

ABC SPIRITS



MECKLENBURG COUNTY
ALCOHOLIC BEVERAGE CONTROL BOARD

August 2025 – July 2026



HELPING YOU UNDERSTAND
Your Benefit Choices



This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your employer's benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

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

**This guide may or may not be applicable to union employees.*

WELCOME

BENEFITS MENU | ENROLLMENT GUIDE

BENEFITS OFFERED

MY HEALTH

Medical | **Marpai Health**

Pharmacy | **Optum**

Dental | **Marpai Health**

Vision | **Marpai Health**

Flexible Spending Account | **Inspira Financial**

MY LIFE

Basic Life and AD&D | **The Standard**

Disability | **The Standard**

Voluntary Life and AD&D | **The Standard**

Voluntary Critical Illness,

Hospital Indemnity, Accident | **The Standard**

MY EXTRAS

Teledoc

Personal Insurance Solutions | **InsurChoice**



Helpful Tips To Consider Before You Enroll

1. Do you plan to enroll an *eligible dependent(s)*?

If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.

2. Have you recently been *married/divorced or had a baby*?

If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.

3. Did any of your covered children reach their *26th birthday this year*?

If so, they may no longer be eligible for benefits, unless they meet specific criteria.

The Mecklenburg County ABC Board is pleased to provide a comprehensive package of benefits to our employees and family members.

Your elections will be effective August 1, 2025, through July 31, 2026, and can only be changed during the year if you have a qualifying event such as marriage, divorce or legal separation, birth of a child, etc.

If you have a qualifying event and desire to change your elections, you must notify Human Resources within 30 days of the event. The following Employee Benefit Guide is an overview of our benefits program. Information included in this guide is to help you make decisions that best fit the needs of you and your family.

This guide will give you a summary of our 2025-2026 benefits and how to enroll or make changes.

Table of Contents

Welcome	Page 3
Open Enrollment	Page 4
Common Insurance Terms	Page 5
Medical and Prescription Drug Coverage	Page 6-7
Wellness/ Medical Premiums	Page 8
Teladoc	Page 9
Vision Coverage	Page 10
Dental Coverage	Page 11
ID Card Sample	Page 12
Flexible Spending Account	Page 13-14
Basic Life Coverage/ Voluntary Life Coverage	Page 15
Short-Term/ Long Term Disability	Page 16
Voluntary Benefits	Pages 17-24
InsurChoice	Page 25
401(k)	Page 26
Additional Employee Information	Page 27-28
Glossary of Terms	Page 29
Human Resource contact information	Page 30

ELIGIBILITY

RULES | REQUIREMENTS

Open Enrollment is the time to:

- Enroll, re-enroll, change or terminate individual or dependent coverage in the Medical, Vision and Dental Plan.
- Review all your employee benefits
- Review your Life Insurance beneficiary
- Enroll or reenroll in a Flexible Spending Account for Health Care or Dependent Child Care. FSA elections **do not carry forward**, so the FSA requires a new enrollment form each year.

You can carry over up to \$640 in unused Health Care Funds to the next plan year.

The Annual Open Enrollment period for the 2025-2026 plan year will start on July 1, 2025 and needs to be completed by July 21, 2025.

Open enrollment takes place in July for all coverages and is effective August 1.

To make changes to current elections, you must participate in the enrollment process.

If you are not making any changes from your current elections, you are not required to do anything , with the exception of:

*** If you are currently enrolled in the FSA, you will need to complete a new election/enrollment form.**

Benefits Eligibility

Full-time or Part-Time employees working at least 30 hours per week or a total of 1,560 hours per year are eligible for benefits.

Dependent Eligibility

Your eligible dependents may also participate. Eligible dependents include:

- Your spouse,
- Your dependent children up to age 26.

Please take some time to familiarize yourself with the benefit offerings. If you have questions about any of the benefits mentioned in this guide, or would like to make changes please contact HR Business Partner.

Enrollment

Enrollment will occur either during your introductory period, which includes a waiting period of 30 days from your hire date or during open enrollment on July 1ST.

The benefits plan year for Mecklenburg County ABC Board runs August 1st through July 31st.

The elections you make will remain in effect through July 31, 2026, unless you, your spouse, or your dependent child(ren) experience a qualified change-in-status event.

If you do not make any changes during the annual open enrollment period; you will not be able to change your elections until the next annual open enrollment period; unless you experience a qualifying event.

Employees experiencing a qualifying event may make changes to their benefit elections.

Qualifying event changes can be made within 30 days from the date of the event.

Qualifying events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

HEALTH

MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., \$30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

***OUT-OF-NETWORK** Any services received from an out-of-network provider, with the exception of a true emergency, will be covered a lower level of benefits from the carrier and will cost you more out of pocket.

PPO | In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

Understand Your Care Options & When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

Who administers our medical, dental and vision coverage?

The medical plan is administered through a third-party administrator, Marpai Health. This means that they handle processing claims for payment or assisting with benefits questions.

What is my network?

Mecklenburg County ABC Board employees have access to the Cigna network.

How do I find a doctor within my network?

Go to www.cigna.com, click Find a Doctor/Facility.

Who do I contact if I have a question?

Any questions that you may have regarding your Medical, Dental, Vision and Pharmacy can be answered by contacting Marpai/Maestro Health:

1. Customer service 1-800-228-1803 or;
2. mybenefits.maestrohealth.com



Did You Know?

- ✓ Preventive Services are covered at 100% In-Network and copays & deductibles do not apply.
- ✓ You pay less out of pocket if you receive care from an In-Network provider.

