



EMPLOYEE BENEFITS GUIDE

- ❖ 2025 – 2026 Plan Year
- ❖ Provided by – Laymon Group





INTRODUCTION & DISCLOSURE

This Benefits Guide is designed to give you an overview of the benefits available to you through your employer.

For each benefit, we have provided a summary of the benefit, who is eligible, when you are eligible, and how to make changes to your elections. Also included is the cost to you if any, and where to get more detailed information about the referenced benefits.

The information in this Benefits Guide is provided for illustrative purposes and is based on information provided by your employer. The text contained in this guide was taken from various summary plan descriptions and benefit information.

Disclosure -- While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of any discrepancy between the guide and the plan documents, the actual plan documents will prevail.

All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

If you have any questions about the guide or benefits, please contact HR.



YOUR EMPLOYEE BENEFITS

P 4 - Medical – BCBS of NC (Dual Option)

P 9 - HRA – Flores & Associates, LLC

P 20 - Dental – Delta (Dual Option)

P 22 - Vision – VSP (Dual Option)

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MEDICAL PLAN

BCBS of NC - Base Plan (HDHP with HSA)

BCBS of NC – Buy-Up Plan (Traditional)

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you have the option to elect or decline coverage for yourself and your eligible dependents. *If you are enrolling as a new hire, benefits will be effective after 30 days.*

Benefits You Receive:

We offer medical coverage via traditional plans that utilize a broad network.

Please review the Summary of Benefits and Coverage (SBC) to better understand your benefit costs and coverage options.

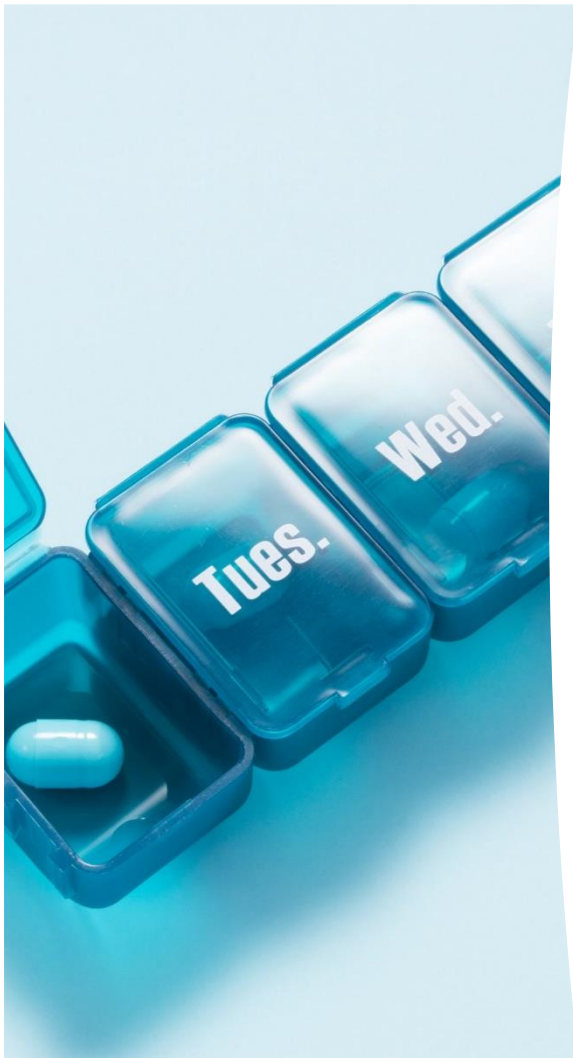


MEDICAL PLAN COMPARISON

Benefit	Base Plan - In-Network	Buy-Up Plan - In-Network
Deductible	\$3,300 Individual / \$6,600 Family	\$1,500 Individual / \$3,000 Family
Preventive	100%	100%
Coinsurance(In & Out)	0%	20% Member Responsibility
OOP Max	\$3,300 Individual / \$6,600 Family	\$4,500 Individual / \$9,000 Family
Primary Care / Specialist	0% + Deductible	\$25 / \$50
Tier 1	0% + Deductible	\$4
Tier 2	0% + Deductible	\$25
Tier 3	0% + Deductible	\$35
Tier 4	0% + Deductible	\$75
Telehealth	0% + Deductible	\$0
Urgent Care / Emergency Room	0% + Deductible	\$50 / \$300
HSA Eligible	Yes, \$2,500	No
HRA Eligible	No	Yes, \$700



WHEN CHANGING MEDICAL PROVIDERS



Things to consider...

- ❖ Once you have your subscriber ID number, reach out to your physician (PCP) – tell them you are changing carriers (*from NCLM - Aetna to BCBS*) and need them to file the appropriate prior authorizations, Rx authorizations, etc. We recommend you do this as soon as possible.
- ❖ This should be all you need to do as the provider's office would facilitate the rest.

