2025-2026 Employee Benefit Guide

MACON COUNTY 1828

MACON COUNTY

Franklin ▪ Highlands ▪ Nantahala ▪ Otto, NORTH CAROLINA

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your eligible dependents in the case of illness or injury.

The Summary of Benefits and Coverage (SBC), which summarizes important information about your health coverage, is available at Human Resources.

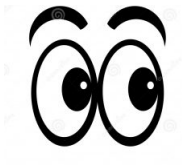
Medicare Part D—Prescription Drug Information

If you (and/or your eligible dependents) are covered by Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 25 and 26 for more details.

About Your Benefits

At Macon County, we are committed to providing a comprehensive and affordable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your Macon County benefits.

Annual Open Enrollment - ACTIVE and ONLINE



Annual Enrollment is held this year from **April 28th-May 12th**. This year's ANNUAL ENROLLMENT is **ACTIVE**. This means, all employees are required to enroll online at www5.benefitsolver.com. **If you fail to enroll, the only benefit coverage you will retain is your medical insurance.** You will lose all other coverages for FY 2025-26. During annual enrollment, you may make any desired changes to your benefits. Any changes or enrollments made during Annual Enrollment will take effect on July 1st. You cannot make any changes to your benefits until the next enrollment period unless you have a qualifying life event.

Table of Contents

What Will It Cost?

Macon County is committed to offering you comprehensive benefits at a fair cost. Macon County pays 100% of the cost for medical coverage and basic life benefits for full-time employees. View page 8 for more information about your costs for medical and prescription drug coverage.

Qualifying Life Event - Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during open enrollment. You may make mid-year changes to your benefits only if you have a qualifying life event. Examples of qualifying life events include:

- Marriage or divorce
- Birth or adoption of a child
- Change in a dependent's eligibility status
- Change in employment status for you or your dependents resulting in the loss/gain of coverage
- A significant change in the cost or coverage of your dependent's benefits
- Change in the cost of dependent care (for dependent care flexible spending accounts only)
- Death of a dependent

You have 30 days from the date of the event to alert Human Resources. Keep in mind, the changes you make must be directly related to the event.

Eligibility and Enrollment

You are eligible to participate in Macon County's benefits if you are a full-time employee working at least 30 hours per week. If you enroll for benefits, you may also cover your:

- Legal spouse
- Children up to age 26
- Unmarried children of any age who are mentally or physically disabled

If you're a new hire, you have 5 days from your hire date to enroll. Your benefits begin on the first of the month following 30 days of continuous full-time employment, rolling forward to the first of the month. For example, if you're first day of employment is May 9th, your benefits will be effective starting July 1st.

How To Enroll in your Benefits NCHIP

Enroll April 28th - May 12th, 2025

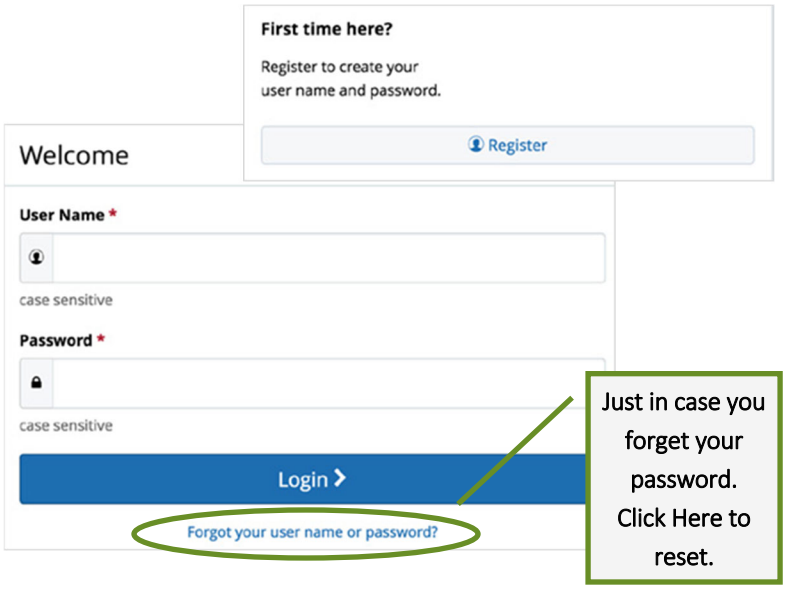
REGISTER AND LOGIN

1. Visit www5.benefitsolver.com and click the Register button to get started. The case-sensitive company key is NCHIP.
2. Create username and password, verify your personal information, and answer a few security questions.
3. Log in using your new username and password.

EXPLORE YOUR OPTIONS

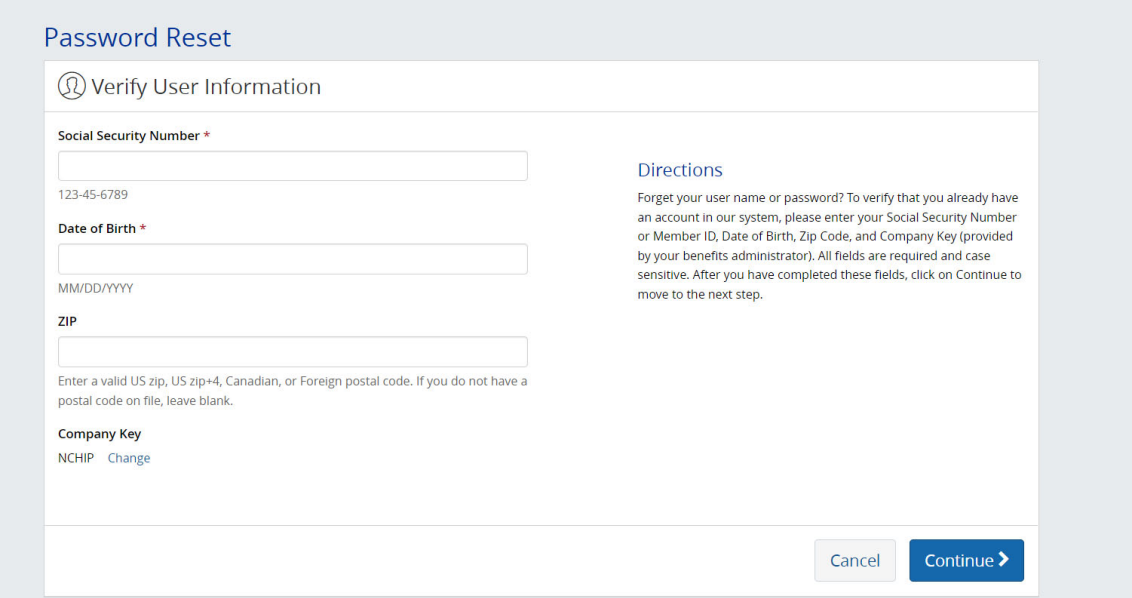
Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

The calendar at the top of the Home page lets you know how many days you have to enroll.



RETURNING USERS: Click on the **Forgot your username or password?** link to reset your login details

Remember to keep your user name and password handy for when you are ready to enroll beginning April 28th.