MEDICAL

HEALTH | PLAN COMPARISON

Your health benefits provide important protection to keep you and your family in good health. Mecklenburg County ABC Board offers medical and prescription to you, administered by Marpai/Maestro Health. This plan provides the option of using both in-network and out-of-network providers, through the Cigna network of providers but you will realize your biggest savings with in-network providers whenever possible.

Below is a brief outline of the medical and prescription drug plan. *Cells in blue indicate plan changes.*

****Deductible and Out of Pocket accumulates on a calendar year (January 1 – December 31)**

Plan Benefits	CIGNA PPO Network	Non-Network
Physician Visit	\$30 Copay	40% after deductible
TelaDoc Virtual Visit	\$0 Copay	\$0 Copay
Minute Clinic Visit	\$10 Copay	\$10 Copay
Specialist Visit	\$30 Copay	40% after deductible
Chiropractor Visit	\$30 Copay	40% after deductible
Tobacco Cessation	No Cost to member	10%, Deductible Waived
Preventive Care <i>ACA mandated benefits</i>	No Cost to member	10%, Deductible Waived
Emergency Room	\$90 copay for first visit, \$250 copay for subsequent visits	\$90 copay for first visit, \$250 copay for subsequent visits
Urgent Care	\$30 Copay	40% after deductible
Member Coinsurance	20%	40%
Hospital Services	20% after deductible	40% after deductible
If you have a test (x-ray, blood work)	\$0	10%, Deductible waived
Imaging (CT/PET scans, MRI's)	\$0	10%, Deductible waived
Hearing Aid	20% after deductible to maximum benefit of \$3,000, every three years. <i>Hearing aid benefit does not accumulate to the out of pocket maximum.</i>	
Deductible **		
Individual	\$800	\$1,200
Family	\$1,600	\$2,400
Out of Pocket Limit**	<i>Includes copayments, deductible and coinsurance.</i>	
Individual	\$3,500	\$6,000
Family	\$7,000	\$12,000
Prescription Drugs		
Generic	30 day supply Retail \$2 Copay / 90 day supply Mail Order \$4 Copay	
Preferred Brand	30 day supply Retail \$25 Copay / 90 day supply Mail Order \$40 Copay	
Non-Preferred Brand	30 day supply Retail \$45 Copay / 90 day supply Mail Order \$80 Copay	
** Specialty/ Tier 4	30% (max \$150 copay) deductible waived	
** Effective 1/1/2026 pharmacy benefit will include a 4th tier for Specialty drugs		

PRESCRIPTION DRUGS

Rx | PLAN COMPARISON

TRADITIONAL DRUGS

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 (PREFERRED BRAND) | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 (NON-PREFERRED BRAND) | Highest copay: In this category are nonpreferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay. **Make sure to check for mail order discounts that may be available.**

SPECIALTY DRUGS

TIER 4 | Lowest specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than nonpreferred specialty drugs.

WHERE CAN I FIND A DRUG LIST?

1. Go to www.optumrx.com.
2. Select Register on the home page.
3. Enter the information from your member ID card.
4. Create a username and password.
5. Complete your profile.

If you already have an account, sign in using your username and password.



Save Money With Generic (Tier 1) Drugs

Ask your doctor if it's appropriate to use a generic drug rather than a brand.

Generic drugs are less expensive, and according to the FDA, they contain the same active ingredients and are identical in dose, form and administrative method as a brand name.

Rx Copays

TIER 1 (GENERIC)	30-day supply Retail \$2 Copay / 90-day supply Mail Order \$4 Copay
TIER 2 (PREFERRED BRAND)	30-day supply Retail \$25 Copay / 90-day supply Mail Order \$40 Copay
TIER 3 (NON-PREFERRED BRAND)	30-day supply Retail \$45 Copay / 90-day supply Mail Order \$80 Copay
Effective as of 1/1/2026 we will be adding **TIER 4	20% up to a maximum of \$150 deductible waived



IMPORTANT INFORMATION REGARDING THE NEW 4 TIER COPAY FOR SPECIALTY MEDICATION

The addition of the 4th tier is so that Employees can take advantage of the Specialty Copay Savings Program under OptumRx. This program maximizes the use of copay assistance dollars provided by drug manufactures to potentially offset member's cost.

If you're taking a Specialty Medication, you'll receive a letter and may receive a call from the pharmacy clinical team. This will provide you with the necessary information to assist with filling your medication and monitor you during the duration of the therapy.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER - Many drugs are available in a 90-day supply, rather than the 30-day retail supply. Typically, you will pay less if you choose to get a mail order 90-day supply.

GOOD Rx - There are many tools online that you can use in order to save on prescription costs. One being GoodRx.com, an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR - Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times, there are generic or different manufacturers that will save you money at the pharmacy.

COST OF COVERAGE

HEALTH | COST COMPARISON | CIGNA

Wellness Incentive Program

At Mecklenburg County ABC Board, we value our employees and are committed to supporting your journey toward a healthier lifestyle—both at work and at home. Two key steps to better health include being tobacco-free and scheduling regular preventative exams to identify potential risk factors before they develop into chronic or serious illnesses.

Annual Physical Requirement

Employees who complete their annual physical during the 2024-2025 plan year will qualify for a Wellness Incentive, which is reflected in reduced medical premiums per pay period. To remain eligible for this incentive, your annual physical must be completed by **October 31, 2025**.

