affordable prices during high-need years.

Whole life insurance provides guaranteed features – cash value accumulation, premium rates and death benefit (minus any loans and loan interest) – that help ensure those benefits will be there to help protect your family's way of life.

Critical illness insurance helps supplement major medical coverage by providing a lump-sum benefit that can be used to help pay the direct and indirect costs related to a covered critical illness. Plan options are available that include cancer benefits.

Hospital indemnity insurance provides a lump-sum benefit for a covered hospital confinement or outpatient surgery to help with co-payments and deductibles.

With most of our insurance plans:

- Benefits are paid directly to you, unless you specify otherwise.
- You're paid regardless of any other insurance you may have with other insurance companies.
- Coverage is available for your spouse and dependent children.

ColonialLife.com

4-26 | NS-2074505-1

Employee Assistance Program (EAP)

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) is a work-based intervention program designed to identify and assist employees in resolving personal problems (e.g., marital, financial or emotional problems; family issues; substance/alcohol abuse; trauma/compassion fatigue) that may be adversely affecting the employee's performance. Managers can also refer employees to the EAP if they are unable to resolve a matter through on-the-job coaching and HR support. EAPs also provide workplace intervention, training and critical incident stress debriefings.

How does EAP help improve an organization like Davidson County?

Studies have shown that EAPs contribute to: decreased absenteeism, reduced accidents, fewer workers' compensation claims, greater employee retention, and significantly reduced medical costs due to early identification and treatment of substance abuse and mental health issues.

How are EAP services beneficial to department supervisors?

The EAP provides consultation to the county's management staff to resolve employee and organizational issues. Supervisors also have the opportunity to refer an employee for services, either formally or informally. This may be necessary when there has been a significant change in the employee's **productivity** or **performance**, standard supervisory interventions have not been effective, or the employee has violated a policy. The EAP is also available to help supervisors develop management skills such as problem-solving, communication or interpersonal skills.

Identifying a troubled employee

- Absenteeism
- Difficulties in Concentration/Confusion
- On-the-Job Absenteeism
- High Accident Rate
- Communication
- Abnormal Behavior
- Lowered Job Efficiency
- Sporadic Work Patterns
- Change in Initiative
- Interpersonal Skills
- Physical Symptoms
- Smell of drugs or alcohol

What services are available through your EAP provider?

Employees and family members (under the same roof or on the employee's insurance policy) are eligible for 5 sessions per issue at no cost to the individual. Services are confidential. Telephonic support as well as face-to-face sessions can be scheduled. The individual has the option of being seen on-site or in the Winston-Salem office.

In what situations might an employee benefit from EAP services?

EAP offers help for many situations including but not limited to:

- Stress, depression and other mental health concerns
- Relationship and family problems
- Trauma/Post Traumatic Stress/Compassion fatigue
- Drug and alcohol abuse
- Job-related problems
- Balancing work/life concerns
- Grief

How do I set up an appointment?

You can schedule an appointment by calling Melissa Snapp at (336) 293-4169 or sending an email to mwsnapp@gmail.com

North Carolina
Total Retirement Plans

Your Retirement System

The Local Governmental Employees' Retirement System is a **defined benefit plan** qualified under Section 401(a) of the Internal Revenue Code. Defined benefit plans use a formula to calculate monthly retirement benefits once eligibility requirements have been met.

PAYING FOR YOUR RETIREMENT BENEFITS

You, your employer and the investment earnings on total contributions pay the cost of providing your retirement benefits. Davidson County contributes 15.14% (17.10% for LEO) and you contribute 6 percent of your compensation to the Pension Plan, and it is automatically deducted from your paycheck. Your compensation includes all eligible salaries and wages, as defined by statute, paid to you from public funds, earned at your covered job while working for your employer.

Your employer's share of the cost is based on calculations prepared by an **actuary.**

TAX SAVINGS

Beginning July 1, 1982, if your employer adopted a resolution to have your contributions made on a before-tax basis, your contributions have been tax deferred. This means your contributions are deducted from your pay before taxes are calculated, and you pay taxes on them when you begin receiving monthly retirement benefits or if you elect a refund of your contributions. This is a benefit to you because your current taxable income is lowered and the amount of annual taxes you pay is less than if you made contributions after paying taxes.