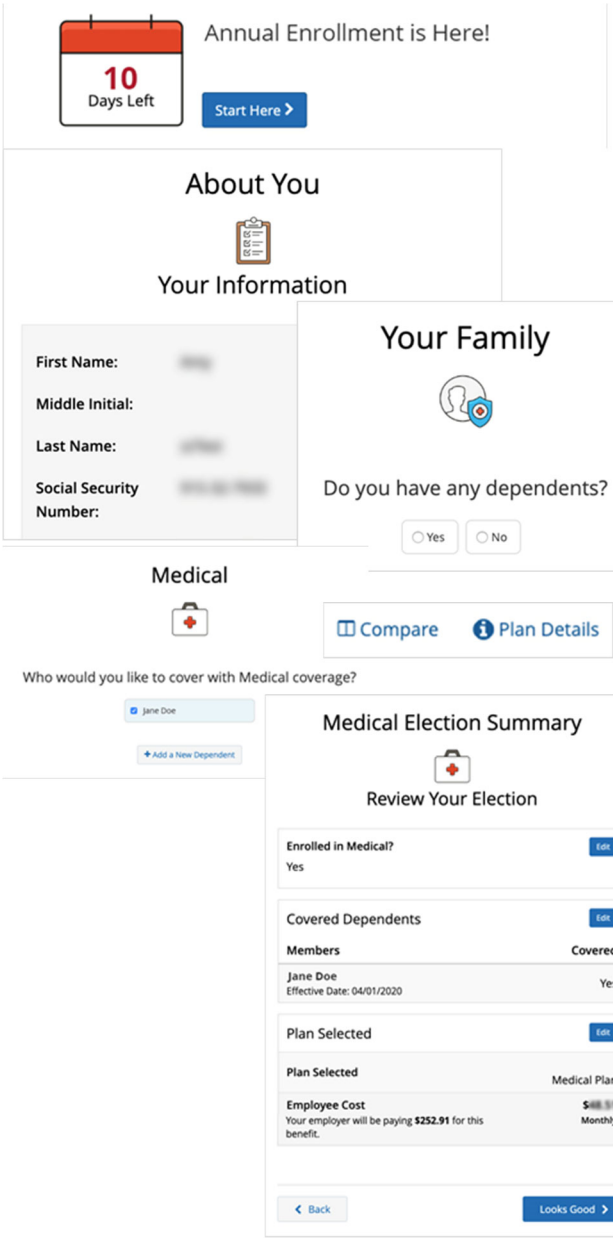
Reach out to Human Resources with questions.

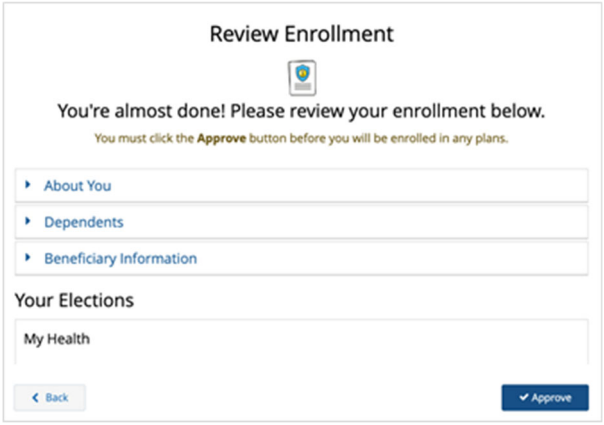
www5.benefitsolver.com

Company Key: NCHIP

How To Enroll in your Benefits

NCHIP





START YOUR ENROLLMENT

Click the **Start Here** button to review your personal information and add or edit any dependents you wish to cover.

You will need to provide each dependent's legal name, Social Security Number, and birth date to add them to your coverage.*

*You may be required to provide documentation to prove your relationship to each dependent.

ENROLL IN COVERAGE

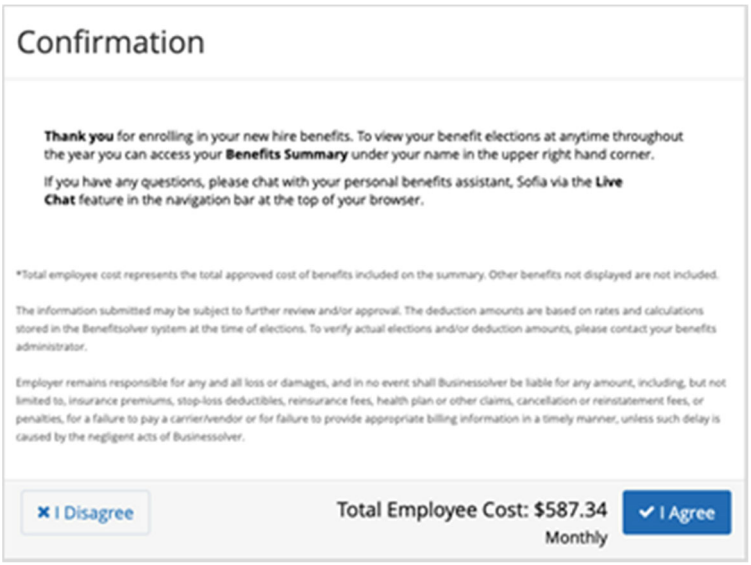
Use the **Next** and **Back** buttons to review and elect options available to you. Choose or decline coverage for each option and select which family members you want to cover.

Review plan documents and use the **Plan Details** tools to view details and costs for the options available to you.

REVIEW AND FINALIZE YOUR ELECTIONS

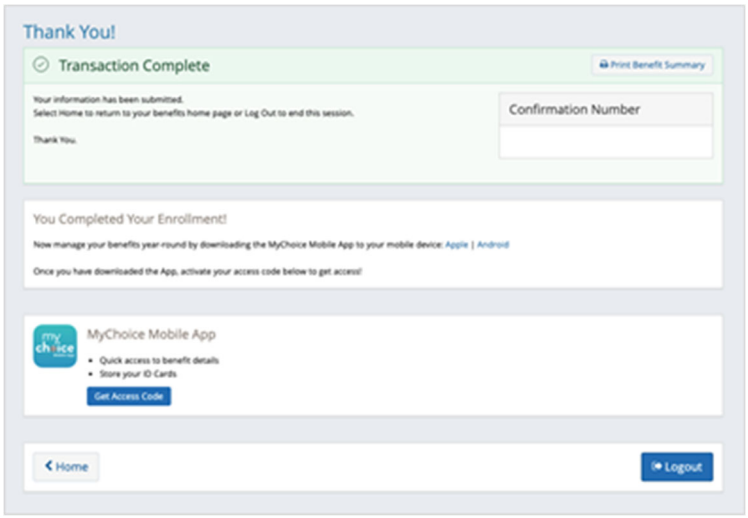
Make sure your personal information, elections, dependents, and beneficiaries are accurate, then approve your elections.

To finish, click **I Agree**. When your enrollment is complete, you will receive a confirmation and print your **Benefit Summary** for your records.



After you Enroll in your Benefits

NCHIP



AFTER YOU ENROLL

Return to the **Home** page to check for any additional tasks needed to complete your enrollment, view or download your **Benefit Summary.**

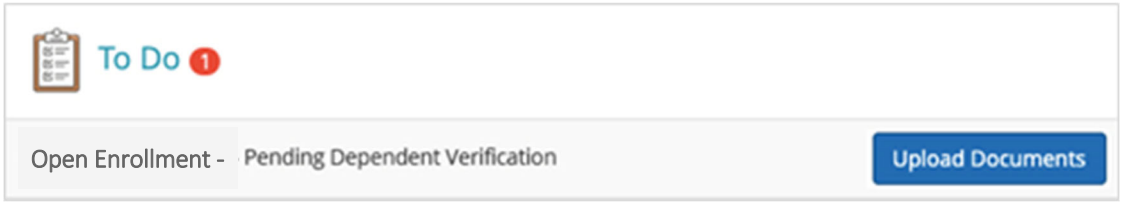
Visit this site anytime you want to learn more about your benefits (if you experience a qualifying life event).