- **No Documentation Needed:** Employees do not need to submit attestations or medical records unless specifically requested.
- **Verification Process:** Marpai, our medical carrier, will provide an Explanation of Benefits (EOB) report to confirm which employees have completed their annual physical by the deadline.

Alternative Wellness Options

Mecklenburg County ABC Board is dedicated to helping all employees achieve their best health. If you believe you are unable to meet the standard requirements for the Wellness Incentive, you may qualify for an alternative method to earn the same benefit. Contact Human Resources to discuss options. We will work with you—and your doctor, if needed—to identify a wellness program tailored to your health status.

Take advantage of this opportunity to prioritize your health and enjoy the benefits of living well!

Weekly Payroll Deductions for Medical Coverage				
Base Plan/ Wellness Weekly Payroll Deductions	Employee only	Employee Spouse	Employee Child (ren)	Employee Child (ren)
	\$5.37	\$77.95	\$53.32	\$99.57

Weekly Payroll Deductions for Medical Coverage				
Non-Wellness Weekly Payroll Deductions	Employee only	Employee Spouse	Employee Child (ren)	Employee Child (ren)
	\$5.88	\$85.38	\$58.40	\$109.05

ONLINE HEALTHCARE

24/7 | VIRTUAL DOCTOR VISITS

No crowded waiting rooms. No Driving. See a doctor when you need a doctor.

A virtual visit lets you see and talk to a doctor from your mobile device or computer. When you use one of the provider groups in our virtual visit network, you have benefit coverage for certain non-emergency medical conditions. Costs must be paid by you at the time of the virtual visit and will apply toward your deductible and out-of-pocket maximum.

WHEN CAN I USE A VIRTUAL VISIT?

When you have a non-emergency condition and:

- your doctor is not available;
- you become ill while traveling;
- When you are considering visiting a hospital emergency room for a non-emergency health condition.

*Your covered children may also use Virtual Visits when a parent or legal guardian is present for the visit.

Examples of Non-Emergency Conditions:

- | | |
|---------------------|----------------|
| ✓ Bladder infection | ✓ Rash |
| ✓ Bronchitis | ✓ Seasonal flu |
| ✓ Diarrhea | ✓ Sinus |
| ✓ Fever | ✓ Sore throat |
| ✓ Pink eye | ✓ Stomach |

24/7/365 medical coverage for you and your dependents

You and your eligible dependents can talk to a U.S. board-certified doctor anytime, anywhere, by phone or video. Teladoc® doctors can treat many of your medical conditions. [Give your family access to Teladoc.](#)

1. Teladoc membership card

- Card will be mailed to your address.
- Visit the website and click 'set up account'. Follow the online instructions to provide the necessary information and to complete your medical history.

2. Set up minor dependents (17 OR YOUNGER)

Log into your account and click 'My Family' from the top menu. Follow the online instructions to provide the necessary information and complete your dependent medical history.

3. Set up adult dependents (18 OR OLDER)

Adult dependents set up their own account by visiting the website and clicking 'Set up account'. They should follow the online Instructions to provide the necessary information and to complete their medical history.

4. Request a consult

Once your account is set up, request a consult anytime and anywhere you seek care. With your consent, Teladoc is happy to provide information about your Teladoc consult to your Primary Care Physician.

Do I have a username?

When setting up your account online, you will be asked for a username. Your Username can be found on your Teladoc membership card. If you do not have a membership card or you do not know your username, simply select 'No' and Complete the information requested.

Talk to a doctor anytime for free!

 Teladoc.com

 Facebook.com/Teladoc

 1-800-Teladoc (835-2362)

 Teladoc.com/mobile



TELADOC™

VISION

COVERAGE OVERVIEW

The Vision Coverage is not a stand-alone benefit, it is included under your medical coverage

Vision Benefits	This benefit will provide for one examination and, if medically necessary, frame type lenses and/or contact lenses, in a calendar year period. Plan payment is 80% of usual, customary and reasonable (UCR) fee. Member cost share is 20% of UCR and amount exceeding UCR.
------------------------	---

Can I enroll in the Vision if I do not elect the medical?

- The vision benefits are part of the medical coverage. In order to have the vision coverage, you must be enrolled under the medical plan also.

How do I find a Provider in the vision network?

Employees can see any provider for vision services. Please note Cigna does have a limited amount of in-network but you do not need to use an in-network provider to receive services.

If you use an out of network vision care provider you may be responsible to pay for the services out of pocket, then submit a claim to Marpai Health (formerly Maestro Health). Marpai will reimburse you directly.

- Claim forms can be found on the internal Meck ABC Website (www.meckabc.com) under *Meck ABC Forms and Link*.

If you would like to see if Cigna has an in-network vision care provider you can go to www.cigna.com, click Find a Doctor/Facility.

- DISCLAIMER: Please check with your vision provider to determine acceptance of Marpai Insurance.

Who do I contact if I have questions about my vision benefit or need to verify my benefit?

- Any questions that you may have concerning your vision benefits can be answered by contacting;

Call Marpai Health at

800-228-1803 or email

info@maestrohealth.com



[Click on images below for more information on Vision.](#)

DENTAL

COVERAGE OVERVIEW

COMMON TERMS

PRE-TREATMENT ESTIMATE

If your dental care is extensive and you want to plan for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE

You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS

Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.



[Click on images below for more information on Dental.](#)

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. 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. You may choose to visit any dental provider of your choice, however, if you seek services from an in-network dental provider you will receive additional discounts.