Laymon Group Tip - Refill any prescriptions you need before 6/30, this way if there is any delay with prior authorizations via your provider's office you will have a supply available*



HEALTHCARE SAVINGS ACCOUNT (HSA)



How do I use my HSA?

You will have a debit card that you use at the point of service to pay for qualified healthcare expenses.

Will my employer help fund my HSA?

Yes; Emerald Isle has agreed to contribute \$2,500 towards your HSA per year. *Half will be funded in July, and the other half will be funded in January. Through this contribution your out-of-pocket responsibility under the HDHP is lowered to just \$800!*

You can also contribute to your HSA balance up to the plan year maximum contribution amounts.

*Notes - IRS contribution maximums for the year are \$4,300 for Individual Coverage and \$8,550 for Family Coverage. You can add up to \$1,000 more as a "catch up" contribution if you are 55 or older***

If the H.S.A. balance is not used in the fiscal year the employee keeps the H.S.A.

*New employees are eligible for prorated contributions following the one-month waiting period**



HEALTHCARE SAVINGS ACCOUNT (HSA)



Can I use my HSA funds for my dependents even if they are not on my medical plan?

Yes. HSA funds can be used to cover qualified healthcare expenses for your dependents even if they are not enrolled on your medical plan.

What is covered under my HSA?

- ❖ HSA eligible expenses including Dental and Vision.
- ❖ Hospital, Doctor, Physical and Mental Health, Prescriptions, Eyeglasses, Durable Medical Equipment
- ❖ Medicare Premiums (Premiums for a group or under 65 major medical plan are not covered under an HSA.)
- ❖ A good question to ask yourself when determining eligible expenses should be “is this service medically necessary? Does it treat or cure an illness?”



HEALTHCARE REIMBURSEMENT ARRANGEMENT (HRA)



HRA Plan & Design:

The Town of Emerald Isle has established a Healthcare Reimbursement Arrangement (HRA). The HRA has been established to offset the out-of-pocket costs to employees for inpatient and outpatient services incurred towards your deductible.

Emerald Isle *has agreed to pay the last \$700 of your \$1,500 Individual Deductible under the Traditional Plan.* Note - This is not applicable to your Coinsurance responsibilities under this plan**

If your EOB shows you have incurred an HRA-eligible expense, submit your EOB along with a copy of your Claim Form to Flores for processing.

How do I file a claim?

Claims can be submitted online at www.flores247.com, or by using the Flores Mobile application, fax, or by mail.

Note - *If the H.R.A. balance is not used in the fiscal year, the employee forfeits the H.R.A., as it returns to the Town.*

New employees are eligible for prorated contributions following the one-month waiting period*



MEDICAL – RATES

(MONTHLY)

Cost to You:

Your premium contributions for Medical Insurance are deducted from your paycheck on a pre-tax basis, referred to as Premium Conversion under Section 125 of the IRS Code.

Base Plan	Employee Only	Employee + Sp	Employee + Child	Employee + Children	Family
Carrier Rate	\$565.93	\$1,227.05	\$951.58	\$1,171.95	\$1,722.88
Employer Contribution	\$565.93	\$565.93	\$565.93	\$565.93	\$565.93
Employee Cost	\$0	\$661.12	\$385.65	\$606.02	\$1,156.95
Buy-Up Plan	Employee Only	Employee + Sp	Employee + Child	Employee + Children	Family
Carrier Rate	\$584.14	\$1,267.11	\$982.54	\$1,210.19	\$1,779.33
Employer Contribution	\$584.14	\$584.14	\$584.14	\$584.14	\$584.14
Employee Cost	\$0	\$682.97	\$398.40	\$626.05	\$1,195.19



PROOF OF COVERAGE

when you don't have your ID card

While Blue Cross and Blue Shield of North Carolina (Blue Cross NC) makes every attempt to distribute ID cards before the plan year begins, sometimes this process is delayed.

If you are still on the same Blue Cross NC plan as last year, you can use last year's ID card to receive benefits. If you are on a new plan, there are several ways you can verify your coverage if you haven't received your new ID card yet.

Access Your Digital ID Card

Our member portal, **Blue ConnectSM**, gives you convenient access to all the things you need to feel confident in your health care decisions – including your digital ID card.

Simply visit BlueConnectNC.com and, if you're already registered, log in and click "ID Card" to view and download your digital ID card. If you're not registered, click on Register Now, and take a few minutes to set up your account to start getting on-the-go access to tools and resources for your health journey.

Other Options

At the Doctor's Office

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

At the Pharmacy

- Pharmacists can use your Social Security number, your date of birth and Blue Cross NC's Rx Bin Number: **015905**.

Questions?

Call Blue Cross NC's
Customer Service line at
1-877-258-3334.