INVESTING CONTRIBUTIONS

Contributions to LGERS are invested by the Department of State Treasurer and these funds are protected by the Constitution of North Carolina from being used for any purpose other than retirement system benefits and expenses.

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24 HOURS

ORBIT

ORBIT ONLINE ACCOUNT ACCESS

ORBIT is a secure site that allows you to view your personal account information, download retirement forms, and access retirement resources 24 hours a day, seven days a week.

To set up or log in to your personal ORBIT account, go to the ORBIT website ORBIT.myNCRretirement.com and follow the log in instructions, or register for an ORBIT account.

When creating your account, you are required to use your personal email address.

If you already have an account and use your work email, we recommend logging in and changing this to your personal email so you will continue to have access to your account should you switch jobs or retire.

Membership in LGERS

You become an LGERS member on your hire date (or after a required local unit waiting period) if you are employed by a participating unit in a regular position that requires at least 1,000 hours of work in a calendar year. You will not be a contributing member of LGERS if your work is considered temporary employment or statutorily-required interim employment.

A participating unit is any county, city, town or other local government entity that has agreed to participate in LGERS.

If you are an Agricultural Extension Service employee and a member of the Federal Employees' Retirement System, you may not join LGERS. Contact your employer for more details about the alternate systems.

FORFEITING ELIGIBILITY BASED ON CRIMINAL OFFENSES

If you were not vested as of December 1, 2012, and are convicted of a state or federal felony directly related to your employment while in service under LGERS, you are prohibited from receiving any retirement benefit other than a return of your contributions plus interest.

If you were vested as of December 1, 2012, you are prohibited from receiving any retirement benefit for service rendered after December 1, 2012, other than a return of your contributions plus interest for the period of service after December 1, 2012.

Elected government officials who were not vested on July 1, 2007, will forfeit their right to a monthly benefit from LGERS if convicted of certain state or federal offenses related to their service as an elected official.
Elected officials who were vested on July 1, 2007, are not entitled to creditable service accrued in LGERS after July 1, 2007, if convicted of certain state and federal offenses related to their service as an elected official.

As of June 26, 2018, convictions on state charges of embezzlement were added to the list of offenses. Also, if any portion of a register of deeds' Local Governmental Employees' Retirement System benefit is forfeited, then that member's entire Registers of Deeds' Supplemental Pension Fund benefit is also forfeited.

DESIGNATING BENEFICIARIES

After your employer enrolls you in LGERS, and within one to two pay periods, you should be able to create your secure ORBIT account and name beneficiary(ies) to receive a return of your retirement contributions and, if applicable, a death benefit, should you die before retirement. A member has the option to name any person as their beneficiary regardless of relationship to member (ie the beneficiary does not have to be a spouse or family member).

To add or change beneficiaries as an active employee:

- Log in to ORBIT.
- Click the Maintain Beneficiaries tab on the left side of the screen.
- Add or edit beneficiaries for your eligible benefits.
- Perform a beneficiary check-up every couple of years or if you have a life-changing event, such as marriage, divorce, family changes or adoptions.

Qualifying for Benefits

VESTING

You become vested in LGERS once you have completed a minimum of five years of creditable service. This means that you are eligible to apply for lifetime monthly retirement benefits based on the retirement formula in effect at the time of your retirement and the age and service requirements described in this handbook, provided you do not withdraw or transfer your contributions.

SERVICE RETIREMENT (UNREDUCED BENEFITS)

You may retire with an unreduced service retirement benefit after you:

- Reach age 65 and complete five years of creditable service
- Reach age 60 and complete 25 years of creditable service
- Complete 30 years of creditable service at any age

EARLY RETIREMENT (REDUCED BENEFITS)

You may retire early with a reduced retirement benefit after you:

- Reach age 50 and complete 20 years of creditable service
- Reach age 60 (age 55 if you are a firefighter or rescue squad worker) and complete five years of creditable service

Your early retirement benefit is calculated using the same formula as a service retirement benefit multiplied by a reduced percentage based on your age and/or service at early retirement. Because your benefit may be paid over a longer period of time than if you had waited until being eligible for service retirement, your benefit will be reduced.