	Dental Benefits
Calendar Year Deductible	\$50 Individual / \$150 Family
Calendar Year Maximum	\$1,500 per covered member. <i>Preventive services do not apply to this maximum</i>
Claim Payment Basis	Usual, customary and reasonable charges
Preventive Services	100% deductible does not apply oral exams, cleanings, X-rays, fluoride treatment and sealants
Basic Services	80% after deductible Anesthesia, oral surgery, periodontal services, endodontic services, fillings, space maintainers
Major Services	80% after deductible Inlays, onlays, crowns, dentures, implants
Orthodontia	80% after deductible Preliminary study, appliance placement, extractions in connection with orthodontia

Weekly Payroll Deductions for Dental Coverage				
Weekly Payroll Deductions	Employee only	Employee Spouse	Employee Child (ren)	Employee Child (ren)
	\$0.00	\$2.93	\$1.66	\$4.97

How do I find a doctor within my network?

Go to www.cigna.com, click Find a Dentist.

Who do I contact if I have a question?

Any questions that you may have concerning your Medical, Dental, Vision and Pharmacy can be answered by contacting Marpai/Maestro Health:

Call **Marpai/Maestro Health** at **800-228-1803** or email info@maestrohealth.com

IMPORTANT REMINDERS

COVERAGE OVERVIEW



Important Reminders about our Medical Plan

- Be sure to show your ID card to your doctor or pharmacist, and
- Call Marpai Health (formerly Maestro) to verify your benefits, not CIGNA.
- We use the CIGNA PPO Network, but Marpai Health is our Plan Administrator.

Who do I contact with questions

For questions on Medical, Prescription, Vision, Dental or FSA benefits including:

- Verify Benefits
- Find a PPO Provider
- Check claim status

Call Marpai/Maestro Health at
800-228-1803 or email
info@maestrohealth.com

Administered By
MARPAI

PLAN INFORMATION

MEDICAL GROUP ID: 213
MEMBER: JOHN MILLER
MEMBER ID: 0021000006
COVERAGE TIER: FAMILY
DENTAL/VISION: FAMILY

Benefit	In-Network	Out of Network
Primary Care	\$30 Copay	\$60 Copay
Specialist	\$50 Copay	\$100 Copay
Urgent Care	\$30 Copay	\$60 Copay
ER Visit	\$80 Copay (at visit)	\$200 Copay after
Deductible	\$800/\$1,500	\$1,200/\$1,500
Out of Pocket	\$3,000/\$6,000	\$7,200/\$11,400
Coinsurance	20%	40%

NETWORK INFORMATION

CIGNA PPO
MidlandsChoice

To find a Cigna provider, please visit: www.myCigna.com

PHARMACY PLAN

OPTUM

RxBIN: 610011
RxPCN: 1RX
RxGRP: VPOBXMCA
Member Customer Service:
800-997-3784

Benefits are not insured by Cigna or affiliates.

CUSTOMER SERVICE

ELIGIBILITY / BENEFITS / PRECERTIFICATION:
MEDICAL PLAN BENEFIT VERIFICATION
PRECERTIFICATION: 877.694.9949
Marpai Online: mybenefits.marpaihealth.com

CLAIMS SUBMISSION

Submit Medical Claims: Cigna PPO, PO Box 188061, Chattanooga, TN 37422-0161, EDI: 62308
Submit Dental & Vision Claims: Marpai Health, PO Box 211291, Eden, MN 55121, EDI: 56139

IMPORTANT REQUIREMENTS

All inpatient (hospital) admissions and skilled nursing facility admissions MUST be reported before an admission. If an inpatient stay is not authorized, benefits will be reduced. EMERGENCY admissions must be reported within 48 hours.

\$30.00 Copayment applies to all in-network office visits and includes labwork, x-rays, outpatient surgery and diagnostic tests performed during the visit and billed from the physician's office.

For precertification, call Marpai Health at 877.694.9949

AWAY FROM HOME CARE

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE



Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year (**January 1st through December 31st**). The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at www.irs.gov.
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at www.fsastore.com.

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | \$3,300

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general-purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **\$5,000** annually in pre-tax dollars, or **\$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

HEALTH CARE FSA ROLLOVER

Health Care FSA's have a **\$640 roll over** feature, which allows any amount of \$640 or less remaining in your account at the end of the plan year to roll over into the new plan year.

“USE IT” OR “LOSE IT”

This is a “use if Or Lose it” plan so any money over the \$640 that remains in your FSA at the end of the year will be forfeited.

You may use your FSA funds for expenses incurred between August 1, 2025 and July 31, 2025.



[Click on images below for more information on Flexible Spending Account \(FSA\)](#)

*ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:

1. ‘Care’ for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. ‘Care’ for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. ‘Care’ for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

‘Care’ is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE



HERE'S HOW IT WORKS

An employee earning \$30,000 elects to place \$1,000 into a Health Care FSA. The payroll deduction is \$110.42 based on a 24-pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of \$574.

	Without FSA	With FSA
Gross Income	\$30,000	\$30,000
FSA Contributions	\$0	-\$2,650
TAXABLE INCOME	\$30,000	\$27,350
Estimated Taxes		
Federal	\$3,090*	-\$2,817*
State	\$1,104**	\$1,106**
FICA	\$2,295	\$2,092
AFTER TAX EARNINGS	\$23,511	\$21,435
Eligible Out-Of-Pocket Expenses	\$2,650	\$0
AVAILABLE/SPENDABLE INCOME	\$20,861	\$21,435

That's a savings of \$574 for the year!