If a provider is unable to
verify coverage, they can call
Blue Cross NC's provider line
at **1-800-214-4844**.

BLUE CROSS®, BLUE SHIELD®, the Cross and Shield symbols, and service marks are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Blue Cross NC is an independent licensee of the Blue Cross and Blue Shield Association. U39492, 12/21



Scan to access the Blue Connect mobile app



**BlueCross BlueShield
of North Carolina**



REGISTER WITH BLUE CONNECT

Your guide to online tools and resources

Dear Member,

This visual guide will help you register for BlueConnectNC.com, your personalized member services website. It is the guide to the tools and information you need to manage your health plan and health care.

Blue Connect is personalized to you, to help you understand your own health care and treatment options. You can also find information about your coverage and claims. It's designed to make health care easier, giving you on-the-go access when, where and how you want it. Register today to set up your User ID and Password!



Guide topics

- ✓ **How to register for Blue Connect**
- ✓ **How to add additional Blue Cross and Blue Shield of North Carolina (Blue Cross NC) plans to your Blue Connect account**

Note: This guide is for your reference only, and the examples provided in this document do not determine the benefits covered under your health plan.

HOW TO REGISTER FOR Blue Connect

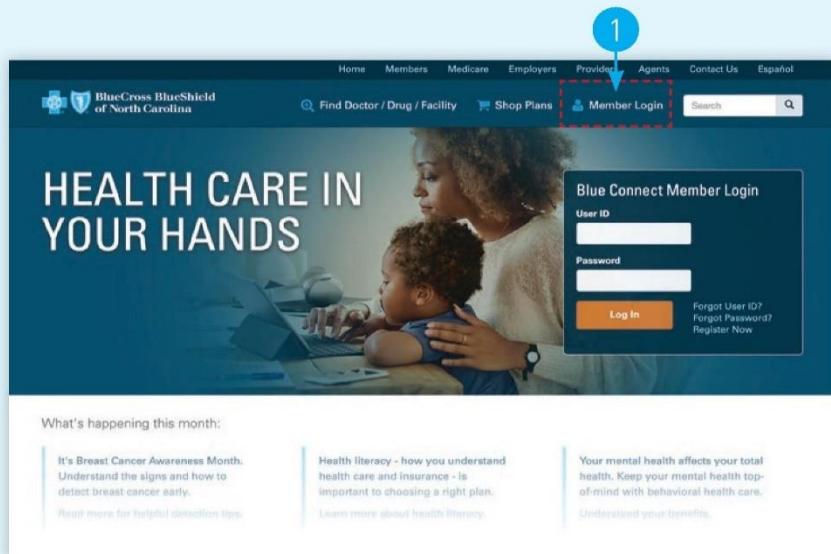
Have your Blue Cross NC member ID card on hand and follow the instructions below.

1

Navigate to BlueConnectNC.com then click Member Login.

Click **Register Now**. The following screen will appear.

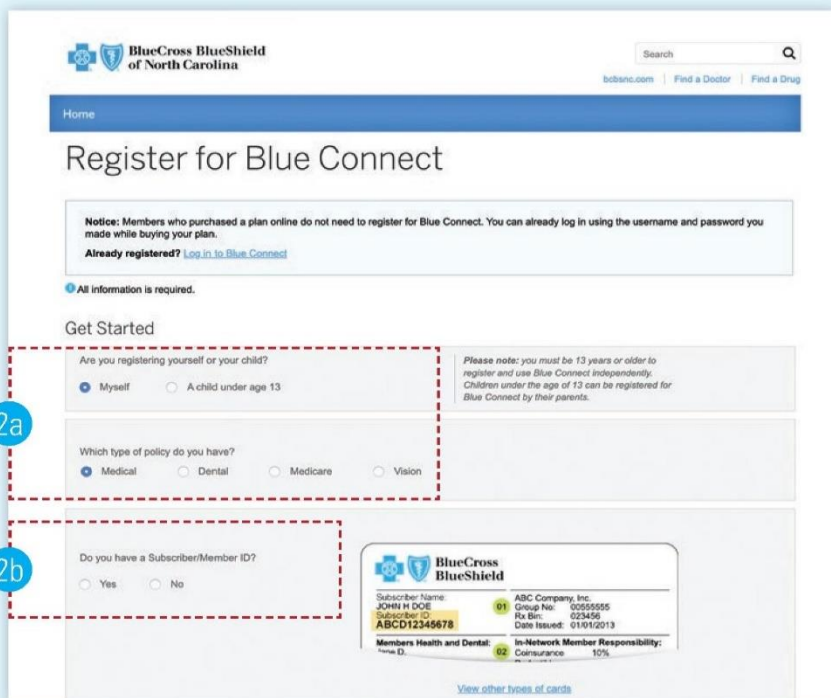
Note: You can still register even if you don't have your member ID card. Just keep reading.