VESTED DEFERRED BENEFIT

If you leave LGERS for any reason other than retirement or death, you can either receive a refund of your contributions, plus interest, or leave your contributions in LGERS and keep all the creditable service you earned to that date.

You may be entitled to receive a deferred benefit at a later date once you meet eligibility requirements after you have completed five years of creditable service, provided you do not withdraw your contributions. Your benefit is calculated using the formula in effect on your retirement date. It is based on your average final compensation and years of creditable service at that time.

If you withdraw your retirement contributions, you forfeit your retirement service credit and rights to all benefits associated with the service for that time period, including medical coverage through the State Health Plan, if applicable.

REFUND OF CONTRIBUTIONS

If you leave LGERS before you have five years of creditable service, the only payment you can receive is a refund of your contributions and interest.

State law prohibits us from making a refund earlier than 60 days after you leave employment with an employer that participates in LGERS.

However, if you leave LGERS employment and you do not take a refund, you will retain your benefits and rights should you return to LGERS service at a later time. Set by state law, the interest credited on your contributions and paid with a refund is currently four percent (4%) compounded annually on your prior year ending balance. To apply for a refund, log into your ORBIT account and click **Apply for a Refund Online**.

North Carolina Retirement Systems | NC 401(k) Plan

The Plan offers you these benefits:

Automatic payroll deductions

Contributions to the NC 401(k) Plan are made through payroll deduction.

You may change or stop your contributions at any time.

100% vesting[1]

You are fully vested in the NC 401(k) Plan from your first contribution to your last. To be "vested" means to own, which means the money is always yours.

Convenient asset consolidation

To simplify your financial life, the NC 401(k) Plan allows for rollovers from other retirement plans you may have from former employers, including 401(k), 401(a), 403(b), Governmental 457 and TSP plans, and some IRAs.

One-on-one assistance

The Plan has knowledgeable NC 401(k)/NC 457 Plans' Retirement Plan Counselors[3] strategically located throughout North Carolina to help you get the most from your participation in the Plan. These representatives are a resource available to Plan members by phone, email or in person.

Multiple investment choices

You can invest in vehicles that range from potentially high growth to highly conservative, so you can make the most appropriate choice to help you meet your savings goals.

For details about the Plan's investment options, please visit **myNCPlans.gov** to view the quarterly fund fact sheets.

Simple investing with GoalMaker*

With GoalMaker®, you can spread your money across various asset classes and investment options. Just select a model with the year that best aligns with your retirement plans.[2] *Past performance of investments or asset classes does not guarantee future results.*

Quarterly statements to keep you informed

Statements are provided after the end of each quarter to help you monitor activity in your account.

Online retirement planning tools

You may access your account 24 hours a day, 7 days a week. You may also access a host of retirement articles, interactive calculators and other resources at **myNCPlans.gov**.

* The North Carolina GoalMaker models are subject to change — including, for example, the replacement of investment options and allocations within the models. You will be notified in advance of such changes.

[1] Subject to North Carolina's felony forfeiture law and other applicable North Carolina and federal laws.

[2] Asset allocation models are pre-established asset allocation strategies composed of a plan's core investment options. The models are not securities. When you allocate your investment to a model, you will be invested in the various underlying investment options composing each model, as made available by the plan and according to the model's allocation methodology.

An asset allocation model provides targeted asset allocation for your plan account and allocates your account across the model's underlying investments. Your plan may include asset allocation models designed according to certain risk levels (e.g., aggressive, moderate, or conservative), asset allocation models that follow a glidepath based on a target date, or both model types depending upon the models selected by your plan. Neither model type is without risk or guarantee of positive returns. The date in the name of a target date model is an assumed date in which an investor will retire. The asset allocation becomes more conservative as the target retirement date nears and, depending on the model's design, can remain static at the target date or adjust further through retirement. There is no guarantee the investment will provide adequate retirement income.

Investors should review the prospectus, summary prospectus for SEC-registered products, or disclosure document for unregistered products, if available, for underlying fund objectives, risks, fees, and expenses.

Empower is not undertaking to provide investment advice with respect to the presentation of any particular investment option or asset allocation model described herein.