This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

*Varies, assumes 10.30%;

**Varies, assumes 3.68%

OVER-THE-COUNTER (OTC) MEDICATION REMINDER

Effective for purchases on or after January 1, 2025, thousands of items, including pain relievers, cold and flu medications, antacids, acne remedies, and allergy medicines are now reimbursable from an FSA, Section 213 HRA, or HSA without a prescription.

In addition to eliminating the prescription requirement on OTC drugs and medicine, the new CARES Act has added hundreds of menstrual products to the list of approved expenses, including tampons, pads, liners, cups, sponges and similar items. As was the case prior to the passage of the ACA, vitamins and supplements will continue to require a physician's "prescription" indicating that they are being taken to treat a diagnosed medical condition (e.g., anemia) rather than for general health and wellness.

ELIGIBLE HEALTH FSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Artificial teeth/dentures
- Blood pressure monitors
- Braces
- Braille-books & magazines
- Breast pumps & lactation supplies
- Chiropractors
- Co-insurance, co-pay & deductibles
- Cost of operations & related treatments
- Crutches
- Diabetic supplies
- Drug addiction treatment
- Eye exams, eye glasses, contacts
- Hearing devices & batteries
- Hospital services
- Operations
- Pregnancy tests
- Radial keratotomy & lasik eye surgery
- Smoking cessation programs
- Speech therapy
- Surgical fees
- Vaccines
- Walkers & wheelchairs
- X-rays and more.

*A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.



**100% ELIGIBILITY
GUARANTEED**

**ALL FSA CARDS
ACCEPTED**

**2,500+ FSA ELIGIBLE
PRODUCTS**

FSAstore.com.

NOTE: Funds rolled over from previous year will not be available for use until October 1st.

LIFE

COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A **Beneficiary** is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary**. A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

Basic Life Coverage (Full Time Employees)

As part of your benefits package, Mecklenburg County ABC Board provides you with group term Life and Accidental Death and Dismemberment (AD&D) insurance, at no cost to you. These plans are underwritten by The Standard Insurance Company and will be available to you after 1 year of employment.

Basic Life and AD&D	
All Full Time Eligible Employees	2 Times Base Annual Earnings to Maximum of \$200,000

Supplemental and Voluntary Life Insurance (100% Employee Paid)

In addition to the basic life insurance that Mecklenburg County ABC Board is providing to employees, eligible employees can purchase coverage for their spouse and /or dependent children by enrolling in a Supplemental Life Insurance plan administered through The Standard Insurance Company. This benefit is portal, and rates are variable based on age. Coverage is available up to \$100,000 without evidence of insurability. Maximum coverage is **\$500,000**.

Employees can purchase optional \$10,000 Dependent Life coverage (spouse and children) for the weekly payroll deduction of \$1.72.

REMINDER – Please take time to update your beneficiary information.



WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

DISABILITY

SHORT-TERM | LONG-TERM

Short-Term Disability Coverage

Mecklenburg County ABC Board provides short term disability coverage to all full-time employees after 30 consecutive days of employment. Benefits equal 60% of a full-time employee's regular pay and benefits are payable for non-work related injuries, illness, pregnancy or mental disorder.

- Payments will be distributed by Standard in the form of a paper check, mailed to your address.

Benefit Detail	Short-Term Disability Income
Elimination Period	14 days and exhaustion of all sick time
Benefits Payable/Duration	90 days or the date Long Term Disability benefits begin
Percentage of Income Replaced	60% of your income
<i>If you are disabled for less than one full week, Standard Insurance Company will pay one seventh of the STD Benefit for each day of disability.</i>	

Long -Term Disability Coverage

Mecklenburg County ABC Board provides long term disability coverage to all full-time employees after 30 days of consecutive employment. Long term disability income benefits are fully paid by Mecklenburg County ABC Board and provided through The Standard Insurance Company. The plan pays 60% of an employee's monthly income, with a maximum monthly benefit of \$5,000 for a disability due to illness or non-work related injury. *exclusions and limitations apply*

Benefit Detail	Long -Term Disability Income
Elimination Period	90 days
Percentage of Income Replaced	60% of your income
Maximum monthly benefit	\$5,000
Benefits Payable/Duration	Social Security Normal Retirement Age



[Click on images below for more information on Short Term Disability.](#)



[Click on images below for more information on Long Term Disability.](#)

VOLUNTARY BENEFITS

ACCIDENT | The Standard

Mecklenburg County ABC Board offers various Voluntary Benefits you may purchase to enhance your overall benefits package. These benefits are standalone products, that work independently of the medical and other benefits and pay cash directly to you in the event of a claim. The Standard elections will be payroll deducted.

Accident Insurance

A serious injury can cost you a lot of money – not only in medical bills but in things like income from lost work hours. Some injuries are minor, but others are debilitating and require significant medical care. If you get hurt, accident insurance pays you money that you can use to cover personal expenses, bills, and out-of-pocket medical costs.

Who Gets Paid?

You get paid. When you have a covered accident or injury, your health insurance company pays your doctor or hospital, but your accident insurance company pays you.

What's Covered?

Not all accidents are “qualifying injuries.” The kinds of accidents that are covered can vary by plan, but accident insurance plans typically cover things like:

- Emergency Room Visits
- Ambulance Transportation
- Hospital Admissions & Per Diem Charges
- Intensive Care & Rehabilitation Unit Care
- Diagnostic Exams
- Follow-up Treatments
- Physical Therapy

What is the Cost of Accident Insurance?

Cost will vary depending on if you cover yourself and/or other dependents, as well as which plan you elect. Payroll deduction will be provided through ADP.

What it Doesn't Cover

Accident insurance will not typically cover things like check-ups or hospitalization due to illness. Accident insurance will not cover you for injuries suffered before you purchased the plan.

	Enhanced - Plan 2
Emergency Care Benefits	
Air Ambulance	\$800
Blood, Plasma, Platelets	\$300
Emergency Dental (Crown)	\$200
Emergency Dental (Extraction)	\$100
Emergency Room Benefit	\$500
Ground Ambulance	\$300
Initial Physician's Office	\$500
Major Diagnostic Exam	\$300
Urgent Care	\$500
X-Ray	\$300
Specific Injury Benefits	
Burns, 2nd Degree, <15%	\$200
Burns, 2nd Degree, >15%	\$1,000
Burns, 3rd Degree, <15%	\$5,000
Burns, 3rd Degree, >15%	\$10,000
Coma	\$7,500
Concussion	\$500
Eye Injury	\$200

VOLUNTARY BENEFITS

ACCIDENT | The Standard

Plan Design (continued)

	Enhanced - Plan 2
Lacerations, < 2"	\$75
Lacerations, 2" - 6"	\$200
Lacerations, > 6"	\$500
Skin Graft	25% of Burn Benefit
Fracture Benefits Non-Surgical/Surgical	
Ankle, Arm, Collarbone, Elbow, Foot, Hand, Kneecap, Lower Jaw, Shoulder Blade, Sternum, Wrist	\$550/\$1,100
Bones of Face, Coccyx, Nose, Vertebrae	\$500/\$1,000
Finger, Toe	\$100/\$200
Hip	\$2,500/\$5,000
Leg (hip to knee)	\$2,000/\$4,000
Leg (knee to ankle), Pelvis, Vertebral Column	\$1,200/\$2,400
Rib	\$400/\$800
Skull (Depressed)	\$4,000/\$8,000
Skull (Non-Depressed)	\$1,500/\$3,000
Chip Fracture	25% of Non-Surgical Fracture Amount
Dislocation Benefits Non-Surgical/Surgical	
Ankle, Collarbone (Sternoclavicular), Elbow, Foot, Hand, Lower Jaw, Shoulder, Wrist	\$800/\$1,600
Collar Bone (Acromioclavicular)	\$400/\$800
Finger, Rib, Toe	\$150/\$300
Hip	\$2,500/\$5,000
Knee	\$900/\$1,800
Spine	\$400/\$800
Partial Dislocation	25% of Non-Surgical Dislocation Amount
Surgical Benefits	
Knee Cartilage Repair	\$750
Knee Cartilage Exploratory Surgery	\$200
Tendon, Ligament, Rotator Cuff Repair of One	\$750
Tendon, Ligament, Rotator Cuff Repair of Two or More	\$1,000

VOLUNTARY BENEFITS

ACCIDENT | The Standard

Plan Design (continued)

	Enhanced - Plan 2
Tendon, Ligament, Rotator Cuff Exploratory Surgery	\$200
Raptured Disk, Repair	\$750
Abdominal/Thoracic Exploratory Surgery	\$200
Abdominal/Thoracic Laparoscopic Surgery	\$750
Abdominal/Thoracic Open Surgery	\$1,500
Outpatient Surgical Facility	\$150
Hospital Benefits	
Critical Care Unit Admission	\$2,000
Daily Rehabilitation Facility	\$100/day up to 90 days per accident
Daily Critical Care Unit Confinement	\$600/day up to 31 days
Daily Hospital Confinement	\$600/day up to 365 days
Hospital Admission	\$2,000
Follow-Up Care Benefits	
Medical Appliance	\$500
Chiropractic	\$100 up to 3 days
Follow-Up Care Treatment	\$350 up to 3 days
Hearing Device	\$500
Prosthesis, One	\$500
Prostheses, Two or More	\$1,000
Therapy Services	\$350 up to 6 days
Additional Benefits	
Youth Organized Sports	25% Additional of total benefits
Health Maintenance Screening Benefit	\$100
Lodging (up to 30 days per Accident)	\$175/per day
Transportation (up to 30 days per Accident)	\$1,000/per day
Accidental Death & Dismemberment Benefits	
Accidental Death – Employee	\$150,000
Accidental Death – Spouse	\$75,000
Accidental Death – Child	\$37,500
Accidental Death & Dismemberment Benefits	
	Percentage of Accidental Death Benefits
Common Carrier	100%

VOLUNTARY BENEFITS

ACCIDENT | The Standard

Plan Design (continued)

	Enhanced - Plan 2
Loss of Two or More Fingers or Toes	5%
Loss of One Finger or One Toe	2%
Loss of Both Hands, or Both Feet	30%
Loss of One Hand or One Foot	15%
Loss of One Hand and One Foot	30%
Loss of Sight for Both Eyes	30%
Loss of Hearing of Both Ears	30%
Loss of Sight in One Eye	15%
Loss of Hearing in One Ear	15%
Accidental Impairment Benefits	Percentage of Accidental Death Benefits
Uniplegia	15%
Paraplegia	30%
Triplegia	30%
Hemiplegia	30%
Quadriplegia	50%
Airbag Benefit	10%
Helmet Benefit	10%
Seatbelt Benefit	10%
Repatriation Benefit	10%

	Monthly Premium
	Enhanced - Plan 2
Employee	\$10.92
Employee and Spouse	\$17.40
Employee and Child(ren)	\$20.79
Employee and Family	\$32.67

- To convert monthly rates to deductions, multiply by twelve, then divide by the number of deductions per year and round to two decimals.

- To see a full list of coverage and exclusion, see *The Standard Benefit Proposal* included in your packet.

VOLUNTARY BENEFITS

HOSPITAL INDEMNITY | The Standard

A trip to the hospital can be costly - and many employees aren't prepared for the out of pocket expenses that come with a hospital stay, even with medical coverage. Hospital Indemnity insurance pays cash benefits to employees in the event of a hospitalization, regardless of treatment costs or other insurance coverage. It's an affordable way for employees to keep their finances on track.

	HSA - Plan 2
Hospital Confinement Benefit	\$150/Day
Number of Covered Days per Hospital Confinement	15 Days
Hospital Admission	\$1000/Calendar year
Critical Care Unit (CCU) Confinement - Pays in addition to Hospital Confinement benefit	\$150/Day
Number of Covered Days per CCU Confinement	15 days
Critical Care Unit (CCU) Admission	\$1000/Calendar year
Health Maintenance Screening	\$50
Annual Open Enrollment	Included
Pre-existing Limitation	None

	Monthly Premium
	HSA - Plan 2
Employee	\$15.49
Employee and Spouse	\$26.48
Employee and Child(ren)	\$21.98
Employee and Family	\$39.06

- To see a full list of coverage and exclusion, see *The Standard Benefit Proposal* included in your packet.

VOLUNTARY BENEFITS

CRITICAL ILLNESS | The Standard

	Premier - Plan 2
Covered Conditions	Coverage Percentage or Flat Amount
Amyotrophic Lateral Sclerosis	100%
Benign Brain Tumor	100%
Bone Marrow Transplant	100%
Loss of Hearing	100%
Loss of Speech	100%
21 Childhood Diseases	100%
Additional Occurrence Benefit – Separation Period	None
Coverage Amount: Employee	\$10,000 to \$20,000 in increments of \$10,000
Coverage Amount: Spouse	\$5,000 to \$10,000 in increments of \$5,000
Coverage Amount: Child (at no additional charge)	50% of the Employee Amount
Rates	Composite, Unisex, Blended
Guarantee Issue (Employee)	\$20,000
Guarantee Issue (Spouse)	\$10,000
Annual Open Enrollment	Included
Pre-existing Condition	None
Health Maintenance Screening Benefit	\$75 per insured per calendar year
Portability	Included
Reoccurrence	100%
Reoccurrence Treatment-Free Period	6-month

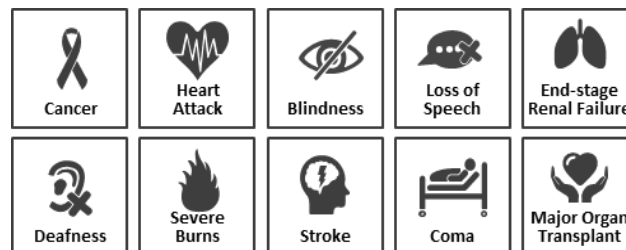
• To see a full list of coverage and exclusion, see *The Standard Benefit Proposal* included in your packet.

VOLUNTARY BENEFITS

CRITICAL ILLNESS | The Standard

Plan Design (continued)

	Premier - Plan 2
Covered Conditions	Coverage Percentage or Flat Amount
Cancer	100%
Carcinoma In Situ (non-invasive cancer)	25%
End-stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Myocardial Infarction (Heart Attack)	100%
Severe Coronary Artery Disease with Recommendation of Bypass	25%
Stroke	100%
Coma	100%
Paralysis	100%
Loss of Sight	100%
Occupational Hepatitis	100%
Occupational HIV	100%
Advanced Alzheimer's Disease	100%
Advanced Multiple Sclerosis	100%
Advanced Parkinson's Disease	100%



VOLUNTARY BENEFITS

CRITICAL ILLNESS | The Standard

		Composite - Monthly Premium	
		Employee - All Ages	
		Blended	
Benefit Amount		Premier - Plan 2	
	\$10,000		\$14.20
	\$20,000		\$28.40
Benefit Amount		Spouse - All Ages	
	\$5,000		\$7.10
	\$10,000		\$14.20

Annual Rate Per \$1,000	
Premier - Plan 2	
Age Band	Blended
18-29	\$17.04
30-39	\$17.04
40-49	\$17.04
50-59	\$17.04
60-69	\$17.04
70+	\$17.04

- To convert annual rates to deductions, multiply by units of coverage, divide by the number of deductions per year and round to the nearest penny.

A New Insurance Experience

InsurChoice™

Personal Insurance Solutions. Digitally.

All-around protection for what matters most to you — spanning the entire breadth of NFP's focused expertise.

InsurChoice offers you the ability to personalize your own protection — bringing you quick, convenient, holistic coverage with incredible cost-saving discounts across a variety of top-rated insurance products and carriers.

Get competitive coverage at competitive prices. For more information, click [here](https://digital.nfp.com/pc/MC_IC_MP) or go to https://digital.nfp.com/pc/MC_IC_MP



Your Personalized Solutions



Discount Program



Pet Insurance



Travel Protection



Renters Insurance



Auto Insurance



Home Insurance



Mental Wellness

401K

OVERVIEW

Local Governmental Employees' Retirement System:

This is our pension plan. There is a mandatory employee contribution of 6% of your gross pay each pay period. It is deducted pre-tax, therefore reducing your taxable income. This amount is posted to an account in your name. When you retire, your annual pension amount is calculated as follows: (Average of 4 highest paid years in a row) x (number years service) x (1.85%). If you leave the system before retirement, you have the option to withdraw your contributions, subject to income tax and an early withdrawal penalty if you are under age 59-1/2 at the time of withdrawal. You can access the Retirement System website for more information, including the current employee handbook, by going directly to the Retirement System's website, at www.nc.retirement@nctreasurer.com .

Supplemental Retirement Income Plan - 401(k):

- The ABC Board presently contributes 8% (for L.E. officers) or 5% (other employees) of your gross pay to your account each pay period, regardless of your contribution amount, if any. The Board will match an additional 1% if an employee contributes at least 1% of his or her salary to the 401-k plan. The website provides more information regarding the plan and investment options – the address is;
- [Empower Website](#)
- <https://participant.empower-retirement.com/participant/#/login>.



[Click on images below for more information on 401\(k\)](#)

ADDITIONAL EMPLOYEE INFORMATION

For complete details about Benefits please see Personnel Manual Section II Benefits located under Documents on the Board website. www.meckabc.com Employee login and password space located on bottom righthand corner of website.

Sick Leave

- 12 days per year (96 hours)

Vacation Leave

Under 2 years	10 days (1.54 hours per pay period)
2 – 4 years	12 days (1.85 hours per pay period)
5 – 9 years	15 days (2.31 hours per pay period)
10 – 14 years	18 days (2.77 hours per pay period)
15 – 19 years	21 days (3.23 hours per pay period)
20+ years	24 days (3.69 hours per pay period)

Bereavement Leave

- Up to 3 days per year (24 hours) depending on employee start date
- Bereavement leave hours for employees who are full-time after January 1st will be prorated and issued as follows:

Full Time Employment Starts	Bereavement Leave Hours for Partial Year	Bereavement Leave Hours Issued
January 2 nd - April 30 th	16 hours	May 1 st
May 1 st - August 31 st	8 hours	September 1 st
Sept. 1 st - December 31 st	0 hours	Eligible January 1 st the following year, if full time

Holidays Observed

- New Year’s Day – Jan.1st
- Dr. Martin Luther King Jr. Day – Jan. 20th
- Good Friday (Stores Open) – Friday before Easter
- Memorial Day – May 27th
- Juneteenth (Stores and HQ is closed) – June 19th
- Independence Day – July 4th
- Labor Day- First Monday in Sept.
- Veteran’s Day – Nov. 11th
- Thanksgiving Day – Fourth Thursday in Nov.
- Christmas (2) Days – Dec. 25th, plus one additional day.
- Employee’s Birthday

ADDITIONAL EMPLOYEE INFORMATION

Educational Assistance Program

- Available to all full-time employees who have completed at least 6 months of employment with the Board and are in good performance standing.
 - To use towards obtaining an Associates, a Bachelor's, a Master's, or a Doctorate degree.
 - Up to \$3,500 per calendar year.
 - Please contact lindsay.sutton@meckabc.com with questions related to this program.

Student Loan Repayment Program

- Available to all full-time and part-time employees who are in good performance standing and have worked for the Board at least 2 years, beginning July 1, 2020.
- Up to \$2,625 per calendar year.
- Please contact lindsay.sutton@meckabc.com with questions related to this program.

Employee Assistance Program (EAP)

- Benefits available to full-time employees the offers support and resources to address personal or work related challenges and concerns
- 1.800.633.3353 or visit the Meck ABC Website www.meckabc.com and login with employee credentials
 - Assessment and counseling
 - Online Services
 - Legal Advice
 - Financial Services

Anderson Counseling & Consulting

- Available to full-time and part-time employees
- Receive up to 3 outpatient counseling sessions at no cost
 - 704. 208.4458 Press ZERO to speak with someone directly.
 - 2315 E. W.T. Harris Blvd Suite 102 Charlotte 28213

Bi-lingual Pay Incentive

- Available to full time and part time employees who speak a second language
- Assessment available through The Language Academy
- Proficiency will determine quarterly pay-out
 - Contact your HR Business Partner with questions and to schedule assessment

Gym Reimbursement

- \$10 monthly gym reimbursement
- Paid out each quarter
- Email receipts, or bank statements to Gym Receipts - Cloud <gymreceipts@meckabc.com>

Service Awards

- In recognition of years of service, full time employees are eligible to receive a gift card or personalized plaque for every 5 years of consecutive service with the Board
 - 5 years of service= \$100
 - 10years of service= \$150
 - 15 years of service= \$200
 - 20 years of service= \$250
 - 25 years of service= \$300
 - 30 years of service= \$400

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term “charges” means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits – The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term “in-network” refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of “emergency services” and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term “out-of-network” refers to care that does not qualify as in-network.

Maximum Out of Pocket – The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term “Primary Care Dentist” means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term “Primary Care Physician” means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.



*For questions regarding benefits, enrollment,
payroll or general Human Resources questions contact*

Anthony Watson| VP of Human Resources : 704-731-5905 Anthony.Watson@meckabc.com

Lindsay Sutton| HR Business Partner: 704.731.5907 Lindsay.Sutton@meckabc.com

Kelly Jenkins-Bey| HR Business Partner: 704.731.5914 Kelly.JenkinsBey@meckabc.com

Nakyhia Darby| Talent Acquisition: 704-731-5906 Nakyhia.Darby@meckabc.com