Examples included:

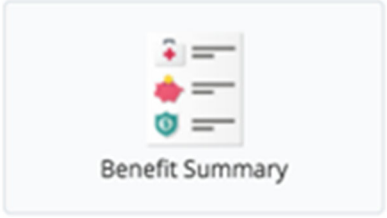
- Marriage or divorce
- Birth or adoption of a child
- Change in a dependent's eligibility status
- Change in employment status for you or your dependents resulting in the loss/ gain of coverage
- A significant change in the cost or coverage of your dependent's benefits
- Change in the cost of dependent care (for dependent care flexible spending accounts only)
- Death of a dependent

To Dos

You will have to provide documentation to prove your relationship to each dependent or to support your qualifying life event to the Human Resources Department.



You can **Print** your **Benefit Summary** for your records.



Reach out to Human Resources with questions.

www5.benefitsolver.com

Company Key: NCHIP

Medical Coverage

You have a choice of two medical plans through BCBS of North Carolina - the **Base Plan** and **Enhanced plan**. Review the chart below for the amount you will pay for the medical service listed.

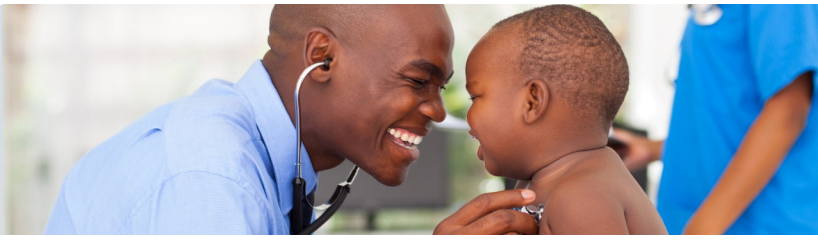
	Base Plan		Enhanced Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual/Family)	$2,250 / $4,500	$4,500 / $9,000	$1,250 / $2,500	$2,500 / $5,000
Coinsurance (Member Pays)	30% after deductible	50% after deductible	20% after deductible	40% after deductible
Annual Out-of-pocket Maximum (Individual/Family)	$6,600 / $13,200	Unlimited / Unlimited	$4,000 / $8,000	$8,000 / $16,000
Preventive Care	Covered at 100%, No Deductible or Copay	50% after deductible for Health Care Reform services	Covered at 100%, No Deductible or Copay	40% after deductible for HealthCare Reform services
Office Visits Teladoc (Telemedicine) Primary Care Specialist Urgent Care	 $0 copay $35 copay $70 copay $70 copay	 50% after deductible 50% after deductible 50% after deductible $70 copay	 $0 copay $25 copay $50 copay $50 copay	 40% after deductible 40% after deductible 40% after deductible $50 copay
Emergency Room	$500 copay		1st Visit—$300 copay Subsequent Visits—$500 copay	
Inpatient Hospital	30% after deductible	50% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	30% after deductible	50% after deductible	20% after deductible	40% after deductible

Terms to Know

- **Copay** - A set dollar amount you pay for a covered health care service, usually when you receive the service.
- **Deductible** - What you pay out-of-pocket for health care services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered health care services after you reach the deductible. You pay the percentage noted in the table above, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide health care services. In-network providers typically provide services at a lower negotiated rate.

Finding In-network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to **www.bcbsnc.com** or call **877-258-3334** to find providers in the BCBS of North Carolina network.



Potential Financial Responsibility When Using Out-of-Network Providers

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

Prescription Drug Coverage

Prescription drug coverage through Prime Therapeutics is included with both of our medical plans. Review the chart below for the amount you will pay for the prescription drug service listed.

	Base Plan		Enhanced Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Rx Deductible	$200		N/A	
Retail (30-day Supply)				
Generic	$10 copay	Not Covered	$10 copay	Not Covered
Preferred	25% up to $100		25% up to $100	
Non-Preferred	25% up to $100		25% up to $100	
Specialty	50% up to $250		50% up to $250	
Mail-order (90-day Supply)				
Generic	$20 copay	Not Covered	$20 copay	Not Covered
Preferred	25% up to $200		25% up to $200	
Non-Preferred	25% up to $200		25% up to $200	
Specialty	50% up to $500		50% up to $500	

Semi-monthly Cost for Medical / Prescription Drug Coverage—No Changes!

Coverage Tier	Base Plan	Enhanced Plan
Employee Only	$0.00	$0.00
Employee + 1 Child	$54.00	$80.00
Employee + Children	$166.50	$246.50
Employee + Spouse	$133.00	$197.00
Employee + Family	$234.50	$346.50

Mail Order Pharmacy - Amazon MedsYourWay™

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) offers access to Amazon Pharmacy, which lets you easily order and quickly get non-specialty medicines delivered at home.

Generic Drugs

Generic drugs are FDA-approved, and shown to be just as safe and effective as their more expensive brand-name counterparts.

Preferred Drugs

Prime Therapeutics regularly reviews the latest prescription drugs on the market and maintains a list of preferred drugs that are clinically effective and not cost-restrictive. These drugs are available at a lower price than those not included on the list, which are called non-preferred drugs.

Specialty Drugs

Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring.

Plus, you'll get access to MedsYourWay prescription drug discount card pricing. The prescription discount card gives you up to 80% savings on brand and generic medicines and is seamlessly built-in to the Amazon Pharmacy experience. You can get the lowest cost available on your prescription, all while saving time and money. Using the MedsYourWay discount card is not insurance; however, using it for covered medicines will count toward your Blue Cross NC out-of-pocket maximum.

How To Use QR Code:

- Open/tap the camera (app) on your smartphone.
- Point your camera over the QR code so it's clearly visible within your camera screen.
- A link will show up on your camera screen. Click on the link, and the Amazon Pharmacy Customer Care site will open.

Start saving today

Sign up www.amazon.com/bluecrossNC.

Amazon Pharmacy Customer Care: 855-963-4546
M - F 8am - 10pm and Sat - Sunday 10am - 8pm EST.

amazon pharmacy

SHOP – Easy to use

- 24/7/365 access to a pharmacist/ Optional 90 day fills.

SAVE - Built-in drug discount card

- At checkout, you'll see the lowest cost available for your prescription.

SHIP – Free home delivery

- Prime members 2-day free shipping ; standard free shipping for non-Amazon Prime members is 5 days.

Primary 360—Teladoc

Healthcare from the break room, living room or anywhere else

Your care options with **Primary360** include:

New

Primary Care - $0 Copay

Manage your overall health body and mind with a U.S. board-certified primary care provider and care team of nurses and medical assistants.

24/7 Acute Care - $0 Copay

Need care for non-urgent and common conditions? Get a same-day appointment with a certified provider from wherever you are.

Start using your Teladoc Health benefits

TELADOC.

New

Dermatology - $0 Copay

Start an online skin review with a dermatologist by uploading images and details of your concern. Get a treatment plan and prescription if needed in 24 hours or less.

Mental Health - $0 Copay

Have real conversations and see progress with a therapist of your choice. Available 7 days a week from the privacy of your own home.

Nutrition Counseling - $0 Copay

Work with a registered dietitian to get personalized help with meal planning, healthy eating tips or even managing a condition like diabetes or high blood pressure (limit 30 visits/ year).

How does a primary care visit work virtually?

Before your visit. After selecting your provider, you'll answer health related questions for your care team to review before your visit. You'll receive a complimentary blood pressure monitor to share readings during visits.

During your visit. You'll have dedicated time with your provider to address health questions, concerns, and next steps for your health goals. Providers are trained to diagnose and treat via phone and video, saving you time, money, and the hassle of office visits.

Your primary care provider can order lab work, X-rays, referrals, and vaccinations. Your care team can connect you to an in-network lab or facility if needed. Results will be reviewed with you, added to your care plan, and uploaded to your Teladoc Health account.

Teladoc Health providers can prescribe new medications. They do not prescribe opioids, narcotics, or DEA-controlled substances.

There is no cost for annual preventive care visits, but you must be an established patient first. Nutritional counseling is considered preventive care, and you are allowed up to 30 visits per plan year.

Acute Care

Allergies
Cold, cough or flu
Diarrhea
Ear Problems
Fever
Headache
Insect bite
Nausea and vomiting
Sinus problems
Sore throat
Urinary problems

Dermatology

Acne
Alopecia
Bruises
Cold sores
Eczema
Psoriasis
Rashes
Rosacea
Skin Infections
Warts

Set up your account or log in to schedule a visit

Visit Teladoc.com | Call 855-549-2214

Download the app

Livongo—Chronic Condition Management

Take advantage of this program to better your health and wellness—Livongo for Chronic Condition Management of Diabetes, Hypertension, and Weight Management (Pre-Diabetes)

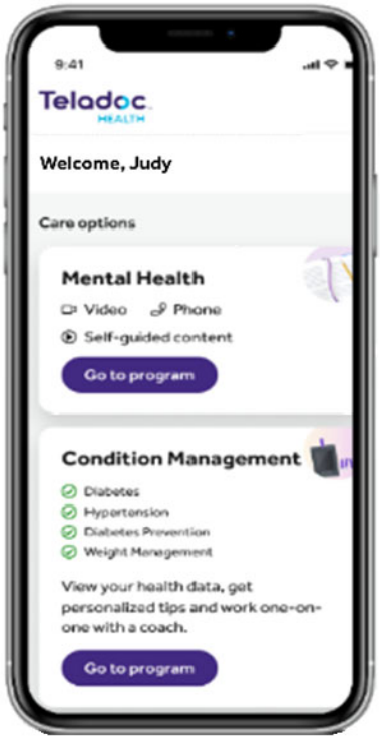
Blue Cross and Blue Shield of North Carolina and Teladoc Health are offering Livongo Whole-Person solutions to manage chronic conditions.

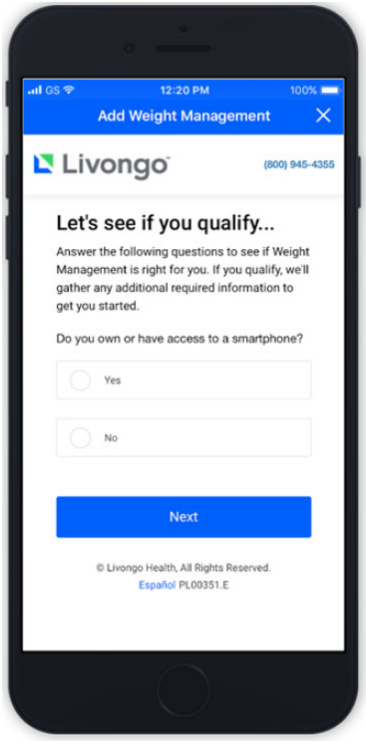
Livongo helps you stay on top of your health. Join today and get connected devices, personalized guidance, on-demand coaching, an easy-to-use app, and more. Login to Livongo through your Teladoc account. Answer the questionnaire to see if you qualify for these chronic condition programs!

Members can access Livongo from the Teladoc Health App with a single log-in. Once you've logged in, select the "**Condition Management**" card for streamlined registration and use of the Livongo app.

Use Code BCNC2 to login.

This program is offered at **no cost to members** and covered dependents with coverage through the Blue Cross and Blue Shield of North Carolina health plan.





Teladoc HEALTH | Livongo®

What's Included...

Diabetes

Connected blood glucose monitor

Testing strips

Lancing device

Lancets

Control solution

Carrying case

Hypertension

Connected blood pressure monitor

Carry case

Weight Management (Pre-Diabetes)

Connected scale

Questions?

Call Livongo Member support at (800) 945-4355

Lantern (Formerly Known as SurgeryPlus)

Lighting the Path to the Right Surgical Care

What is Lantern?

Lantern provides you with access to excellent and affordable care for many planned surgical procedures. Lantern partners with the best-in-class surgeons at the top facilities nationwide. Because of these partnerships, Lantern can provide significant cost-savings on many planned surgical procedures.

Your Lantern benefit includes access to the Lantern network of Surgeons of Excellence and High Quality Facilities.

Your coverage includes:

- Consults and appointments with your Lantern surgeon
- Anesthesia, procedure and facility (hospital) fees
- Access to the Lantern network of thousands of highly qualified and carefully selected surgeons
- Dedicated support and guidance

Note: If travel is required, travel costs are covered.

As member of the North Carolina Health Insurance Pool (NCHIP), when you and your dependents enroll in your medical plan, coverage is also offered through Lantern for certain surgical procedures.

If you elect to utilize the Lantern Network and services, you will use their ID card, work with a care advocate, and the surgery costs for covered surgical procedures are covered at 100% for Macon County's medical plans.

Let us Guide you Back to Health

Just follow these simple steps:

Step 1

Call a Care Advocate to get started. They'll share more information about your benefits and ask about the care you're looking for.

Step 2

Based on your needs, your Care Advocate will match you with a hand-picked list of excellent surgeons.

Step 3

After you choose a surgeon, your Care Advocate will help set up appointments and guide you through every step of the experience.

LANTERN

Formerly Known As Surgery Plus Same Trusted Team

Commonly Covered Procedures

- Spine
- Orthopedic
- Ear, Nose & Throat
- Cardiac
- Gynecology
- General Surgery
- Gastrointestinal
- Spine and Ortho Injections
- Bariatrics

You deserve excellent and affordable surgical care. Call Us to Learn More at (833) 423-2021

Website: www.mylanterncare.com

Headway Behavioral Health

Headway | BlueCross BlueShield of North Carolina

Headway partners with Blue Cross to bring members affordable and accessible behavioral health solutions. Headway offers the first asset-free national network of therapists who accept insurance. With Headway, you can expect personalized matching support that matches you with a provider who fits your needs, the choice of in-person or virtual care, affordable and transparent pricing, and on-demand matching with providers who have openings within 48 hours, including for dependent children and adolescents.

How it Works

1. **Scan this QR code** or go to headway.co/BlueCrossNC

2. **Tell Headway what you're looking for**

   Choose your concerns and/or preferences for therapy to find the best match for you. Headway will calculate the exact cost before your session.

3. **Start therapy**

   Choose a therapist from your matches and book your first appointment right on Headway.

NCHIP Concierge Program

Enjoy the benefits of personalized service! Connect with North Carolina Health Insurance Pool (NCHIP) Concierge Program advocates for expert help by phone, chat or email. As a Blue Cross and Blue Shield of North Carolina (Blue Cross NC) customer, you have free access to one-on-one guidance finding the best care and cost options; advice from registered nurses; help with claims, billing and more. Learn more today at: BlueCrossNC.com/NCHIPconcierge.

Connect with us

Call 1-800-795-9402

Monday-Friday, 8am—9pm EST

or

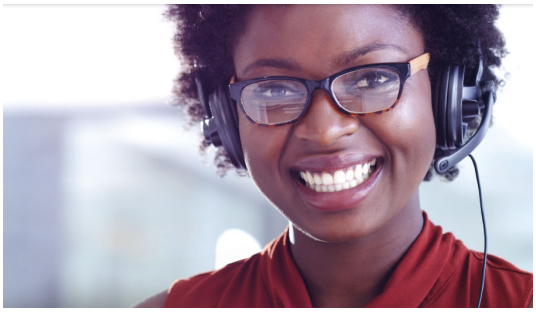
Send secure email by logging in to BlueConnectNC.com

WE'RE HERE FOR YOU

With personalized customer support

Key Benefits:

- Convenient access to expert help
- Extended hours via phone or email
- Connects you with registered nurse support
- Assistance finding the best care and cost options
- Help making informed health care decisions
- Support for health issues
- Help with claims and billing



Eat Smart, Move More, Weigh Less

BE THE BEST YOU!

Now's the time to Eat Smart, Move More, Weigh Less®.
Sign up today, complete the program and it won't cost you a thing!
Take advantage of Eat Smart, Move More, Weigh Less, a total healthy lifestyle program based around you (and valued at $245) for just $30.
Complete at least 10 of the 15 weeks in the program, and you'll get the $30 back!

Eat Smart, Move More, Weigh Less looks at you as a whole. It uses evidence-based lifestyle strategies to help you reach a weight that's healthy for you — and build healthy habits that can last a lifetime.

You'll get:

- Interactive online classes led by passionate Registered Dietitian Nutritionists (RDNs)
- A personal journal to take notes on your food, exercise and weight habits along the way
- The Weekly Tracker — a private online tool you'll use to monitor progress, interact with your instructor and get one-on-one feedback in-between classes
- A full-color magazine with tips and recipes to help you along the way

Does it work?

- Those who completed the program lost an average of 8 pounds and trimmed 2 inches from their waist size
- 95% were more mindful of what and how much they eat
- 90% were more mindful of getting physical activity each day
- 89% eat fewer calories
- 70% maintained their weight (or lost even more) six months after the program ended
- 98% would recommend the real-time online classes to others

Reaching a healthy weight through good nutrition and exercise is also important for people with diabetes or prediabetes. In fact, 20% of *Eat Smart, Move More, Weigh Less participants* on diabetes medication at the start of the program were advised by their doctor to reduce or discontinue medication as a result of the program.

How do I sign up?

Go to *esmmweighless.com/enroll-choose-a-class*

- Pick the class time that works best for your schedule
- Enter your employer's special coupon code (**ASOMaconCo)** to waive the program's $245 registration fee.

Make a refundable $30 deposit via credit card or PayPal®, which you'll get back by completing at least 10 weeks in the program and logging your weight (this helps you stay motivated to reach the finish line).

Wellness Rewards/Rally Coin Benefits

Earn Rally Coins to Purchase Blue Rewards

Build healthy habits and get rewarded for your efforts on our wellness portal powered by Rally Health. You can earn Rally Coins to spend in the portal, with lots of different ways to get fun products and discounts. Your wellness program also comes with Blue Rewards, where you can earn extra Coins for doing wellness activities and more!

How it works:

- **Get an alert when an activity is waiting**—BCNC will notify you by mail, email and/or SMS about some of the activities in your package when you become eligible.
- **View your available activities**—Go to BlueConnectNC.com to access your wellness portal on Rally and see your available activities on the Blue Rewards page.
- **Select an activity to complete**—Read each activity and how to complete it to qualify for rewards.
- **Earn Rally Coins**—Once the activity is completed, Rally Coins will be deposited into your Coins Balance in the wellness portal.
- **Enjoy your reward**—Cash in your Coins for discounts on fitness trackers and more, bid on rewards at auctions, use them to enter a sweepstakes or help a charity—all from your wellness portal.

All about Rally® Coins

What are Rally Coins?

Almost everything you do on the wellness portal will earn you Rally Coins. These are incentives to keep you logging in and on track with your health and wellness goals. You can redeem your Coins for chances to win great rewards such as fitness trackers, gift cards and more

Where can I find my Coins Balance

You can always see your Coins balance right below your username in the top right corner of any page in the wellness portal. You can also find your Coins portal and check the Rally rewards tab to view available Sweepstakes Marketplace items, Auctions and Donations.

How do I earn Coins

There are many ways to earn Rally Coins. For example you earn Coins for logging in every day, completing the Health Survey and making progress on Missions and Challenges. The number of Coins you can earn depends on the activities you complete.

RALLY®

Activity	Coins Earned
Logging in once	5
Logging in on consecutive days	10
Completing the Survey	150
Successfully reaching a daily Mission objective	10
Successfully reaching a weekly Mission objective	20
Successfully completing a Mission	75
Placing 1st in a Challenge	100
Placing 2nd in a Challenge	75
Placing 3rd in a Challenge	50

Dental Coverage

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Macon County dental benefit plan now administered by Delta Dental.

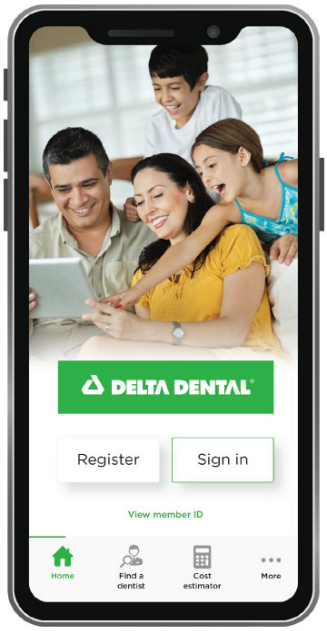
	Dental	
	Low Plan	High Plan
Annual Deductible (Individual/Family)	$50/$150	$50/$150
Annual Maximum (Per Person)	$1,000	$1,000
Preventive Care (Routine Cleaning and X-rays)	No Copay*	No Copay*
Basic Services (Fillings, Extractions)	80% after deductible	80% after deductible
Major Services (Root Canals, Crowns)	Not Covered	50% after deductible
Orthodontia (Children up to age 19)	Not Covered	50% after deductible
Orthodontia Lifetime Maximum (Per Person)	Not Covered	$1,000

*This benefit applies to your annual maximum. If your annual maximum has been met, you may be charged for preventive cleanings and x-rays.

DELTA DENTAL®

Semi-Monthly Cost		
	Low Plan	High Plan
Employee	$12.07	$16.64
Employee + Spouse	$23.73	$35.69
Employee + Child(ren)	$35.01	$56.71
Family	$46.67	$75.61

DELTA DENTAL MOBILE APP



Maximize your health, wherever you are! Search for a dentist near you, view ID cards and more, right on your mobile device. Scan the QR Code below to download the app right to your Apple or Android device.

Mobile ID Card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access.

Find a Dentist

Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.

Dental Care Cost Estimator

Our easy to use tool provides estimated costs on common dental care needs, now with the option to select your dentist for tailored cost estimates.

Save your preferred Dentist

Save your favorite dentists using the Delta Dental Mobile App for quick access to contact information making it easy to schedule your routine cleaning.