North Carolina Retirement Systems
NC 457 Plan

The Plan offers you these benefits:

Automatic payroll deductions

Contributions to the NC 457 Plan are made through payroll deduction.

You may change or stop your contributions at any time.

100% vesting

You are fully vested in the Plan from your first contribution to your last. To be "vested" means to own, which means the money is always yours.

Penalty-free withdrawals

Withdrawals from your NC 457 Plan account are **never** subject to a 10% federal income tax penalty, regardless of your age at the time of withdrawal. Remember that the NC 457 Plan is a single-state plan, administered by the North Carolina Department of State Treasurer, available to all eligible employees whose employers offer the Plan. Withdrawal restrictions apply to participants who retire or leave a covered position at an employer that participates in the NC 457 Plan, and, after doing so, transition to a covered position with another employer that participates in the Plan.

Convenient asset consolidation

To simplify your financial life, the NC 457 Plan allows for rollovers from other retirement plans you may have from former employers, including 401(k), 401(a), 403(b), governmental 457 and TSP plans, and some IRAs.

Online retirement planning tools

You may access your account 24 hours a day, 7 days a week. You may also access a host of information, interactive calculators and other resources at **myNCPlans.com**.

Multiple investment choices

You can invest in vehicles that range from potentially high growth to highly conservative, so you can make the most appropriate choice to help you meet your savings goals.

For details about the Plan's investment options, please visit **myNCPlans.com** to view the quarterly fund fact sheets.

Simple investing with GoalMaker*

With GoalMaker®, you can spread your money across various asset classes and investment options. Once you provide your chosen retirement age and risk tolerance, you will be provided a suggested NC GoalMaker model comprised of the investments offered in the Plan.[1] *Past performance of investments or asset classes does not guarantee future results.*

Quarterly statements to keep you informed

Statements are provided after the end of each quarter to help you monitor activity in your account.

One-on-one assistance

The NC 457 Plan has knowledgeable NC 401(k)/NC 457 Plans' Retirement Plan Counselors[2] strategically located throughout North Carolina to help you to get the most from your participation in the Plan. These representatives are a resource available to Plan members by phone, email or in person.

*The North Carolina GoalMaker models are subject to change — including, for example, the replacement of investment options and allocations within the models. You will be notified in advance of such changes.

[1] GoalMaker's model allocations are based on generally accepted financial theories that take into account the historic returns of different asset classes. Past performance of any investment does not guarantee future results. Participants should consider their other assets, income and investments (e.g., equity in a home, Social Security benefits, individual retirement plan investments, etc.) in addition to their interest in the plan, to the extent those items are not taken into account in the model. Participants should also periodically reassess their GoalMaker investments to make sure their model continues to correspond to their investment objectives, risk tolerance and retirement time horizon.

Paid Holidays

As a full-time employee, you are eligible to receive the following paid holidays each year:

New Year's Day
MLK, Jr. Day
Good Friday
Memorial Day
Independence Day
Labor Day
Veteran's Day
Thanksgiving Day
Day after Thanksgiving
Christmas (3 Days)

A full-time employee must be on pay status on the regularly scheduled workday before and after the holiday.

Vacation Leave

Vacation leave accumulates from year to year to a maximum of 240 hours annually. At the end of the calendar year, any vacation hours above than the maximum (240) will be transferred to sick leave.

Vacation leave must be approved by the immediate supervisor or Department Head prior to use and must be taken in increments of at least fifteen (15) minutes.

All full-time regular, employees that have completed the initial 12 months of probation who are terminated regardless of reason will be paid for vacation leave not to exceed a maximum of twenty-five (25) days or 200 hours and will be calculated to the nearest hour. Employees must work the entire termination notice period and may not take vacation leave unless approved by the Department Director. If the employee does not give at least a two (2) week advance notice of resignation they will not be eligible to be paid for accrued vacation leave.