2a

Complete the two questions in the **Get Started** section.

When you select Medical, Dental, Vision or Medicare, the screen will expand to display an additional question: "Do you have a Subscriber/Member ID?"





2b

If you click “Yes,” you will see the screen at right with additional fields for you to complete and a sample ID card for the type of coverage you selected will display.

Complete the fields and click the **Continue** button.

(Skip to step 4 in this document if you answered “Yes.”)

Do you have a Subscriber/Member ID?

☒ Yes ☐ No

Subscriber/Member ID

YPDW12345678

Subscriber/Member ID: Enter the letters and/or numbers exactly as you see them on your Subscriber/Member ID card

Member Code

01

Member Code is the 2-digit code next to each member's name.

Registrant's date of birth

12 31

1970

ZIP code

27601

ZIP code for the mailing address on file with BCSSNC

Continue

Need Help? Call Web Support at 1-888-705-7050 or [email us](#).



BlueCross BlueShield

Subscriber Name: JOHN H DOE	Group No: 00555555
Subscriber ID: ABCD12345678	Rx Bin: 023456
Date Issued: 01/01/2013	
Members Health and Dental: 02	In-Network Member Responsibility: 10%

[View other types of cards](#)

Don't Have Your Subscriber/Member ID?

If you purchased your own plan through HealthCare.gov (Federal Exchange), access your Subscriber/Member ID here. If not, please [Contact Us](#) for help.

2c

If you click “No,” you will see this screen. Click one of the options to receive a verification code by text message or voice call.

Do you have a Subscriber/Member ID?

☐ Yes ☒ No

How would you like to receive your code?

☒ Text Message ☐ Voice Call

Don't have your Subscriber/Member ID? We can help you register with Blue Connect using your phone.

- An authorization code will be sent to you as a text message or phone call to the phone number you provide below.
- Have your phone close by, the authorization code will expire in 10 minutes from the time of your request.
- You must be enrolled to receive an authorization code.
- If you just enrolled, it may take up to 48 hours for us to verify your enrollment.
- Please do not close or navigate away from this page during your registration.

2d

Additional fields display. Complete the fields and click **Get Code**.

You will receive a code via text or voice call. The code is a six-digit number and expires after 10 minutes.

2d

All information is required.

Mobile Number

Phone number must be associated with the registering member.

Standard message rates and data charges from your carrier may apply when receiving Blue Cross NC text messages. Check with your carrier for more information.

First Name

Last Name

Social Security Number (Last 4 Digits)

Registrant's Date of Birth

ZIP Code (First 5 Digits)

ZIP code for the mailing address on file with BCBSNC.

Get Code

Note: If the member is not on file or fully enrolled, this error message displays.

We apologize, we cannot verify your identity. You must be enrolled to receive a verification code. If you just enrolled, it may take up to 48 hours for us to verify your enrollment. Please re-enter your information, call technical support at 1-866-705-7050 or email us. 4012

3

When you receive the code, enter it here, and then click **Continue**. The screen below displays.

Note: You have four attempts to correctly enter the code. The code expires after 10 minutes.

3

 BlueCross BlueShield of North Carolina

Search

[bcbsnc.com](#) | [Find a Doctor](#) | [Find a Drug](#)

Home

Register for Blue Connect

Please allow up to 2 minutes for the authorization code to arrive via text or phone call at the phone number you provided. The authorization code will expire 10 minutes from the time of your request.

Didn't receive the authorization code? [Try Again.](#)

Enter authorization Code

Cancel **Continue**

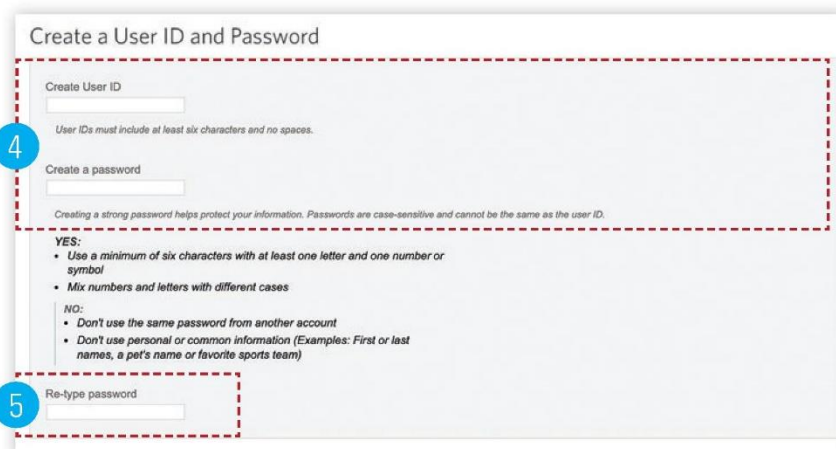
4

Next, create a User ID and Password. You will use these to log in to the system.

- The **User ID** must be at least 6 characters with no spaces, and it can be a combination of numbers and letters.
- The **Password** must be at least 6 characters with no spaces, and it must include a number or symbol.

4

5



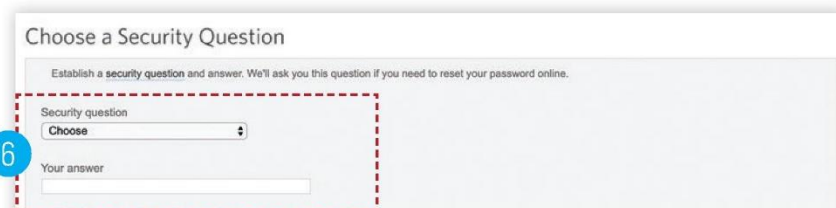
5

Enter your Password a second time to confirm it.

6

Select a security question or choose to create your own and create your answer.

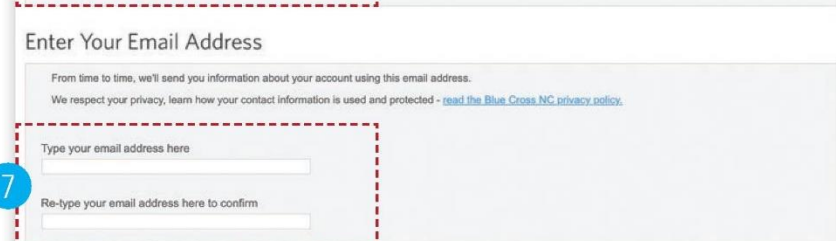
6



7

Enter your email address.

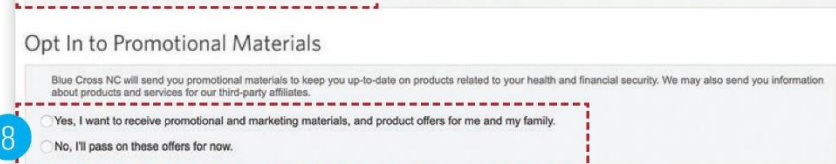
7



8

Select whether or not you want to receive promotional and marketing materials from Blue Cross NC.

8



9

Click the **OK** button. A message saying, "Thank you for registering for Blue Connect" displays.

9





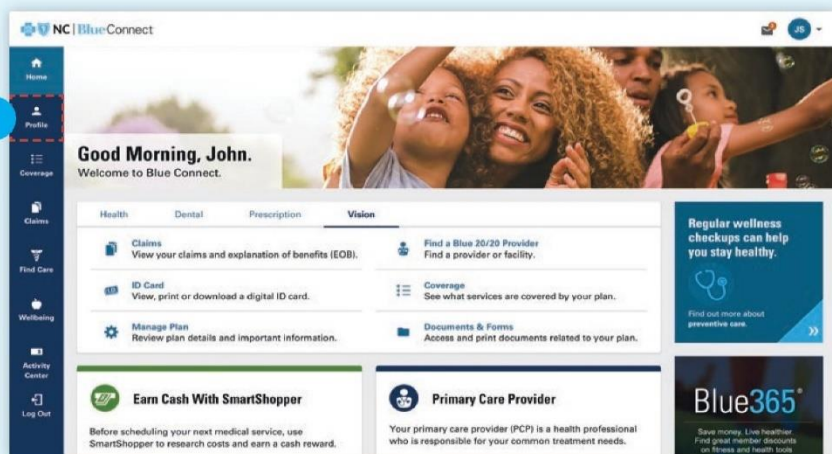
HOW TO ADD additional Blue Cross NC plans to your Blue Connect account

You can easily link additional Blue Cross NC plans to your existing Blue Connect account. Simply follow the steps below.

1

Log in to BlueConnectNC.com and click **Profile**.

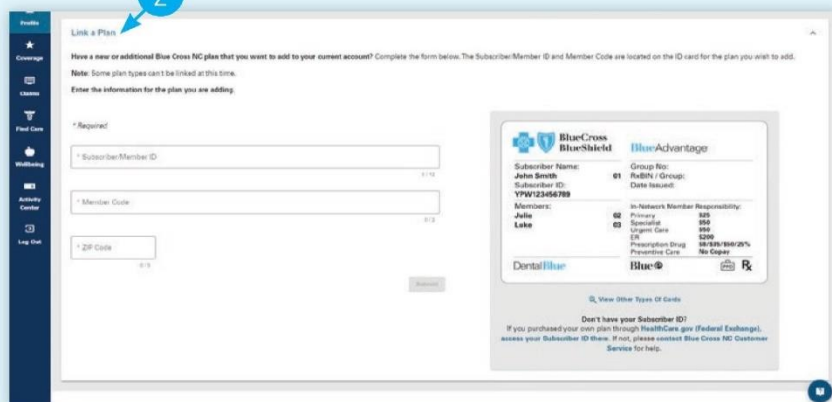
1



2

Click **Manage Plan**, then choose **Link a Plan**.

2



3

Provide the Subscriber Member ID for the plan you want to add to your Blue Connect account. There are two text boxes for you to enter the letters (e.g., YPP) and the numbers (e.g., 12345678) of the Subscriber ID.

Enter your member number for this plan (e.g., 01, 02, etc.). This is the number that appears next to your name on your member ID card. Then, click **Next**.

4

Enter the ZIP Code for the mailing address tied to that policy.

5

Once you have filled in this information, click **Submit**.

6

You'll now be able to access your Benefits, Claims and Account information for your linked plans on Blue Connect.

Contact us

If you need assistance to register for Blue Connect, please call Web Support at 1-888-705-7050 or visit BlueCrossNC.com/Contact-Us to email us.



Scan for the
Blue Connect Mobile app

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 que aparece en el reverso de su tarjeta del seguro para obtener ayuda.

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BlueCrossNC.com



HRA Guide

IMPORTANT INFORMATION & FAQs

WHAT IS AN HRA?

A Health Reimbursement Arrangement (HRA) is an employer funded account that helps you pay for qualified out-of-pocket medical expenses, such as deductible, co-insurance, and prescriptions.

HOW CAN I FILE CLAIMS?

You may fax, mail, upload, or use e-Receipt to file your claims for reimbursement. Claims may be filed at any time during the plan year, but these must be submitted by the claims filing deadline for the plan year in which the expenses were incurred.

WHAT INFORMATION MUST BE INCLUDED ON DOCUMENTATION?

Most HRA plans require that you submit an Explanation of Benefits (EOB) from your insurance carrier. Please consult your specific plan documents for more information.

HOW WILL REIMBURSEMENTS BE ISSUED?

Reimbursements will be mailed as a check to your home address, unless you have setup direct deposit. You may add your direct deposit information on the participant website or by submitting a completed Direct Deposit Information form to Flores.

WHAT IF I AM ALSO ENROLLED IN A MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)?

If you are also enrolled in an FSA, any out-of-pocket medical expenses that are not reimbursed by the HRA plan may be submitted to this account. If you are enrolled in both the HRA and FSA plans with Flores, you are able to submit one claim that will automatically rollover to be paid from both accounts. This allows you to maximize the reimbursement available to you with less paperwork.



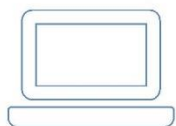
DOES THE MONEY I HAVE IN MY HRA ROLL OVER FROM YEAR TO YEAR, OR DO I LOSE THE MONEY AT THE END OF THE PLAN YEAR?

Whether or not your money rolls over to the next plan year is subject to plan design and may vary from year to year. Contact your Human Resources department for specific information about your plan design, or visit the participant website for more information about your plan.

WHAT HAPPENS TO THE MONEY IN MY HRA IF I LEAVE MY JOB OR RETIRE?

In most cases, the HRA is a COBRA eligible benefit. Contact your Human Resources department for specific information about your plan design, or log in to our website to view more information about your plan.

HOW DO I OBTAIN MY ACCOUNT DETAILS?



WEBSITE

Visit www.flores247.com and log in using Participant ID or User Name and password



MOBILE WEBSITE

Visit our mobile website at m.flores247.com



INTERACTIVE VOICE SYSTEM

Dial 800.331.9610
Enter PID for your account details

PID & PASSWORD ASSISTANCE
Dial 800.840.7684

HOW DO I SUBMIT DOCUMENTS TO FLORES?

ONLINE

Visit www.flores247.com and upload scanned documents securely

MOBILE

Download e-Receipt smartphone app
Available for Apple or Android devices

MAIL

Flores & Associates, LLC
PO Box 31397
Charlotte, NC 28231

FAX

800.726.9982 or 704.335.0818



CUSTOMER SERVICE 1.800.532.3327



DENTAL PLAN COMPARISON

Did you know your dentist may be able to spot other medical conditions by examining your teeth and gums? More than 90% of all systemic diseases have oral signs and symptoms, such as swollen gums, mouth ulcers and dry mouth. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you have the option to elect or decline coverage for yourself and your eligible dependents. *If you are enrolling as a new hire, benefits will be effective after 30 days.*

Benefits You Receive:

Utilizing a dentist in their network may provide cost savings for you as well as ease of claims filing.

Benefit	Base Plan In-Network	Buy-Up Plan In-Network
Deductible	\$50 Ind / \$100 Family	\$50 Ind / \$100 Family
Preventive (Oral Exam, Cleaning)	100%	100%
Basic (Oral Surgery – Simple and Surgical Extractions)	80%	80%
Major (Crowns, Dentures, Bridges, Implants)	50%	80%
Orthodontics (Lifetime Maximum)	N/A	\$1,000
Annual Maximum	\$1,000	\$1,500



DENTAL – RATES

(MONTHLY)

Cost to You:

Your premium contributions for Dental Insurance are deducted from your paycheck on a pre-tax basis, referred to as Premium Conversion under Section 125 of the IRS Code.

Base Plan	Employee Only	Employee + Sp	Employee + Child(ren)	Family
Carrier Rate	\$29.71	\$58.69	\$80.06	\$109.96
Employer Contribution	\$29.71	\$29.71	\$29.71	\$29.71
Employee Cost	\$0	\$28.98	\$50.35	\$80.25
Buy-Up Plan	Employee Only	Employee + Sp	Employee + Child(ren)	Family
Carrier Rate	\$36.74	\$72.68	\$98.88	\$135.86
Employer Contribution	\$29.71	\$29.71	\$29.71	\$29.71
Employee Cost	\$7.03	\$42.97	\$69.17	\$106.15



VISION PLAN COMPARISON

Driving to work, reading a news article, and watching TV are all activities you likely perform every day. However, your ability to do all these activities depends on your vision and eye health.

Vision insurance can help you maintain your vision as well as detect various health problems. Your vision provider can identify early signs and symptoms of conditions such as glaucoma, cataracts, high blood pressure, diabetes, heart disease, and high cholesterol.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you have the option to elect or decline coverage for yourself and your eligible dependents. *If you are enrolling as a new hire, benefits will be effective after 30 days.*

Benefits You Receive:

There are two vision plans to choose from. Utilizing a provider in their network may provide cost savings for you as well as ease of claims filing.

Benefit	Base Plan In-Network	Buy-Up In-Network
Eye Exam - (1, per 12 months)	\$10 Copay	\$10 Copay
Routine Retinal Scanning	Up to \$39 Copay	Up to \$39 Copay
Frames / Lens - (1, per 12 months)	\$20 Copay	\$20 Copay
Frames - (1, per 12 months)	\$120 Frame Allowance 20% off after; plus, an extra \$20 on featured brands**	\$180 Frame Allowance 20% off after; plus, an extra \$20 on featured brands**
Contact Lens Exam, Fitting, Evaluation	Up to \$60 Copay	Up to \$60 Copay
Contact Lens Allowance - (1, per 12 months)	\$120 Allowance Covered in full if medically necessary**	\$180 Frame Allowance Covered in full if medically necessary**



VISION - RATES

(MONTHLY)

Cost to You:

Your premium contributions for Vision Insurance are deducted from your paycheck on a post-tax basis, referred to as Premium Conversion under Section 125 of the IRS Code.

Base Plan	Employee Only	Employee + One	Employee + Children	Family
Carrier Rate	\$9.84	\$15.74	\$16.07	\$25.91
Employer Contribution	\$9.84	\$9.84	\$9.84	\$9.84
Employee Pays	\$0	\$5.90	\$6.23	\$16.07
Buy-Up	Employee Only	Employee + One	Employee + Children	Family
Carrier Rate	\$12.95	\$20.72	\$21.15	\$34.09
Employer Contribution	\$9.84	\$9.84	\$9.84	\$9.84
Employee Pays	\$3.11	\$10.88	\$11.31	\$24.25



ADDITIONAL BENEFIT OFFERINGS



- ❖ Short Term Disability Renaissance
- ❖ Long Term Disability Renaissance
- ❖ Base Life and AD&D Renaissance
- ❖ VTL and AD&D Renaissance



SHORT-TERM DISABILITY

Short-Term disability can protect your income should you become seriously ill or injured and are unable to work. This plan also covers maternity leave due to birth.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you receive Short-Term Disability coverage as an employer sponsored benefit. *If you are enrolling as a new hire, benefits will be effective after 30 days.*

Benefit	Coverage Amount
Benefit	60% of Annual Salary
Maximum Benefit	\$2,000 Weekly
Elimination Period	7 th day of an accident, or illness
Maximum Duration	26 Weeks
Contributions	Employer Paid



LONG-TERM DISABILITY

Long-Term Disability can protect your income should you become seriously ill or injured and are unable to work.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you receive Long-Term Disability coverage as an employer sponsored benefit. *If you are enrolling as a new hire, benefits will be effective after 30 days.*

Benefit	Coverage Amount
Benefit	60% of Annual Salary
Maximum Benefit	\$6,000 Monthly
Elimination Period	180 Days
Maximum Duration	SSNRA
Contributions	Employer Paid



BASE LIFE AND AD&D

Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? With these items in mind, we offer employer-paid Basic Life and AD&D.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you receive Basic Life and AD&D coverage as an employer-sponsored benefit. *If you are enrolling as a new hire, benefits will be effective after 30 days.*

Benefits You Receive:

This plan provides the following benefits in the event of a loss of life, accidental death, or dismemberment.

Benefit	Coverage
Base Life and AD&D	1x Annual Salary
Guaranteed Issue	\$250,000 Maximum of \$300,000
Dependent Life and AD&D	Spouse - \$2,000 Child - \$2,000
Contributions	Base Life and AD&D - Employer Paid Dependent Base Life and AD&D – Employee Paid



VOLUNTARY TERM LIFE AND AD&D

Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? With these items in mind, we also offer Voluntary Term Life and AD&D.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you may elect Voluntary Term Life and AD&D coverage for you and your family. *If you are enrolling as a new hire, benefits will be effective after 30 days.*

Benefits You Receive:

This plan provides the following benefits in the event of a loss of life, accidental death, or dismemberment.

Benefit	Coverage
Guaranteed Issue Life and AD&D Amount	Employee - \$100,000 <i>Not to exceed 5x annual salary**</i> Spouse - \$20,000 Child - \$5,000
Maximums (EOI Required)	Employee - \$100,000 <i>Not to exceed 5x annual salary**</i> Spouse - \$50,000 Child - \$5,000
Portability	Included
Contributions	Employee Paid



LAYMON GROUP EMPLOYEE SERVICES



We are here for you every step of the way, below are some examples of how we extend our services to you during plan years:

- ❖ Benefit Plan Inquires
- ❖ Enrollment / Coverage Discrepancies
- ❖ ID Card Assistance
- ❖ Claims Assistance
- ❖ Online Enrollment via BerniePortal
- ❖ And more...



FREQUENTLY ASKED QUESTIONS



- ❖ **Q:** When do our benefits renew?
- ❖ **A:** Your renewal anniversary date is July 1st.

- ❖ **Q:** When can I make changes to my benefits?
- ❖ **A:** During Open Enrollment, this is normally a 1-2 week long period prior to your renewal where changes can be made without a “qualifying event” for the upcoming plan year.

- ❖ **Q:** What is a “Qualifying Event”?
- ❖ **A:** Some of the more common “QEs” are marriage, birth of a child, or change in employer; when these things occur you are eligible to make changes during the plan year, prior to open enrollment.

- ❖ **Q:** How do I enroll?
- ❖ **A:** Via BerniePortal!



How to Enroll in BerniePortal



How do I login?

1. A BerniePortal account has been created for you!
2. You will login at app.bernieportal.com/en/employercode/login with the following credentials:
 - a. **A 2 Digit Code:** This will be the two digits of your birth month.
 - E.g.: If you were born in June this would be "06"
 - b. **4 Digit Code:** This will be the last 4 digits of your SSN.
 - c. **Employer Code:**

fQbXPO



What do I do next?

1. Verify your information on the Personal Information screen when you login.
2. Enroll in benefits.
 - a. List your spouse and dependents (if applicable).
 - b. If you don't know one of their SSNs use "111-11-1111."
 - c. Elect or waive each coverage: health, dental, & vision.
 - d. Confirm your elections, sign with your mouse & select "I Agree."
3. You're finished! You can login to your BerniePortal account anytime to view your elections.



3 Tips for electing benefits

1. Use the sidebar on the left to navigate among the benefit types.
2. Use the cart on the right to budget your elections.
3. Use the sidebar on the left if you need to review/adjust your elections.



Forgot your password?

1. Go to www.bernieportal.com
2. Click Login
3. Click Forgot Password
4. Type in email address
5. Submit



LAYMON GROUP CONTACT INFORMATION

Lead Benefit Consultant – Chad Laymon - chad.laymon@laymongroup.com

Account Manager – Trey Allen - trey.allen@laymongroup.com

Account Manager – Naomi Polar - naomi.polar@laymongroup.com

Customer Service – customer.service@laymongroup.com

Address – 5700 Oleander Dr. Wilmington, NC 28403

Phone – 910-791-2259

Toll Free – 1-800-467-2259



NOTES

Important Notice 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 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. has determined that the prescription drug coverage offered by the (Insert Name of Plan) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 coverage will (or will not) be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). See pages 7- 9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will (or will not) (Medigap issuers must insert “*will not*”) be able to get this coverage back.

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 **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.

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

Contact the person / department 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 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 **CMS Form 10182-CC** **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

“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).

Contact--Position/Office: Human Resources Department

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **your Human Resources department**.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

NOTICE CONCERNING WOMEN'S HEALTH AND 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 this plan.

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

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

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/dftr/ 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.medicicaid.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: HSHIPPProgram@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
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

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)
 Menu Option 4, Ext. 61565

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid. 1-877-267-2323,

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.