Vision Coverage

Macon County's vision plans are administered by Community Eye Care. These plans cover routine eye exams and helps you pay for glasses or contact lenses. Review the chart below for the amount you will pay for the vision service listed.

	Vision Plan	
	150 Plan	200 Plan
Eye Exam (Once every 12 months)	$0 copay	$0 copay
Eyewear Allowance (once every 12 months)	$150 flexible allowance 20% off amount over allowance for frames 10% off amount over allowance for contact lenses	$200 flexible allowance 20% off amount over allowance for frames 10% off amount over allowance for contact lenses
Contact Lens Fitting, Re-Fit or Evaluation (once every 12 months)	$15 copay	$15 copay

Out of Network Benefits—CEC allows you to use your full benefit when visiting an out-of-network provider. You'll need to submit an out-of-network claim form and will be reimbursed for the cost of the exam and for the cost of the eyewear, up to the amount of the eyewear allowance. Note that copays for out-of-network visits are deducted from reimbursements. Reimbursement generally occurs within 60 days of submission. To learn more about filing an out-of-network claim, go to cecvision.com/oonform.

CEC community eye care a VSP company

Enjoy the Simplicity of CEC!

Semi-Monthly Cost		
	150 Plan	200 Plan
Employee	$5.69	$7.53
Employee + 1 Dependent	$10.78	$14.30
Family	$15.93	$21.07

Portability Benefit

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

Lasik Discounts

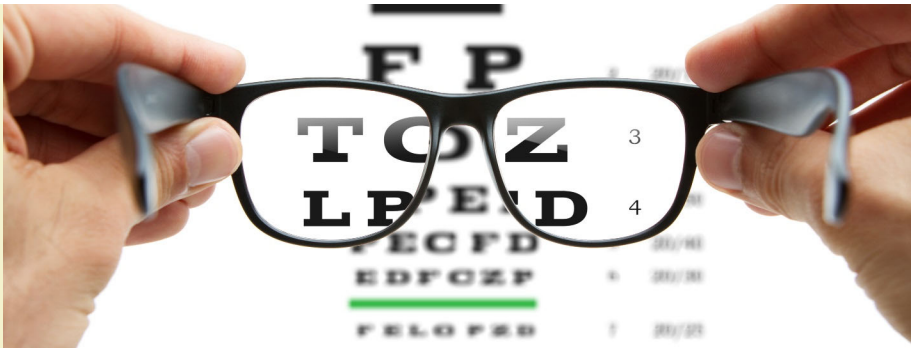
Members receive up to a 50% discount on Lasik from participating providers.

Coverage for Fittings & Evaluations

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

Finding In-network Eye Doctors

You can find an in-network eye doctor in the Community Eye Care network by calling 888-254-4290 Monday—Friday, 8:30AM— 7:00PM and Saturday 10:00AM—4:00PM or by visiting www.cecvision.com



Flexible Spending Account

Save Money with FSA pre-tax benefit accounts.

Flexible Spending Accounts (FSAs) allow employees to allocate *pre-tax* dollars to a healthcare and/or dependent care spending account to pay for eligible after-tax expenses. These accounts allow you to use a portion of your pay, before it is taxed, to provide coverage that can reimburse you for certain qualified expenses. You can participate in one, both or neither of the accounts—it is your choice. The FSA Plan year runs from July 1st through June 30th.

HEALTHCARE	DEPENDENT CARE
Medical/ Dental Office Visit Copays	Daycare Expenses
Dental/Orthodontic Care visits	Before & After School Care
Prescriptions and Eligible OTC Medications	Nanny/ Nursery School
Eye Exams; Prescription Glasses/Lenses	Elder Care

	Health Care Flexible Spending Account (FSA)
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses) https://www.irs.gov/pub/irs-pdf/p969.pdf
When can I use the funds?	All of the funds you elect for the year are available July 1st
Can I roll over funds each year?	If you do not incur enough expenses during the plan year to use all of the coverage provided by your medical spending account, the plan allows $660 to be rolled over to be used in the next plan year.
How do I pay for eligible expenses?	With your Flores debit card (you can also submit claims for reimbursement online at www.flores247.com
How much can I contribute each year?	Your maximum contribution is $3,300 in 2025
Can I change my contributions throughout the year?	No, unless you have a qualifying life event, you choose an annual election amount during open enrollment and that amount is taken out of each paycheck in equal increments throughout the year.

Flores

Mobile App

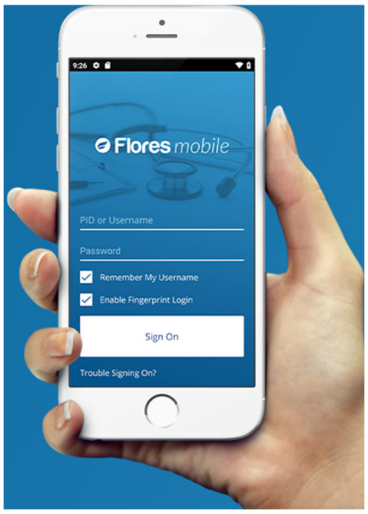
Self-Service Features:

Access your account information

Requests for reimbursement from your account

Submit supporting documentation for transactions

Available through App store or Google Play



NOTE:

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

1-800-532-3327

HOW TO SUBMIT:

- Online: www.flores247.com
- Get form online and fax in claim
- Download the app for mobile filing

Dependent Care FSA

Paying for Dependent Care

You can contribute pre-tax dollars into a Dependent Care FSA to pay for eligible child or elderly care expenses.

	Dependent Care FSA
What is it?	An account that allows you to set aside pre-tax dollars from each paycheck to pay for eligible child or elderly care expenses while you and your spouse work full time.
Why should I consider it?	You can lower your taxable income to save some money while you take care of your daycare expenses.
What expenses are eligible?	Daycare expenses for your children under age 13 or dependents who are mentally or physically incapable of caring for themselves (including elderly dependents).
When can I use the funds?	Funds are available as you contribute to the account with each paycheck.
Can I roll over funds each year?	No, you will lose any funds remaining in your account at the end of the year.
How do I pay for eligible expenses?	You can also submit claims for reimbursement online at www.flores247.com or by using the Flores mobile app. You may also submit via fax or mail.
How much can I contribute each year?	The maximum you can contribute is $5,000 or $2,500 if you are married and file separate tax returns.

Important Note

Both the health care and dependent care FSAs have a **use-it-or-lose-it rule**. For the health care FSA, you can rollover $660 into the next plan year, anything greater will be forfeited. The dependent care FSA does not have a rollover provision. Any unused funds at the end of the year will be forfeited.

The following are some examples of eligible expenses for dependent care:

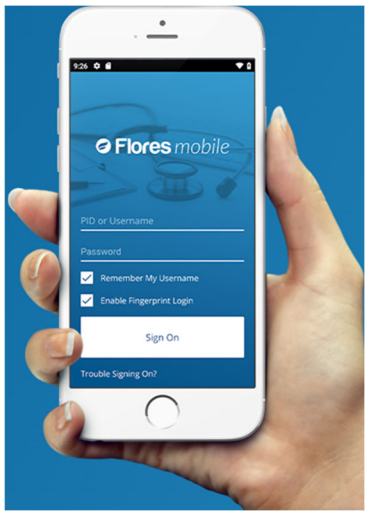
- Before and after school programs
- Nursery and pre-school tuition
- Summer and sports day camp
- Au pair / nanny expenses
- Day care centers
- Care at home by a licensed provider

1-800-532-3327

HOW TO SUBMIT:

- Online: www.flores247.com
- Get form online and fax in claim
- Download the app for mobile filing
- Mail: P O Box 313397 Charlotte, N.C. 28231
- Fax: 704.335.0818 or 800.726.9982

Flores



Mobile App

Self-Service Features:

Access your account information

Requests for reimbursement from your account

Submit supporting documentation for transactions

Available through App store or Google Play

Life and AD&D Insurance

Life and Accidental Death & Dismemberment Insurance (AD&D)

Insured by the Standard

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Macon County. The County provides basic life insurance of **$30,000** at no cost to you.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Macon County provides AD&D coverage of **$30,000** at no cost to you. This coverage is in addition to your company-paid life insurance described above.

Voluntary Dependent Basic Life

You are also able to elect additional Basic Life insurance at a flat $5,000 of coverage for your spouse and children.

Dependent Life Rate	
For all covered dependents	$1.35

Keep Your Beneficiaries Up to Date

Please be sure to designate a beneficiary (the person who will receive the benefit) for your Life and AD&D insurance. Make sure to keep this person's information updated so your benefit is paid according to your wishes.

Voluntary Life and AD&D Insurance

Insured by the Standard

You may purchase Voluntary Life and AD&D insurance in addition to the county-provided coverage. You may also purchase Life and AD&D insurance for your dependents as long as you purchase additional coverage for yourself. At this open enrollment, you may elect coverage for yourself and your dependents up to the guaranteed issue amount without having to answer medical questions.

Employee Benefit— Up to the lesser of 8x your annual earnings or $100,000 in increments of $5,000. Accidental Death & Dismemberment coverage is equal to 100% of the Supplemental Life coverage elected. Guaranteed issue: $100,000.

Spouse Benefit—Up to $30,000, not to exceed 50% of the employee benefit, in increments of $5,000. Accidental Death & Dismemberment coverage is equal to 100% of the Supplemental Life coverage elected. Guaranteed issue: $30,000.

Child Benefit—Up to $10,000, in increments of $5,000. Accidental Death & Dismemberment coverage is equal to 100% of the Supplemental Life coverage elected. Guaranteed issue: $10,000.

Voluntary Life and AD&D Rates per $1,000	
Employee/Spouse Age	Monthly Premium
0-29	$0.090
30-34	$0.100
35-39	$0.120
40-44	$0.190
45-49	$0.300
50-54	$0.460
55-59	$0.730
60-64	$0.870
65-69	$1.270
70+	$3.430
Child Life Rate	$0.200
AD&D Rate	$0.030

Disability Coverage

LONG TERM DISABILITY INSURANCE

Long Term Disability Insurance can help replace a portion of your income if you are unable to work for an extended period of time due to a sickness or accidental injury. All active, full-time employees working at least 30 hours per week have the option to purchase voluntary long term disability insurance through the Standard. Employees will have one plan option to choose from.

LTD	90 PLAN
Monthly Benefit	60% of Pre-disability Earnings to a max of $6,500
Elimination Period	90 Days
Duration	Social Security Normal Retirement Age*

*Benefit for employees that are 60+ will be subject to a reduction in benefit duration. See your plan documents for more details.

MONTHLY RATE PER $100 OF COVERED PAYROLL	
EMPLOYEE AGE	RATE
0-29	0.165
30-34	0.425
35-39	0.435
40-44	0.660
45-49	0.905
50-54	1.165
55-59	1.490
60-64	1.240
65+	1.000

MONTHLY PREMIUM CALCULATION WORKSHEET	
A. Annual Earnings = Please Note: If your annual earnings exceed $130,000 the premium is based on $130,000 due to the maximum benefit cap.	$
B. Monthly Earnings = (A divided by 12)	$
C. Your Monthly Earnings divided by 100 = (B divided by 100)	$
D. Estimated Monthly Premium (C multiplied by the applicable age-banded rate)	$

Disability Coverage

SHORT TERM DISABILITY INSURANCE

Short Term Disability Insurance can help replace a portion of your income if you are unable to work for an extended period of time due to a sickness or accidental injury that occurs off the job. All active, full-time employees working at least 30 hours per week have the option to purchase voluntary short term disability insurance through Aflac.

STD	BENEFITS
Monthly Benefit (Total Disability)	60% of Pre-disability Earnings to a max of $4,000
Monthly Benefit (Partial Disability)	50% of Pre-disability Earnings to a max of $4,000
Elimination Period	14 Days for injury or illness
Duration	3 Months

Total Disability—This convenient, affordable disability income plan will help provide needed income if you become Totally Disabled and are unable to work due to a covered injury or illness. Total disability benefits will be payable monthly once the elimination period has been satisfied.

Partial Disability—The Partial Disability Benefit helps you transition back into full-time work after suffering a disability. If you remain partially disabled and are only able to work earning less than 80 percent of your pre-disability income at any job, this plan will still pay you 50 percent of your selected monthly benefit for up to the maximum partial disability benefit period of 3 months after the elimination period. You do not have to have received the Total Disability benefit to receive the Partial Disability benefit.

STD RATE PER $100 OF MONTHLY BENEFT	$2.00

MONTHLY PREMIUM CALCULATION WORKSHEET	
A. Annual Earnings = Please Note: If your annual earnings exceed $80,000 the premium is based on $80,000 due to the maximum benefit cap.	$
B. Monthly Benefit = (A divided by 12, then multiplied by 0.60)*	
C. Your Monthly Benefit divided by 100 = (B divided by 100)	$
D. Estimated Monthly Premium (C multiplied by $2.00)	$

*Please note, you may choose your benefit level up to 60% of your salary or no greater than $4,000 in increments of $100

Voluntary Benefits

Accident Insurance

Accident Insurance provides a benefit payment directly to you for covered injuries as a result of an accident that occurs on or off the job. No medical questions or tests are required for coverage. Coverage is also available for your spouse and your children up to age 26, if you elect coverage for yourself. This coverage is portable, meaning you can take your plan with you if you choose to leave your place of employment. This coverage is guarantee issue. No evidence of insurability is required.

TREATMENT	BENEFIT
Initial Hospital Confinement (per confinement)	$1,250
Daily Hospital Confinement (up to 365 per covered accident)	$300
Intensive Care (up to 30 days)	$500
Ambulance (Ground/Air)	$300/$1,500
Emergency Room/Urgent Care	$250
Emergency Room/Urgent Care with X-ray	$300
Outpatient Surgery and Anesthesia (per day)	$300
Inpatient Surgery and Anesthesia (per day)	$750
Fractures (open)	Up to $5000
Lacerations/Burns	Up to $10,000
Concussion	$350

* Please see plan document for full list of covered conditions .

$100 Wellness Benefit
when you receive a preventive screening
1 Time per Employee/ year
1 Time per Spouse/year
1 Time per Dependent Child/year

SEMI-MONTHLY COSTS	
Employee	$5.34
Employee + Spouse	$9.43
Employee + Child(ren)	$12.82
Family	$16.91

Organized Sports Benefit Rider pays an extra 10% of the eligible benefit if a covered person has an accident due to an organized sports activity.

Hospital Indemnity Insurance

Hospital indemnity insurance offers peace of mind and financial protection if you or a family member is hospitalized. This benefit pays a lump sum benefit for a hospital stay. This coverage can help pay your deductible and other costs associated with a hospital confinement.

HOSPITALIZATION BENEFITS	AMOUNT
Hospital Admission (per confinement)	$1,500
Hospital Confinement (per day)	$150
Intensive Care (per day)	$150

$100 Wellness Benefit
when you receive a preventive screening
1 Time per Employee/ year
1 Time per Spouse/year
1 Time per Dependent Child/year

SEMI-MONTHLY COSTS	
Employee	$12.20
Employee + Spouse	$24.68
Employee + Child(ren)	$19.38
Family	$31.86

Voluntary Benefits

Critical Illness Insurance with Cancer

Group Critical Illness Insurance offers financial support for expenses related to a covered critical illness diagnosis. The Aflac Group Critical Illness Plan provides a lump-sum cash benefit directly to you, helping cover out-of-pocket medical and living expenses. There are no medical questions or tests are required for coverage. Benefits are payable for a condition as long as it occurs on or after the coverage effective date. This coverage is portable, meaning you can take your plan with you if you choose to leave your place of employment.

You can enroll in coverage in the following amounts:

For you - You may elect a Minimum $10,000, $20,000 or $30,000

For your spouse - 50% of employee benefit ($5,000, $10,000 or $15,000)

For your children (up to age 26) - 50% of employee elected benefit amount at no additional charge

Aflac Group Critical Illness pays an Initial Diagnosis Benefit of:

$10,000*

COMMON COVERED CONDITIONS*	% OF ELECTED BENEFIT
Stroke, Heart Attack, Major Organ Transplant,	100%
Coronary Artery Bypass Surgery, Advanced	100%
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Type 1 Diabetes	100%
Bone Marrow Transplant (Stem Cell Transplant) /	100%
Coma, Paralysis, Sever Burns, Loss of Sight, Hear-	100%

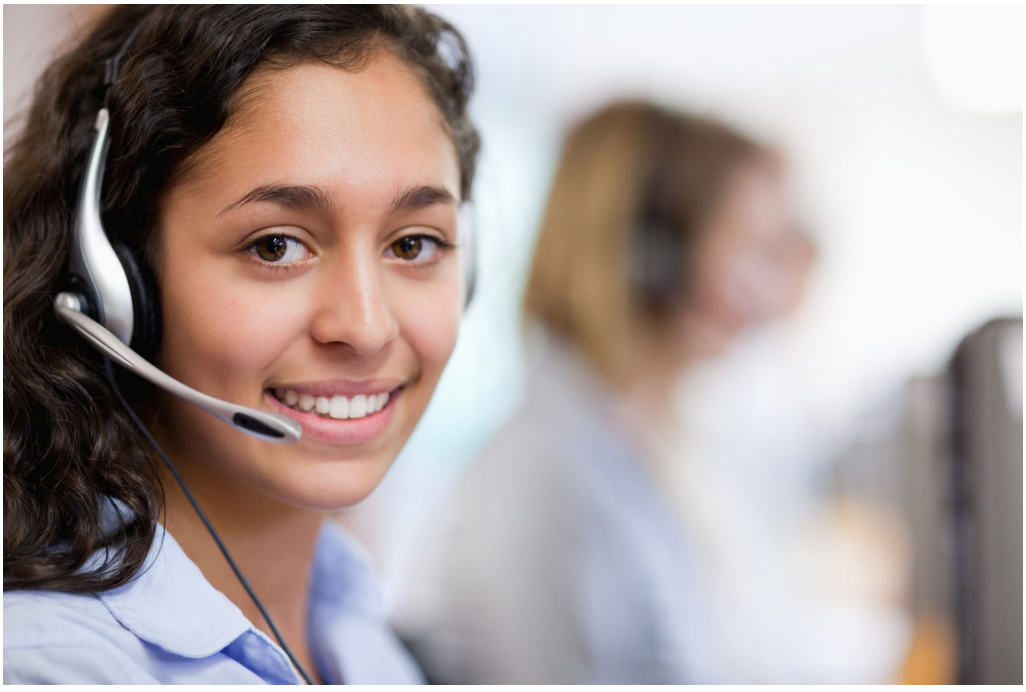
* please see plan document for full list of covered conditions

$100 Wellness Benefit
when you receive a preventive screening
1 Time per Employee/ year
1 Time per Spouse/year
1 Time per Dependent Child/year

AGE BAND	EMPLOYEE SEMI-MONTHLY COST (PER $10,000 OF	SPOUSE SEMI-MONTHLY COST (PER $5,000 OF
18-29	$2.57	$1.29
30-39	$3.87	$1.94
40-49	$6.00	$3.00
50-59	$11.52	$5.76
60-64	$17.64	$8.82
65-69	$32.31	$16.16
70+	$33.35	$16.68

Important Contacts

Benefit	Vendor	Phone	Website or Email
Medical	Blue Cross & Blue Shield of North Carolina	800-795-9402	www.bluecrossnc.com
Prescription Drug	Blue Cross & Blue Shield of North Carolina	800-795-9402	www.bluecrossnc.com
Planned Surgery Provider	Lantern	833-423-2021	www.lanterncare.com
Dental	Delta Dental	800-587-9514	www.deltadentalnc.com
Vision	Community Eye Care	888-254-4290	www.cecvision.com
Flexible Spending Account	Flores	800-532-3327	www.flores247.com
Life and AD&D	The Standard	800-628-8600	www.standard.com
Long Term Disability	The Standard	800-628-8600	www.standard.com
Short Term Disability	Aflac	800-433-3036	www.aflac.com/myaflac
Accident/Hospital Indemnity/Critical	Aflac	800-433-3036	www.aflac.com/myaflac



Legal Notices

Notice of Creditable Coverage

Important Notice from Macon County

About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Macon County coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Macon County coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period unless you experience a qualified life event.

Note that your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan and keep your coverage under the Macon County Benefit Plan.

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

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

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

Legal Notices

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Macon County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**July 01, 2025**
Name of Entity/Sender:	**Macon County**
Contact—Position/Office:	**Tammy Keezer—HR Director**
Office Address:	**5 W Main St** **Franklin, North Carolina 28734-3005** **United States**
Phone Number:	**828-349-2020**

Legal Notices

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

Legal Notices

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Tammy Keezer.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov/**.

Legal Notices

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Macon County
Tammy Keezer—HR Director
5 W Main St
Franklin, North Carolina 28734-3005
United States
828-349-2020

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Legal Notices

HIPAA Special Enrollment Rights

Macon County Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Macon County Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (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).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Tammy Keezer—HR Director at 828-349-2020 or tkeezer@maconnc.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Macon County is committed to the privacy of your health information. The administrators of the Macon County Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Tammy Keezer—HR Director at 828-349-2020 or tkeezer@maconnc.org.

Legal Notices

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, 2024. 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

Legal Notices

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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) 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://kynect.ky.gov 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/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

Legal Notices

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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 and CHIP**
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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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

Legal Notices

To see if any other states have added a premium assistance program since July 31, 2024, 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)

Newborns' and Mothers' Health Protection Act

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

Women's Health & Cancer Rights Act

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 the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Base Plan (Individual: 30% coinsurance and $2,250 deductible; Family: 30% coinsurance and $4,500 deductible)
Plan 2: Enhanced Plan (Individual: 20% coinsurance and $1,250 deductible; Family: 20% coinsurance and $2,500 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 828-349-2022 or droland@maconnc.org.

Notes

The Fine Print

The information contained in this summary should in no way be construed as a promise or guarantee of employment. The company reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this brochure and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents available from your Human Resources Office. This benefits enrollment guide highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept with your most recent summary plan description.