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2021 **benefits** **DIGEST**

Yadkin Valley Economic Development District, Inc.

We are pleased to provide you with the 2021-2022 Benefits Digest. This guide is intended to provide a high level summary of the benefit programs available to all benefit eligible employees.

At Yadkin Valley Development District, Inc., we are confident that our people are the reason behind our success. We value you as an employee and part of our professional team. With this in mind, we have developed a comprehensive employee benefit package to protect you and your family.

This brochure provides benefit information available December 1, 2021 through November 30, 2022.

If you have comments, questions or other inquiries, please contact Human Resources.

Employee Eligibility

All employees working 30 hours or more per week are eligible for benefits.

Benefits Begin: Date following 90 days of employment
Benefits Terminate: End of the month following date of termination (Medical, Dental, & Vision);
Date of termination (Life & Voluntary Life)

Dependent Age Limits

Medical, Dental, Vision:

Age 26

Voluntary Life:

Age 19 or 26 if a full time student

Your medical coverage through Blue Cross Blue Shield of NC is an “open access” PPO plan using the Blue Options Network, which means that you do not need to select a primary care doctor nor will you need a referral to visit a specialist. As long as you remain in the network, your benefits will be covered at the higher in-network benefit amount.

	IN-NETWORK	OUT-OF-NETWORK
Benefit Year	12/1-11/30	
Preventive Care	100%	70%*
Office Visit	PCP: \$20 Copay Specialist: 60%* Virtual: \$10 Copay	PCP: 50%* Specialist: 50%* Virtual: Not Covered
Prescription Drugs Essential Limited NC Formulary	Retail: \$4/\$25/\$35/\$75/25% ¹ Mail Order: 3x Copay	Copay + charge over in-network allowed amount
Emergency Room	60%*	60%*
Urgent Care	\$100 Copay	\$100 Copay
Annual Deductible	\$2,000/\$4,000	\$4,000/\$8,000
Out-of-Pocket Maximum	\$4,000/\$8,000	\$8,000/\$16,000
Inpatient Care	\$250 Copay, then 80%*	\$500 Copay, then 50%*
Outpatient Care	60%*	50%*

*Coverage provided after deductible

¹Tier 5 Specialty Drugs are subject to 25% coinsurance and have a \$100 per Drug Minimum and a \$200 per Drug Maximum for each 30-day supply.

Preventive Care is covered at 100% with a preventive primary diagnosis code. The service must be a covered preventive care benefit under healthcare reform.

Certain over the counter preventive medications for which you have a prescription are now available at no cost.

During your annual physical if anything is discussed or performed outside of the healthcare reform approved screenings, your visit may not be covered at 100%.

For a list of covered preventive benefits under healthcare reform please visit www.bcbsnc.com/preventive

Virtual Visits

BCBSNC has partnered with virtual visit provider Teladoc to provide you and your family with access to fast and convenient quality medical care. Video consultations are available 24/7.

- This is intended for non-emergency care only.
- Provides diagnosis and treatment (including some prescription drugs) by board- certified physicians for ailments such as allergies, sore throat, flu, respiratory infections etc.
- Consultations available online or available through the Teladoc mobile application available on the iTunes store and Google Play.
- Members will pay a \$10 consultation fee. Reference your BCBSNC Group Number (on your medical ID card) when accessing care.
- Pediatric, behavioral & psychiatric services are available.

Dental Plan

www.principal.com | 800-247-4695

Your dental plan is provided by Principal. Dentists who are in-network cannot balance bill you for amounts over the allowed charges. In-network dentists will always file claims on your behalf.

BASE PLAN	IN-NETWORK	OUT-OF-NETWORK
Benefit Period		1/1-12/31
Single/Family Deductible	\$0	\$100 Lifetime per Member
Benefit Max		\$1,000
Benefit Max Rollover		\$250 up to \$1,000 max
Orthodontia Lifetime Max		N/A
Preventive Care	100%	100%*
Basic Care	80%	80%*
Major Care (includes endo & periodontics)	50%	50%*
Orthodontia Care		N/A
UCR Level	Negotiated Fee	90 th

*Coverage provided after deductible

BUY UP PLAN	IN-NETWORK	OUT-OF-NETWORK
Benefit Period		1/1-12/31
Single/Family Deductible	\$0	\$100 Lifetime per Member
Benefit Max		\$2,000
Benefit Max Rollover		\$500 up to a \$2,000 max
Orthodontia Lifetime Max		\$1,000
Preventive Care	100%	100%*
Basic Care (includes endo & periodontics)	80%	80%*
Major Care	50%	50%*
Orthodontia Care (Child Only)	50%	50%
UCR Level	Negotiated Fee	90 th

*Coverage provided after deductible

Vision Plan

www.superiorvision.com | 800-923-6766

Your vision plan is provided by Superior Vision. Using an in-network provider will lower your cost.

	IN-NETWORK	OUT-OF-NETWORK ²
Benefit Frequency		Exam- 12 months Lenses & Contacts- 12 months Frames- 24 months
Exam	\$10 Copay	Ophthalmologist: Up to \$44 Optometrist: Up to \$39
Frames & Lenses	\$25 Copay ¹	Frames: Up to \$60 Allowance Lenses: Allowance varies from \$26-\$76
Elective Contact Lenses in lieu of Lenses & Frames	Up to \$150 Allowance	Up to \$100 Allowance

¹Frames are covered up to \$150 Allowance plus discount on balance over allowance after copay

²Copays apply to Out of Network providers for exams, lenses, and frames

- 100% Employer paid benefit
 - 1 x earnings to a maximum of \$50,000
 - Age reduction schedule applies beginning at age 65 and benefits terminate at retirement
- Additional life insurance is available for your spouse and dependents
 - Spouse - \$1,000 benefit
 - Dependents - \$100 from birth to 6 months, then \$1,000 from 6 months to age 19 or age 26 if a full time student
 - If you are interested in dependent life coverage, please see Human Resources

Employee Deductions

Employee contributions are the employee’s share of premium cost and are made through payroll deductions. Payroll deductions, as listed below, are deducted on a pre-tax basis. Teachers and Teacher Assistants will contribute during 19 pay periods. All other employees will contribute semi-monthly.

MEDICAL PLAN	SEMI-MONTHLY CONTRIBUTION	19 PAY PERIODS CONTRIBUTION
Employee	\$62.42	\$78.84
Employee + 1 Child	\$239.50	\$302.52
Employee + Children	\$463.47	\$585.44

DENTAL BASE PLAN	SEMI-MONTHLY CONTRIBUTION	19 PAY PERIODS CONTRIBUTION
Employee	\$15.26	\$19.28
Employee + Spouse	\$28.67	\$36.21
Employee + Child(ren)	\$34.58	\$43.67
Family	\$50.30	\$63.54

DENTAL BUY UP PLAN	SEMI-MONTHLY CONTRIBUTION	19 PAY PERIODS CONTRIBUTION
Employee	\$21.61	\$27.30
Employee + Spouse	\$39.08	\$49.36
Employee + Child(ren)	\$51.97	\$65.65
Family	\$73.07	\$92.30

VISION PLAN	SEMI-MONTHLY CONTRIBUTION	19 PAY PERIODS CONTRIBUTION
Employee	\$3.27	\$4.12
Employee + Spouse	\$6.53	\$8.25
Employee + Child(ren)	\$7.50	\$9.47
Family	\$11.55	\$14.59

If you have comments, questions or other inquiries, please contact Human Resources.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by legal counsel who specialize in this practice area.