Years of Service (Based on 40 hrs/week)	Hours Earned Per Pay Period	Days Earned Per Year
Less than 3 years	3.08 hours	10 days
3 but less than 6 years	3.69 hours	12 days
6 but less than 9 years	4.62 hours	15 days
9 years but less than 20 years	5.54 hours	18 days
20 years or more	6.46 hours	21 days
Years of Service (Based on 42.5 hrs/week)	**Hours Earned Per Pay Period**	**Days Earned Per Year**
Less than 3 years	3.23 hours	10 days
3 but less than 6 years	3.88 hours	12 days
6 but less than 9 years	4.85 hours	15 days
9 years but less than 20 years	5.82 hours	18 days
20 years or more	6.79 hours	21 days

Sick Leave

Full-time, benefits eligible employees begin accruing sick leave when employment begins, and leave is eligible to be taken as it is accrued. There is no maximum accumulation of sick leave. Sick leave may accumulate as long as the Employee works for Davidson County. The following schedule will be used for manner of accumulation of sick days:

Average Scheduled Weekly Hours	Hours Earned Per Pay Period	Days of Sick Leave Earned Per Year
40.00	3.69 Hours	12 Days
42.50	5.54 Hours	12 Days

Employees must notify their immediate supervisor of the desire to take sick leave prior to the leave, or no later than one (1) hour before the beginning of a scheduled workday. Such notice must be made in the manor acceptable to the Supervisor and must include the nature of the absence and the expected duration. Sick leave is not paid out upon termination of employment.

Any person that was employed by a State Agency or University, a County, or a Municipality of North Carolina within one year immediately prior to their employment with Davidson County will have their accumulated sick leave transferred in accordance with this provision and with the Local Government Retirement System, G.S. 128-26(e).

Sick leave earned monthly is allowed as creditable service at time of retirement to employees who are members of the N.C. Local Governmental Employee's Retirement System. One month of credit is allowed for each twenty (20) days of unused sick leave at retirement, and an additional month for any part of twenty (20) days leftover.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

Contact Information

Have Questions? Need Help?

Davidson County is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0835 or via e-mail at BRCSouth@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Carrier Customer Service

	CARRIER	PHONE NUMBER	WEBSITE
Medical PPO	Blue Cross and Blue Shield of North Carolina	800-466-8053	www.bluecrossnc.com
Pharmacy	CVS Caremark	800-552-8159	www.caremark.com
Dental PPO	Delta Dental Insurance Company	800-662-8856	www.deltadentalnc.com
Vision	EyeMed	866-723-0596	www.eyemed.com
Life, AD&D	Colonial Life	800-325-4368	www.coloniallife.com
Disability	Unum	866-679-3054	www.unum.com
Medical Virtual Visits	Teladoc	800-835-2362	www.teladoc.com

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

USI®

Benefit Resource Center

BRCSouth@usi.com | Toll Free: 855-874-0835
Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

REQUIRED NOTICES

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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 toward 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).

In addition, 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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

NOTICE REGARDING WELLNESS PROGRAMS

Davidson County has a voluntary wellness program available to all employees. The program is administered according to 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 will be asked to complete a voluntary health risk assessment or "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 will also be asked to complete a 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 will receive an incentive of a medical premium discount for participating in certain activities including a primary care physician visit.

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, such as a premium discount.

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 Davidson County may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program 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 is Wellworks and your provider, 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.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Nate Allman
336-242-2211
nathaniel.allman@davidsoncountync.gov

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.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date: July 1, 2026
- Nate Allman, Nathaniel.allman@davidsoncountync.gov, 336-242-2917

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 July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

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)
Davidson County		56-60000294
5. Employer address		6. Employer phone number
P.O. Box 1067		336-242-2210
7. City	8. State	9. ZIP code
Lexington	NC	27293
10. Who can we contact about employee health coverage at this job?		
Nate Allman		
11. Phone number (if different from above)	12. Email address	
336-242-2917	Nathaniel.allman@davidsoncountync.gov	

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

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    All full-time employees working 30 hours a week.

  - [X] Some employees. Eligible employees are:

    Your spouse, under a legally valid, existing marriage. Your child up to age 26 unless they are eligible to enroll as a covered employee or dependent under an employer sponsored health plan. A Dependent child who is either mentally retarded or physically handicapped and incapable of self-support.

- With respect to dependents:
  - [ ] We do offer coverage. Eligible dependents are:
  - [ ] We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

This brochure summarizes the benefit plans that are available to Davidson County's eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefit