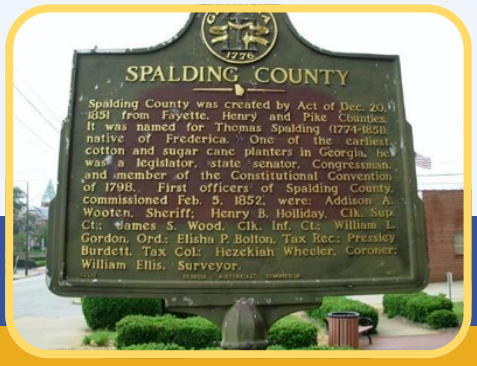
Spalding
Everything you need in Spalding

# Employee BENEFITS Guide

## Plan Year July 1, 2022 thru June 30, 2023



**Go online and enroll at www.eelect.com**

**Enrollment ID = 110747**

**Then follow the on-screen instructions**

# CONTENTS



This booklet is a summary only. Please refer to each plan's certificate of coverage / plan document for a complete description of all benefits and exclusions. If there is any difference between the information provided in this booklet and any certificate of coverage / plan document, the certificate of coverage / plan document will govern. Copies of all certificates of coverage / plan documents are available at the Human Resources department. If some information changes, you will receive notice about the changes prior to the annual Open Enrollment. If you are a new employee, this information will help you to understand the benefit options available to you. If you are already covered by any of the benefit plans, you may refer to this booklet throughout the year as you use your benefits. This booklet also provides information regarding your COBRA rights and responsibilities. You may view copies of all certificates of coverage / plan documents by following the below instructions:

Go to **www.msibg.com**

Click on "Client Portal" at the top right of your screen.

**Username: spaldingEE**

**Password: Benefits123**

# ELIGIBILITY

**Newly hired Full-time employees are eligible for benefits on the first day of the month following 30 days of service.** Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian.

# CHANGES

**Pre-Tax Deduction of Premiums (Section 125 Plan) -** Medical, dental and vision insurance premiums are all deducted (if you have elected deductions) from your pay on a pre-tax basis (exempt from FICA, Federal and State tax) which in turn provides significant cost savings. This will continue and does not require any action on your part unless you desire to make changes. You will be able to make changes on any of your elections during the open enrollment period. Your selections cannot be changed until next year unless the revocation and new election are due to and consistent with a valid status change (e.g., marriage, divorce, death of a spouse or child, birth or adoption of a child or change of employment of your spouse as detailed in the Section 125 Regulations).

***If you have a status change during the year you must notify Human Resources within 30 days. Any request to make changes after 30 days will not be allowed until the next annual open enrollment.*** Please contact Human Resources at (770) 467-4231 if you have any questions regarding the open enrollment period or changes.

# MESSAGE FROM THE CHAIRPERSON

**To:** **All Full Time Employees**
**From:** **Spalding County Commissioners**
**Subject:** **Employee Benefits**

The Spalding County Board of Commissioners appreciates the hard work and dedication of our employees to make Spalding County a great place to work and live. A quality, comprehensive benefits package is a critical component to help Spalding County retain skilled and seasoned employees as well as recruit new talent when needed.

Please review this Employee Benefits Handbook carefully and contact Human Resources with any questions. The booklet is filled with many benefit plans and programs that could be a benefit to you and your family.

**Clay Davis III**
**Chairman**
**Spalding County Board of Commissioners**

# SPALDING COUNTY COMMISSIONERS

**Gwen Flowers-Taylor**
**District 1**

**James R. Dutton**
**(Vice-Chairman)**
**District 2**

**Rita Johnson**
**District 3**

**Ryan Bowlden**
**District 4**

Spalding County is governed by an elected five-member Board of Commissioners, each Commissioner representing a different geographic district of Spalding County. The Board of Commissioners are charged with establishment of Ordinances and Policies relating to operation of the County government. In addition the Board of Commissioners will act on citizen requests such as zoning matters. The Spalding County Chairman and Vice-Chairman positions are elected by the Board of Commissioners and are voted on annually. The first official act of the Board of Commissioners at the first public meeting of each year is to elect a Chairman and Vice-Chairman.

# MEDICAL BENEFIT SUMMARY

**Spalding County offers an Cigna health plan option. The Plan is an Open Access Plus plan.** You are not required to name a primary care physician (PCP) or obtain referrals to visit **a specialist physician. This plan offers an out-of-network benefit however; you receive the best value by staying in network.**

| IN-NETWORK | $1,500 OA Plus |
|---|---|
| Individual Calendar Year Deductible* | $1,500 |
| Family Calendar Year Deductible* | $3,000 |
| Co-Insurance | Member pays 20%<br>Plan pays 80% |
| Individual Benefit Period Out-of-Pocket (includes deductible) | $7,900 |
| Family Benefit Period Out-of-Pocket (includes deductible) | $15,800 |
| Lifetime Maximum | Unlimited |
| **Urgent Virtual Care Services** | $ 5 |
| Primary Care Physician Visit Co-pay | $30 |
| Specialist Physician/Urgent Care Center Co-pay | $60 |
| Surgery Performed in Physician's Office | $30 |
| Emergency Room Co-pay | $150, then member pays 20% |
| **OUT-OF-NETWORK** | |
| Individual Annual Deductible | $3,000 |
| Family Annual Deductible | $6,000 |
| Co-Insurance | Member pays 40%<br>Plan pays 60% |
| Individual Out-of-Pocket | $23,700 |
| Family Out-of-Pocket | $47,400 |
| **PRESCRIPTION DRUG CO-PAYMENTS** | |
| Prescription Benefit Period Deductible (does not apply to Tier 1 Retail or Home Delivery) | $300 |
| Retail Drug - Generic (30 day supply) | $5 |
| Retail Drug - Preferred Brand (30 day supply) | $45 |
| Retail Drug - Non-Preferred Brand (30 day supply) | $80 |
| Retail Drug - Specialty (30 day supply) | Member pays 25% up to $300 |
| Home Delivery Maintenance Drug - Generic (90 day supply) | $5 |
| Home Delivery Maintenance Drug - Preferred Brand (90 day supply) | $90 |
| Home Delivery Maintenance Drug - Non-Preferred Brand (90 day supply) | $240 |

**Your retail prescription *may be eligible* for a 90 day refill at 3 times the copay if you desire.**

*Applied to covered expenses when no co-pay applies. Annual deductible runs calendar year, January 1 thru December 31. Eligible charges during the last three months of a calendar year applied to that year's Deductible can carry over and also apply toward the next year's Deductible.

# EMPLOYEE MEDICAL DEDUCTIONS—Per Pay Check

**Semi- Monthly (24 deductions per Year)**

| MEMBERS COVERED | $1,500 OA POS |
|---|---|
| **Employee Only** | **$ 30.83** |
| **Employee + 1 Dependent** | **$202.80** |
| **Employee + 2 or More Dependents** | **$240.00** |

# MEDICAL BENEFIT SUMMARY

| | $4,500 OA POS | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Covered Services** | | |
| **Benefit Period Deductible**<br>Employee<br>Family | **$1,500**<br>**$3,000** | **$3,000**<br>**$6,000** |
| **Coinsurance** | **Member pays 20%**<br>**Plan pays 80%** | **Member pays 40%**<br>**Plan pays 60%** |
| **Benefit Period Out-of-Pocket Maximum**<br>(Includes benefit period deductible)<br>Employee<br>Family | **$7,900**<br>**$15,800** | **$23,700**<br>**$47,400** |
| *Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member's deductible amount also goes toward the Family deductible and out-of-pocket maximum. Not everyone has to meet hit or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses. The medical and pharmacy copayments, deductible (s), and coinsurance on this plan will apply toward the out-of-pocket maximums. The following do not apply to out-of-pocket maximums: non-covered items, plan premiums, any balance billing due to Out-of-Network services. | | |
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Preventive Care** | | |
| **Routine Preventive Care – All Ages**<br>(preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits)<br>Well-child care, immunizations<br>Periodic health examinations<br>Annual gynecology examinations<br>Prostate Screenings | Member pays 0%<br>no plan deductible | Birth through age 5<br>PCP: Plan pays 70% after deductible<br>Specialist: Plan pays 70% after deductible<br><br>Age 6 and older<br>PCP: Plan pays 70% after deductible<br>Specialist: Plan pays 70% after deductible |
| **Physician Services** | | |
| **Physician Office Visits for Illness and Injury** (including labs, x-rays, and diagnostic procedures and office surgery)<br>Primary Care Physician (PCP)*<br>Specialist Physician<br>*Also applies to services rendered at Retail Health Clinics | $30 copay<br>$60 copay | Plan pays 70% after deductible |
| **Urgent Care Facility -**<br>Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit. | $60 copay, and plan pays 100% | $60 copay, and plan pays 100% |
| **Maternity Physician Services**<br>Office visits in addition to global maternity fee<br>All subsequent prenatal visits, postnatal visits and physician's delivery charges | $30 copay<br>Plan pays 100% | Plan pays 70% after deductible |
| **Urgent Virtual Care Services**<br>Dedicated Virtual Providers may deliver services that are payable under other benefits,(e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician).<br>Lab services supporting a virtual visit must be obtained through dedicated labs.<br>Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video and secure internet-based technologies. | $5 copay, and plan pays 100% | Not covered |
| **Allergy Treatment/Injections and Allergy Serum**<br>Allergy serum dispensed by the physician in the office<br>**Note:** Office copay does not apply if only the allergy serum is provided | $30 copay (PCP)<br>$60 copay (Specialist) | Plan pays 70% after deductible |
| **Outpatient Therapy Services** | | |
| Annual Limits:<br>• Speech Therapy - 20 days<br>• Occupational Therapy and Physical Therapy - 20 days<br>• All other therapies - Includes Cognitive Therapy and Pulmonary Rehabilitation - 20 days<br>• Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.<br>**Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum. | $30 copay | Member pays 40%<br>after deductible |
| **Advanced Radiological Imaging (ARI)** | | |
| **Outpatient Facility** | Plan pays 80% | Plan pays 60% after deductible |
| **Physician's Services/Office Visit** | $30 copay (PCP)<br>$60 copay (Specialist) | Plan pays 70% after deductible |

# MEDICAL BENEFIT SUMMARY

| | $1,500 OA POS | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Emergency** | | |
| **Emergency Room Services**<br>• Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.<br>• Per visit copay is waived if admitted. | $150 copay, and plan pays 80% | $150 copay, and plan pays 80% |
| **Outpatient** | | |
| **Outpatient Facility Services** | Plan pays 80% after deductible | Plan pays 60% after deductible |
| **Outpatient Surgery at Hospital**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists. | Plan pays 80% after deductible | Plan pays 60% after deductible |
| **Inpatient** | | |
| **Inpatient Hospital Facility Services**<br>**Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs | Plan pays 80% after deductible | Plan pays 60% after deductible |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 80% after deductible | Plan pays 60% after deductible |
| **Inpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists. | Plan pays 80% after deductible | Plan pays 60% after deductible |
| **Other Health Care Facilities / Services** | | |
| **Mental Health and Substance Use Disorder**<br>Inpatient Mental Health<br>Outpatient Mental Health - Physician's Office<br>Outpatient Mental Health - All Other Services<br>Inpatient Substance Use Disorder<br>Outpatient Substance Use Disorder - Physician's Office<br>Outpatient Substance Use Disorder - All Other Services | Plan pays 80% after deductible<br>$30 copay, and plan pays 100% after deductible<br>Plan pays 80% after deductible<br>Plan pays 80% after deductible<br>$30 copay, and plan pays 100% after deductible<br>Plan pays 80% after deductible | Plan pays 60% after deductible<br>Plan pays 70% after deductible<br>Plan pays 60% after deductible<br>Plan pays 60% after deductible<br>Plan pays 70% after deductible<br>Plan pays 60% after deductible |
| **Home Health Care**<br>100-visit benefit period maximum<br>**Note:** Includes outpatient private duty nursing when approved as medically necessary. | Plan pays 100% | Plan pays 70% after deductible |
| **Hospice Care Services**<br>**Inpatient Facilities**<br>**Outpatient Services**<br>**Note:** Includes Bereavement counseling provided as part of a hospice program | Plan pays 100% after deductible | Plan pays 70% after deductible<br>Plan pays 60% after deductible |
| **Durable Medical Equipment** | Plan pays 80% after deductible | Plan pays 60% after deductible |
| **Ambulance Services**<br>Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. | Plan pays 80% after deductible | Plan pays 80% after deductible |

# MEDICAL BENEFIT SUMMARY

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- You can choose to fill your medications in a 30– or 90-day supply at any network pharmacy.
- Specialty medications are used to treat an underlying diseases which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicated "Dispense As Written" DAW).
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

| Prescription Drugs | |
|---|---|
| Individual - $300 / Family - $600 | The Pharmacy plan deductible does not apply to the following: Retail Generic, Home Delivery Generic |
| **Retail Rx Options** | |
| $5 | **Generic** (30 day supply) |
| $45 | **Preferred Brand** (30 day supply) |
| $80 | **Non - Preferred Brand** (30 day supply) |
| 25% coins, up to $300 per script | **Specialty Drugs** (30 day supply) |
| **Home Delivery** | **Home Delivery (Mail Order) RX Options** (Maintenance Drugs Only) |
| $5 | **Generic** (90 day supply) |
| $90 | **Preferred Brand** (90 day supply) |
| $240 | **Non - Preferred Brand** (90 day supply) |

**Pharmacy Clinical Management: Essential**

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition medication and condition counseling.

**Patient Assurance Program**

Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications count toward meeting both your deductible and out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications count toward meeting both your deductible and out-of-pocket maximum.

MDLIVE® for Cigna®

# PRIMARY CARE WITHOUT THE WAIT – OR THE WAITING ROOM.

Routine and preventive care that works for you.

MDLIVE for Cigna now offers virtual primary care. This convenient new option makes it easy for you to connect to a board-certified primary care provider (PCP) for routine care, plus preventive care with wellness screenings – all on a schedule that works for you. You can choose the same doctor for every visit or switch at any time.

## What is Virtual Primary Care?

Virtual Primary Care provides a full suite of primary care services, including preventive wellness screenings and routine care for everyday health needs and chronic conditions.

Virtual Primary Care gives you access to board-certified doctors from almost anywhere via video or phone with evening and weekend appointments available.

## VIRTUAL WELLNESS SCREENINGS

### What is a virtual wellness screening and how much does it cost?

A virtual wellness screening is an appointment with a board-certified doctor offered through MDLIVE for Cigna. Prior to your screening, you will complete a health risk assessment survey and get lab work done at a local LabCorp or Quest facility. Then during your scheduled video or phone visit, your doctor will review your health assessment and lab results with you, including identifying any potential health issues, discussing ways you can improve your health, and suggesting follow-up care, if necessary.

Virtual wellness screenings and the associated lab work are covered at no cost* to you as part of your preventive care benefits through your health plan.

### How long does a virtual wellness screening take?

A virtual wellness screening usually takes about 15 minutes to complete. Appointments are easy to schedule, with convenient scheduling options, including weekends and evenings.

### How do I get started with a virtual wellness screening?

There are two easy ways to schedule an appointment:

| | |
|---|---|
| **1.** | Log in to myCigna, click "Talk to a doctor" |
| **2.** | Call 888-726-3171. MDLVE customer care team is available 24/7/365 to help make your appointment. |

Whichever way you access your account, you will select "Primary Care" from the list of services and follow the prompts to schedule your wellness screening.

### Are lab tests required before my virtual wellness screening?

Yes. This allows for a more thorough discussion when you speak with your doctor. Labs can be completed at conveniently located LabCorp or Quest facilities. Fasting is not mandatory for your lab tests.

### Which lab tests are included in the virtual wellness screening?

Lab tests include a general health panel, lipid panel, and HbA1c test. These tests will help your doctor assess your risk for high cholesterol, diabetes, and other health conditions. In addition, the labs will also take readings on blood pressure, height, weight, and waist circumference.

### Can children under age 18 have a wellness screening?

No. Currently both virtual wellness screenings and routine care visits are only available for adults 18 years of age and older.

### Can my primary care provider access my virtual wellness screening results?

Upon request, your virtual wellness screening results can be shared with your primary care doctors.

### Can the MDLIVE doctor write me a prescription as part of a virtual wellness screening?

Yes. Virtual wellness screenings serve the purpose of education, prevention, and early detection of clinical conditions, and a prescription can be written, if necessary, as determined by your doctor. Your doctor may recommend a follow-up routine care visit as part of your treatment which can be scheduled by following the scheduling instructions above.

### I recently completed my labs for my virtual wellness screening. Is there anything else I need to do?

Once MDLIVE receives your lab work, you will receive a text message informing you that the labs have been received. You will be able to review your lab results in your Lab Folder found in the MDLIVE patient portal and prepare any questions for discussion with your doctor.

## VIRTUAL ROUTINE CARE

### What is virtual routine care and how much does it cost?

Virtual routine care helps you manage chronic conditions and establish a relationship with a Virtual Primary Care Provider (PCP). Your dedicated Virtual PCP will help manage your health and well-being through regular visits, labs, diagnostics, and specialist referrals. During your appointments, your doctor can order ad-hoc labs to measure the success of your treatment plans. Your visit cost will be displayed prior to scheduling your appointment.

### Can I see the same doctor each time?

Yes. You can choose a dedicated MDLIVE Virtual PCP, so the doctor can get to know you and your health concerns. You also have the flexibility to change your provider at any time.

### Is it required to have a Virtual wellness screening before a virtual routine care visit?

No. A virtual wellness screening is not required but is recommended.

### I have been diagnosed with a chronic condition in the past. Can I see an MDLIVE Virtual Primary Care provider?

Yes. MDLIVE Virtual PCPs can help you manage new and existing chronic conditions.

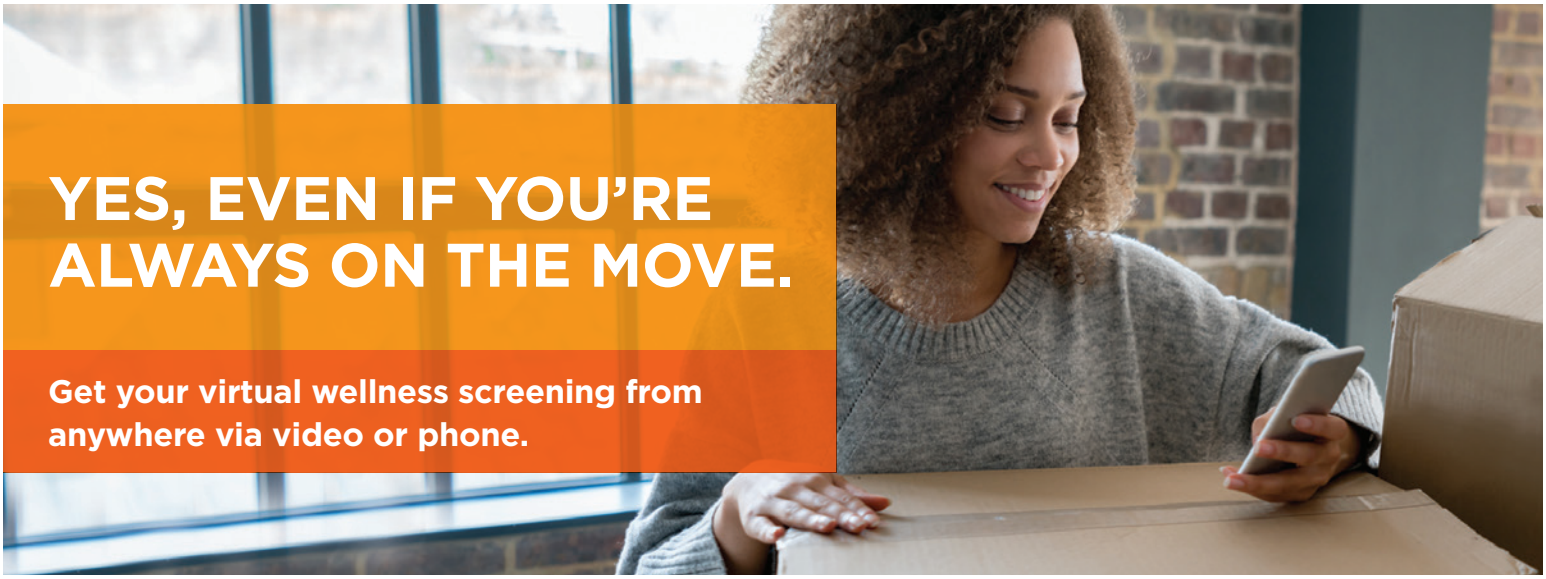
### I have used telehealth for urgent care before. How is routine care different?

Routine care is appropriate for a wide range of non-urgent health needs that you would typically address with an in-person PCP visit, including medication refills and more complicated health needs like diagnosing and managing chronic conditions, such as diabetes, high blood pressure, cholesterol issues, thyroid conditions, asthma, and COPD.

### Can children have a routine care visit?

No. Currently both routine care visits and virtual wellness screenings are only available for adults 18 years of age and older.

*For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.



# YES, EVEN IF YOU'RE ALWAYS ON THE MOVE.

**Get your virtual wellness screening from anywhere via video or phone.**

You're busy. So, chances are, you may not be taking the time to get your preventive check-up. But, what if it could take you less time than you think? With virtual wellness screenings[1] through MDLIVE, it can. Simply make your appointment online and go for a quick visit to a lab for your blood work and biometrics. The rest is completed online and via video or phone, wherever it's most convenient for you. You'll receive a summary of your screening results for your records.

## Key benefits of virtual wellness screenings.

| | |
|---|---|
| **Convenient** | Have your appointment from your phone, tablet or computer – wherever life takes you, with no travel or waiting. |
| **Flexible** | Get an appointment during the day, evening or weekend. |
| **Informative** | Enjoy a more focused and informative visit, since lab work and biometrics are required to be completed and shared with your MDLIVE provider beforehand. |
| **Preventive** | Proactively identify health issues such as diabetes, high cholesterol and other risk factors before they become serious and costly. You can also request to have your virtual wellness screening results shared with your primary care provider. |

### Affordable.

Virtual wellness screenings and the associated labs for your visit are covered at **no additional cost** to you, as part of your preventive care benefits through your health plan.[2]

**Together, all the way.®**

Cigna®

**Offered by: Cigna Health and Life Insurance Company or its affiliates**

# How virtual wellness screenings work, step-by-step.

| | |
|---|---|
| **STEP 1** | Complete your MDLIVE online health assessment. |
| **STEP 2** | Choose an in-network lab and schedule an appointment.[3] |
| **STEP 3** | Choose an MDLIVE provider and schedule your virtual visit. |
| **STEP 4** | Go to your lab appointment. You'll receive a notification when the results are available in the MDLIVE customer portal. |
| **STEP 5** | Attend your virtual visit from anywhere via video or phone. After your visit, you'll receive a summary of your screening results for your records. |

## At the lab, before your virtual visit.

**A technician will conduct:**

- Lab work, including blood count, as well as metabolic, thyroid, lipid/cholesterol and diabetic testing.
- Biometric screenings, including blood pressure, height, weight, BMI and waist circumference.[4]

## During your virtual visit.

**Your provider will:**

- Discuss any allergies and medications.
- Review your medical and family history.
- Explain any risk factors and treatment options based on lab work and biometric screenings.
- Guide you through appropriate next steps for care if health issues are identified.
- Discuss your emotional and psychological well-being.

## Get started with your virtual wellness screening now.

**Go to myCigna.com, and click on the "Talk to a doctor" callout.**

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas or under all plan types. A primary care provider referral is not required for this service. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations.
2. Not applicable to exempt plans with cost share. See your plan documents for details.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Biometric screening experience may vary by lab.

# DENTAL BENEFIT SUMMARY

| BENEFITS | IN-NETWORK | OUT-of-NETWORK |
|---|---|---|
| **Calendar year Maximum**<br>Class I, II and III, IX Expenses | $1,500 | $1,500 |
| **Calendar Year Deductible**<br>• Per Individual<br>• Per Family | $50<br>$150 | $50<br>$150 |
| **Class I Expenses - Preventive & Diagnostic Care**<br>• Oral Exams<br>• Non-routine X-Rays<br>• Routine Cleaning<br>• Routine X-Rays<br>• Fluoride Application<br>• Sealants<br>• Perio Cleaning/Maintenance | 100%<br>No Deductible | 100%<br>No Deductible |
| **Class II Expenses - Basic Restorative Care**<br>• Fillings<br>• Emergency Care to Relieve Pain<br>• Oral Surgery, Simple Extractions<br>• Minor Periodontics<br>• Root Canal Therapy / Endodontics<br>• Major Periodontics<br>• Anesthetics<br>• Oral Surgery, All Except Simple Extractions<br>• Surgical Extraction of Impacted Teeth<br>• Space Maintainers (limited to non-orthodontic treatment) | 80%<br>After Deductible | 80%<br>After Deductible |
| **Class III Expenses - Major Restorative Care**<br>• Crowns / Inlays / Onlays<br>• Implants<br>• Dentures<br>• Bridges<br>• Relines, Rebases and Adjustments<br>• Repairs, Bridges Crowns and Inlays<br>• Repairs - Dentures | 50%<br>After Deductible | 50%<br>After Deductible |
| **Class IV Expenses - Orthodontia**<br>• Coverage for eligible children only<br>• Lifetime Maximum | 50%, No Ortho Deductible<br>$1,000 | 50%, No Ortho Deductible<br>$1,000 |
| **Class IX Expenses –Implants** | 50% After Deductible $1500 | 50% After Deductible $1500 |
| **Dental Plan Reimbursement Levels** | Based on Contracted Fees | 90th Percentile of Allowed Charges |
| **Additional Member Responsibility in excess of Coinsurance** | None | The difference between the member's dentist billed charges and the dental plan reimbursement |

# EMPLOYEE DENTAL DEDUCTIONS—Per Pay Check

**Semi-Monthly (24 / year)**

| MEMBERS COVERED | EMPLOYEE COST |
|---|---|
| **Employee Only** | **$ 0.00** |
| **Employee + One Dependent** | **$12.48** |
| **Employee + 2 or More Dependents** | **$24.95** |

DAVISVISION SEE LIFE

# VISION BENEFIT SUMMARY

| DESIGNER NETWORK BENEFITS INCLUDE |
|---|
| **EXAMINATION**<br>One eye examination, including dilation, when professionally indicated, every July 1 covered at 100% after a $10.00 copayment. |
| **FRAME AND SPECTACLE LENSES**<br>One pair of spectacle lenses every calendar year, an eyeglass frame every other July 1; you may choose a frame from the Davis Vision "Designer Collection" (a $175.00 retail value) covered at 100% after a $10.00 copayment; or a $130 CREDIT plus a 20% discount on any overages toward a network provider's frame. In addition, many lens types and coatings (all ranges of prescriptions and sizes, glass or plastic, oversize lenses, fashion and gradient tinting, glass grey prescription sunglasses, scratch-resistant coating and polycarbonate lenses for dependent children, etc.) ARE INCLUDED while others are offered at significantly discounted prices. An Ultra Progressive Lens Option will have a $140 copayment. |
| **CONTACT LENSES** (in lieu of eyeglasses)<br>Standard soft, daily-wear; disposable or planned replacement contact lenses covered at 100% including the contact lens fitting/evaluation fees from the Davis Vision contact lens Formulary every July 1 after a $10.00 copayment; or a $130 CREDIT plus a 15% discount on any overage toward contact lenses from a network provider's own supply (which may or may not apply toward fitting/evaluation fees). |
| **OUT OF NETWORK COVERAGE**<br>Reimbursement up to the plan maximums for an eye examination and eyewear. |

**DISCOVER THE VALUE……WITH THE DAVIS VISION BENEFIT***

| | AVERAGE RETAIL COST | YOU PAY | YOU SAVE |
|---|---|---|---|
| **Examination (including dilation)** | $75 | $10 | $65 |
| **Eyewear (Frame and bifocal lenses)** | $100-$175 | $10 | $90-$165 |
| **Tints** | $20 | $0 | $20 |
| **Warranty** | $75 | $0 | $75 |
| **Total** | $270-$345 | $20 | $250-$275 |

*Savings based on in-network usage

**USING THE BENEFIT IS AS EASY AS...**

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Davis Vision plan participant.
- Provide the office with the member's ID number and the name and date of birth of any covered children needing services.

The provider's office will verify your eligibility for services, and no claim forms are required.

**CONVENIENT ACCESS TO PROVIDERS**

Our licensed providers are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please call 1-800-999-5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you or you may access our website at www.davisvision.com and utilize our "Find a Doctor" feature.

**OUT-OF-NETWORK BENEFITS**

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

VISION CARE PROCESSING UNIT
P.O. BOX 1525
LATHAM, NY 12110

You will be reimbursed up to $40 for an eye examination, up to $40 for frames, up to $40 for single vision lenses, up to $60 for bifocals, up to $90 for trifocals, up to $100 for lenticular lenses, up to $90 for elective contact lenses, or up to $225 for medically necessary contact lenses.

**FOR MORE INFORMATION**

Please visit the open enrollment section of Davis Vision's website: www.davisvision.com and enter client control code 2321 or call 1-800-999-5431 with questions. Davis Vision Member Service Representatives are available:
Monday -- Friday, 8 am to 11 pm
Saturday, 9 am to 4 pm
Sunday, 12 pm to 4 pm
EASTERN TIME
Participants who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling 1.800.523.2847.

# EMPLOYEE VISION DEDUCTIONS—Per Pay Check

**Semi-Monthly (24 / year)**

| MEMBERS COVERED | EMPLOYEE COST |
|---|---|
| **Employee Only** | **$0.00** |
| **Employee + One Dependent** | **$2.66** |
| **Employee + Two or More Dependents** | **$5.98** |

# BASIC TERM LIFE and AD&D INSURANCE

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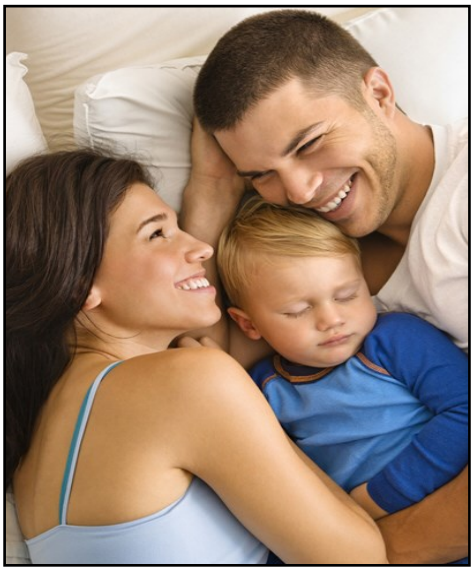

The death of a family provider can mean that a family will not only find itself facing the loss of a loved one, but also the loss of financial security. With our Group Term Life plan, an employee can achieve peace of mind by giving their family the security they can depend on.

**ELIGIBILITY**

All Active Full Time Employees, all Spalding County elected officials and employees of the Spalding County Development Authority in active employment in the United States with the Employer.

**BENEFIT**

1.5 times annual salary to a maximum of $225,000.

**CONTRIBUTION**

**Spalding County pays 100% of the cost for your coverage.**

Employee coverage in excess of $50,000 will result in taxation of benefit exceeding $50,000.

**ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)**

Group Accidental Death & Dismemberment (AD&D) is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is 24-hour coverage.

AD&D benefits include Seat Belt Rider, Airbag Rider, Education, Repatriation benefit, Line of Duty and common carrier.

| AD&D SCHEDULE OF LOSS* | SUM PRINCIPAL |
|---|---|
| Loss of Life | 100% |
| Loss of Both Hands or Both Feet | 100% |
| Loss of One Hand and One Foot | 100% |
| Loss of Speech and Hearing | 100% |
| Loss of Sight of Both Eyes | 100% |
| Loss of One Hand and the Sight of One Eye | 100% |
| Loss of One Foot and the Sight of One Eye | 100% |
| Loss of Sight of One Eye | 50% |
| Loss of One Hand or One Foot | 50% |
| Loss of Speech of Hearing | 50% |
| Loss of Thumb and Index Finger of Same Hand | 25% |

**ACCELERATED DEATH BENEFIT (ADB)**

Upon the employee's request, this benefit pays a lump sum up to 75% of the employee's Life insurance, if diagnosed with a terminal illness and has a life expectancy of 12 months or less. Minimum: $7,500. The amount of group term life insurance otherwise payable upon the employee's death will be reduced by the ADB.

**AGE REDUCTION SCHEDULE**

Life and AD&D benefits reduce to 65% of the original amount at age 70 and to 50% of original amount at age 75. All benefits terminate at end of employment with the County.

**Actively at Work**

Your life insurance policy will terminate if you have not been ACTIVELY AT WORK within the last **six months**. To continue coverage you must elect a portability or conversion option within 30 days of your coverage terminating.

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# SUPPLEMENTAL TERM LIFE INSURANCE

## LIFE INSURANCE AMOUNT

**Employee:** Increments of $10,000 to a maximum of $500,000. Not to exceed seven times annual salary.

**Spouse:** Increments of $5,000 to a maximum of $100,000. Not to exceed 100% of employee's elected amount. Your spouse is not eligible or considered a dependent if they are insured under the Policy as an employee.

**Child:** $10,000. Children are eligible from age 15 days until they reach 26 years

## GUARANTEED ISSUE AMOUNT

**Employee:** **$100,000**
**Spouse:** **$ 30,000**
**Child:** **$ 10,000**

## BENEFIT REDUCTION SCHEDULE

Benefit reduces to 65% of original amount at age 70 and to 50% of original amount at age 75.

## WAIVER OF PREMIUM (IF DISABLED)

If you become totally disabled under age 60 and meet other eligibility requirements, Life insurance coverage may continue under the Waiver provision without premium payments until Age 65.

## Actively at Work:

Your life insurance policy will terminate if you have not been ACTIVELY AT WORK within the last **six months**. To continue coverage you must elect a portability or conversion option within 30 days of you coverage terminating.

| | EMPLOYEE LIFE OPTIONS | | | | SEMI-MONTHLY DEDUCTIONS (24 / Year) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **AGE** | **<30** | **30-34** | **35-39** | **40-44** | **45-49** | **50-54** | **55-59** | **60-64** | **65-69** | **70-74** |
| **$10,000** | $0.35 | $0.40 | $0.60 | $0.90 | $1.45 | $2.45 | $3.95 | $5.25 | $8.30 | $14.50 |
| **$20,000** | $0.70 | $0.80 | $1.20 | $1.80 | $2.90 | $4.90 | $7.90 | $10.50 | $16.60 | $29.00 |
| **$30,000** | $1.05 | $1.20 | $1.80 | $2.70 | $4.35 | $7.35 | $11.85 | $15.75 | $24.90 | $43.50 |
| **$40,000** | $1.40 | $1.60 | $2.40 | $3.60 | $5.80 | $9.80 | $15.80 | $21.00 | $33.20 | $58.00 |
| **$50,000** | $1.75 | $2.00 | $3.00 | $4.50 | $7.25 | $12.25 | $19.75 | $26.25 | $41.50 | $72.50 |
| **$60,000** | $2.10 | $2.40 | $3.60 | $5.40 | $8.70 | $14.70 | $23.70 | $31.50 | $49.80 | $87.00 |
| **$70,000** | $2.45 | $2.80 | $4.20 | $6.30 | $10.15 | $17.15 | $27.65 | $36.75 | $58.10 | $101.50 |
| **$80,000** | $2.80 | $3.20 | $4.80 | $7.20 | $11.60 | $19.60 | $31.60 | $42.00 | $66.40 | $116.00 |
| **$90,000** | $3.15 | $3.60 | $5.40 | $8.10 | $13.05 | $22.05 | $35.55 | $47.25 | $74.70 | $130.50 |
| **$100,000** | $3.50 | $4.00 | $6.00 | $9.00 | $14.50 | $24.50 | $39.50 | $52.50 | $83.00 | $145.00 |
| **$110,000** | $3.85 | $4.40 | $6.60 | $9.90 | $15.95 | $26.95 | $43.45 | $57.75 | $91.30 | $159.50 |
| **$120,000** | $4.20 | $4.80 | $7.20 | $10.80 | $17.40 | $29.40 | $47.40 | $63.00 | $99.60 | $174.00 |
| **$130,000** | $4.55 | $5.20 | $7.80 | $11.70 | $18.85 | $31.85 | $51.35 | $68.25 | $107.90 | $188.50 |
| **$140,000** | $4.90 | $5.60 | $8.40 | $12.60 | $20.30 | $34.30 | $55.30 | $73.50 | $116.20 | $203.00 |
| **$150,000** | $5.25 | $6.00 | $9.00 | $13.50 | $21.75 | $36.75 | $59.25 | $78.75 | $124.50 | $217.50 |
| **$200,000** | $7.00 | $8.00 | $12.00 | $18.00 | $29.00 | $49.00 | $79.00 | $105.00 | $166.00 | $290.00 |
| **$300,000** | $10.50 | $12.00 | $18.00 | $27.00 | $43.50 | $73.50 | $118.50 | $157.50 | $249.00 | $435.00 |
| **$400,000** | $14.00 | $16.00 | $24.00 | $36.00 | $58.00 | $98.00 | $158.00 | $210.00 | $332.00 | $580.00 |
| **$500,000** | $17.50 | $20.00 | $30.00 | $45.00 | $72.50 | $122.50 | $197.50 | $262.50 | $415.00 | $725.00 |

| | SPOUSE LIFE OPTIONS | | | | SEMI-MONTHLY DEDUCTIONS (24 / Year) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **AGE** | **<30** | **30-34** | **35-39** | **40-44** | **45-49** | **50-54** | **55-59** | **60-64** | **65-69** | **70-74** |
| **$5,000** | $0.18 | $0.20 | $0.30 | $0.45 | $0.73 | $1.23 | $1.98 | $2.63 | $4.15 | $7.25 |
| **$10,000** | $0.35 | $0.40 | $0.60 | $0.90 | $1.45 | $2.45 | $3.95 | $5.25 | $8.30 | $14.50 |
| **$15,000** | $0.53 | $0.60 | $0.90 | $1.35 | $2.18 | $3.68 | $5.93 | $7.88 | $12.45 | $21.75 |
| **$20,000** | $0.70 | $0.80 | $1.20 | $1.80 | $2.90 | $4.90 | $7.90 | $10.50 | $16.60 | $29.00 |
| **$25,000** | $0.88 | $1.00 | $1.50 | $2.25 | $3.63 | $6.13 | $9.88 | $13.13 | $20.75 | $36.25 |
| **$30,000** | $1.05 | $1.20 | $1.80 | $2.70 | $4.35 | $7.35 | $11.85 | $15.75 | $24.90 | $43.50 |
| **$35,000** | $1.23 | $1.40 | $2.10 | $3.15 | $5.08 | $8.58 | $13.83 | $18.38 | $29.05 | $50.75 |
| **$40,000** | $1.40 | $1.60 | $2.40 | $3.60 | $5.80 | $9.80 | $15.80 | $21.00 | $33.20 | $58.00 |
| **$45,000** | $1.58 | $1.80 | $2.70 | $4.05 | $6.53 | $11.03 | $17.78 | $23.63 | $37.35 | $65.25 |
| **$50,000** | $1.75 | $2.00 | $3.00 | $4.50 | $7.25 | $12.25 | $19.75 | $26.25 | $41.50 | $72.50 |
| **$60,000** | $2.10 | $2.40 | $3.60 | $5.40 | $8.70 | $14.70 | $23.70 | $31.50 | $49.80 | $87.00 |
| **$70,000** | $2.45 | $2.80 | $4.20 | $6.30 | $10.15 | $17.15 | $27.65 | $36.75 | $58.10 | $101.50 |
| **$75,000** | $2.63 | $3.00 | $4.50 | $6.75 | $10.88 | $18.38 | $29.63 | $39.38 | $62.25 | $108.75 |
| **$80,000** | $2.80 | $3.20 | $4.80 | $7.20 | $11.60 | $19.60 | $31.60 | $42.00 | $66.40 | $116.00 |
| **$90,000** | $3.15 | $3.60 | $5.40 | $8.10 | $13.05 | $22.05 | $35.55 | $47.25 | $74.70 | $130.50 |
| **$100,000** | $3.50 | $4.00 | $6.00 | $9.00 | $14.50 | $24.50 | $39.50 | $52.50 | $83.00 | $145.00 |

| DEPENDENT CHILD(REN) LIFE RATE |
|---|
| **$10,000** Life Insurance Semi-Monthly Cost = $0.35 |

# VOLUNTARY SHORT TERM DISABILITY

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Below is a description of the Voluntary Short-Term Disability insurance coverage underwritten by Anthem Life. The summary highlights some of the features of the Policy, but it is not intended to be a detailed description of coverage. Certificates, which will be available at the Human Resources Department, include the full text of the definitions, exclusions, limitations, reductions and terminating events that apply to the Policy. The Master Policy contains all the controlling terms and provisions of coverage.

**SHORT TERM DISABILITY** insurance is designed to provide income protection in the form of a fixed monthly benefit during periods of disability occurring as a result of a covered accident or sickness. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

**ELIGIBILITY:** All Active Full-Time Employees working 30 hours or more per week

**BENEFITS: Plan replaces 60%** of your Basic Weekly Earnings **up to a maximum weekly benefit of $1,060.**

**BENEFIT WAITING PERIOD: 15 Day(s)** for Accident; **15 Day(s)** for Sickness

**MAXIMUM BENEFIT PERIOD: 24 Weeks**

**Maternity coverage same as any other disability.**

**Occupational benefits are excluded**.

**Pre-existing conditions limitation:** *Are benefits limited for Pre-existing Conditions?*
We will not pay any benefit, or any increase in benefits for a disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time you become disabled:

You have not received Medical Care for the condition for 3 consecutive months while insured under The Policy; or
You have been continuously covered under The Policy for 12 consecutive months

**Other income benefits:** Any income you received from your employer as a result of any accumulated sick time salary continuation or paid time off, which causes the weekly benefit, plus other income benefits to exceed 100% of your weekly earnings. The amount in excess of 100% of your weekly earnings will be used to reduce the weekly benefit.

# HOW TO CALCULATE YOUR INDIVIDUAL PREMIUM

To calculate your per-paycheck cost for this coverage, complete the calculations below.

**Note:** *If your weekly salary exceeds $1,767 use **$1,767** as your weekly salary in the calculation.*

_____ (Annual Salary) ÷ 52 = _____ (Weekly Salary) X 60% = _____ (**Your Weekly Benefit**)

_____ (Your Weekly Benefit) ÷ 10 = _____ X _____ (**Your Rate***) = _____ (**Your Monthly Cost**)

_____ (Your Monthly Cost) X 12 = _____ (Annual Cost) ÷ _____ (# Paychecks per Year) = _____ (**Cost per Paycheck****)

| *RATES BASED ON AGE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Under 25** | **25 - 29** | **30 - 34** | **35 - 39** | **40 - 44** | **45 - 49** | **50 - 54** | **55 - 59** | **60 +** |
| **$0.60** | **$0.634** | **$0.826** | **$0.676** | **$0.617** | **$0.742** | **$0.934** | **$1.084** | **$1.251** |

**Final cost may vary slightly due to rounding

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# VOLUNTARY LONG TERM DISABILITY

Your Long Term Disability Benefits help to protect You from loss of income due to a Disability as defined under the Policy. Your Long Term Disability Benefits are subject to any limitations, maximums, exclusions and reductions under the policy, including any reductions by Your Deductible Sources of Income. This page provides highlights only. The Long Term Disability Insurance Certificate will contain complete details of benefits, policy provisions, limitations, etc. Long Term Disability coverage is non-occupational. This means there is no coverage for any Injury or Illness that was caused by or aggravated by any employment for pay or profit.

**ELIGIBILITY**
All Active Full Time Employees working 30 hours a week, all Spalding County elected officials and employees of the Spalding County Development Authority in active employment in the United States with the Employer.

**BENEFIT PERCENTAGE**
**60% of Basic Monthly Earnings**.
Gross monthly rate of earnings from the employer excluding overtime pay, commissions & bonuses.

**BENEFIT WAITING PERIOD**
**180 days**

**MAXIMUM MONTHLY BENEFIT**
$6,000 per month

**MINIMUM MONTHLY BENEFIT**
Greater of $100 or 10% of the gross Monthly Benefit

**MAXIMUM BENEFIT PERIOD**
For as long as you remain disabled, or until you reach your Social Security Normal Retirement Age

**Guaranteed Issue**
Coverage is Guaranteed Issue at initial offering only.

**Pre-existing Condition Limitation (6/6/12):**
This limitation applies to conditions for which an employee receives medical services within 6 months of the effective date of coverage. No benefits are payable for a disability resulting from such a condition until the employee has been covered for 6 consecutive months with no medical care for the condition, or until the employee has been covered for 12 consecutive months. In addition, the amount of a benefit increase, which results from a change in benefit options, a change of class or a change in the Plan, will not be paid for any Disability that is due to, contributed to by, or results from a Pre-Existing condition.

# HOW TO CALCULATE YOUR INDIVIDUAL PREMIUM

To calculate your per-paycheck cost for this coverage, complete the calculations below.

_____ ÷ 100 = _____ X _____ = _____
Annual Salary — **AGE RATE** (Use Table Below) — Annual Cost

_____ ÷ 24 = _____
Annual Cost — # Paychecks per Year — **Cost per Paycheck***

| AGE RATES | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Under 25** | **25-29** | **30-34** | **35-39** | **40-44** | **45-49** | **50-54** | **55-59** | **60 +** |
| **$0.144** | **$0.153** | **$0.342** | **$0.468** | **$0.576** | **$0.891** | **$1.269** | **$1.548** | **$1.296** |

# HEALTH CARE / DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA/DCA)

Through a Flexible Spending Account (FSA), you are able to set aside money, before it is taxed, in order to pay for eligible out-of-pocket costs for dependent and medical care expenses.

***Spalding County's FSA expense reporting period is July 1, 2022 through June 30, 2023.***

**There are two types of Flexible Spending Accounts:**

- Healthcare FSA
- Dependent Care FSA

## Healthcare Flexible Spending Account (FSA)

Set aside money in a Healthcare Flexible Spending Account for medical, dental and vision expenses incurred by you, your spouse and your dependents. Eligible expenses include deductibles, co-payments, prescription drugs, x-rays and lab.

**FSA Annual Minimum Election:** $240 ($10.00 / 24 deductions per year)

**FSA Annual Maximum Election:** $2,850 ($118.75 / 24 deductions per year)

## Dependent Care Flexible Spending Account (DCA)

Through a Dependent Care Flexible Spending Account, you can pay for dependent care expenses when the services allow you to work. (Please note: We can only reimburse you **up to the amount you've contributed to the plan).**

**DCA Annual Maximum Election:**
**$5,000 per family per year**
**$2,500 per employee per year if married and filing separate tax returns**

## Here's how it works:

First, estimate how much money you will spend in the coming year for eligible healthcare and dependent care expenses. Once calculated, the flexible spending account allows you to set aside a portion from your salary each payday. The amount you allocate to your account is taken out of your pay before taxes are calculated and withheld. That means that part of your pay that goes towards flexible spending account is tax-free. When you pay for eligible medical and dependent care expenses during the year, you get reimbursed for them with the money you have set aside in your flexible spending account. Since the money was set aside on a tax-free basis, you've saved the tax dollars you would have paid on earnings spent for medical and dependent care expenses.

### INTERNAL REVENUE SERVICE RESTRICTIONS:

- Participant cannot receive payment from any other source for reimbursement amounts requested – the participant must certify expenses are not reimbursable under any other coverage.
- Participant cannot claim reimbursed expenses for the purpose of income tax.
- Claims cannot be reimbursed until the service is rendered (regardless of when payment is made).
- Cosmetic Procedures are not eligible (i.e. teeth bleaching, weight reduction, hair loss, face lift, etc).
- A healthcare account cannot be used to reimburse dependent care expenses.
- A dependent care reimbursement account cannot be used to reimburse medical expenses.
- Remaining balances, after all reimbursements for plan year have been processed, will be forfeited.

### CHANGING YOUR ELECTION:

- You can change your election once a year during the open enrollment period.
- It is important to know that federal law places restrictions on changing your election at other times during the year. For this reason, if you participate in the program, you are generally not allowed to change or cancel the amount you allocate until the next annual enrollment period.
- The events that might permit you to make a change are:
- Family status changes, including your marriage or divorce, the birth or adoption of a child, or the death of your spouse or dependent.
- Employment status changes, including a change in your spouse's employment status, a change in full-time vs. part-time employment status of either you or your spouse, or an unpaid leave of absence taken by either you or your spouse.

**Note**: Keep in mind that the only requirement is that the change you make must be consistent with the particular event that has occurred.

### CARRY OVER PROVISION

You will be allowed to carry over ALL of your account balance (unused funds) into the next plan year **FOR THIS PLAN YEAR (June 30, 2022).** You will only be allowed to carry **up to $570** for subsequent years as the IRS requires that any unused portion of your account balance above $570 remaining at the end of the year be forfeited. It is important to estimate your expenses carefully. In order to be eligible to carry over any unused FSA amounts, you must continue to stay enrolled in the FSA plan the following year.

### FSA with Debit Card

The FSA with Debit Card option offers customers the ability to use a debit card for all purchases. A Visa® debit card is preloaded with the individual's annual Health Care FSA goal amount. The card is restricted to approximately 30 merchant types, including pharmacies, hospitals and physician offices, that are considered health-care related.

### Direct Claim Submission, Online Reimbursement and Mobile Reimbursement

Customers can directly submit requests for reimbursement to Cigna via myCigna.com, fax or mail. Reimbursement request forms are available on myCigna.com. Separate forms are required for health care and dependent care. Requests may be submitted in any amount and as often as necessary.

# FLEXIBLE SPENDING ACCOUNT ELIGIBLE / INELIGIBLE EXPENSES

| ELIGIBLE EXPENSES | | INELIGIBLE EXPENSES |
|---|---|---|
| **Medical Expenses**<br>• Acupuncture<br>• Alcoholism treatment<br>• Ambulance<br>• Artificial limbs<br>• Autoette/wheelchair<br>• Bandages<br>• Breast reconstruction Surgery (following masectomy from cancer)<br>• Birth control pills<br>• Braille book and magazines<br>• Chiropractor<br>• Christian science Practitioner<br>• Crutches<br>• Diagnostic services<br>• Disabled dependent medical care<br>• Drug addiction treatment<br>• Drugs and medicines<br>• Fertility treatment<br>• Guide dog<br>• Hearing aids<br>• Home care<br>• Hospital services<br>• Laboratory fees<br>• Lead based paint removal<br>• Maternity care & related services<br>• Meals for inpatient<br>• Medical information plan<br>• Medical services (i.e. physician, surgeon, etc.)<br>• Nursing home<br>• Nursing services<br>• Operations | • Organ donor's medical expenses<br>• Osteopath<br>• Oxygen<br>• Prosthesis<br>• Psychoanalysis<br>• Psychologist<br>• Special education<br>• Sterilization<br>• Stop-smoking programs<br>• Surgery<br>• Telephone/television for hearing-impaired<br>• Therapy<br>• Transplants<br>• Transportation for medical care<br>• Vasectomy<br>• Weight-loss program (specific disease diagnosed by doctor)<br>• Wheelchair<br>• Replacement hair lost due to illness<br>• X-ray<br>**Dental expenses**<br>• Artificial teeth<br>• Dental treatment<br>**Eye care expenses**<br>• Eyeglasses<br>• Contact lenses<br>• Prescription sunglasses<br>• Eye examinations<br>• Eye surgery (for example, LASIK)<br>• Optometrist<br>***Please Note:** **Over the Counter Medications are not an eligible expense.** | • Babysitting, childcare, and nursing services for a normal, healthy baby<br>• Controlled substances without a prescription<br>• Cosmetic surgery<br>• Dancing lessons<br>• Diaper services<br>• Electrolysis or hair removal<br>• Funeral expenses<br>• Hair transplant<br>• Health club dues<br>• Health coverage tax credit<br>• Household help<br>• Illegal operations and treatments<br>• Insurance premiums (for example, HMO premiums, Employer sponsored health insurance plan premiums)<br>• Maternity clothes<br>• Medical savings account (MSA)/health saving account (HSA) contributions<br>• Medicare B and D premiums<br>• Nutritional supplements<br>• Over-the-counter medications<br>• Personal use items<br>• Swimming lessons<br>• Teeth whitening<br>• Veterinary fees<br>• Weight-loss program not part of specific disease treatment |

## Direct Claim Submission, Online Reimbursement and Mobile Reimbursement

Customers can directly submit requests for reimbursement to Cigna via myCigna.com, fax or mail. Reimbursement request forms are available on myCigna.com. Separate forms are required for health care and dependent care. Requests may be submitted in any amount and as often as necessary.

Mobile reimbursement request is a feature that allows customers to submit Choice Fund HRA/FSA claims for reimbursement via the myCigna® mobile app in addition to the traditional experience on the myCigna website. The features will allow customers to:

◊ Save inputs as they're entered
◊ Upload photos of receipts
◊ Check status of reimbursement requests

## Digital Health Statements

Customizable online health statements allow customers with Flexible Spending Accounts to build online health statements customizable to their Preferences. The enhanced customizable online health statements allow customers to:

◊ Choose the data they want in their health statement
◊ Choose a date range from anytime within the previous 24 months for their health statement
◊ Download, save and print a health statement as a PDF file

# DEPENDENT CARE ACCOUNT ELIGIBLE / INELIGIBLE EXPENSES

## To be considered qualified, dependents must meet the following criteria:

•Children under the age of 13
•A spouse who is physically or mentally unable to care for him/herself
•Any adult you can claim as a dependent on your tax return that is physically or mentally unable to care for him/herself

| ELIGIBLE EXPENSES | INELIGIBLE EXPENSES |
|---|---|
| • Babysitter inside or outside household<br>• Before and after school or extended day programs<br>• Custodial childcare or eldercare expenses<br>• Day camps<br>• Daycare centers<br>• Household employee whose services include care of a qualifying person<br>• Late pick-up fees<br>• Looking-for-work expenses<br>• Nanny expenses<br>• Preschool/nursery school for pre-kindergarten<br>• Sick-child care center<br>• Summer day camps | • Educational/tuition expenses<br>• Expenses paid to child of participant<br>• Field trip expenses<br>• Food, clothing education or entertainment expenses<br>• Household services<br>• Incidental expenses<br>• Overnight camps<br>• Payments for care while on a leave of absence, or while on maternity, or other medical leave<br>• Payments for care while you are on vacation or due to illness<br>• Payment for services not yet provided<br>• Payments for care where you are not the custodial parent |

AnthemLife

# EMPLOYEE ASSISTANCE PROGRAM (EAP)

Spalding County will be offering an Employee Assistance Program (EAP). The County will be offering the EAP to employees at no cost. The Anthem EAP provides solutions to help you balance work and life through confidential and easily accessible services. The EAP puts convenient resources within your reach, and that helps you – and your household members – stay healthy. EAP services include:

**With Anthem EAP you have access to:**

- **Six free visits, per concern, with a licensed counselor.** If you need further assistance we may be able to help you coordinate with available resources.

- **Assistance with legal and financial concerns.** The EAP offers access to a free legal consultation that may last for up to 30 minutes. Simply call the EAP to request legal services on virtually any issue, including matters related to criminal, civil, estate issues and more.

- **Financial Services.** The EAP offers access to a free telephonic financial consultation on topics that are important to you including bankruptcy, budgeting, taxes, estate planning, home purchases and more. Financial calculators and tools are available on the EAP website as well.

- **ID Recovery.** Specialist are available 24/7 to assess you risk level and then identify steps to resolve potential identity theft. All services are provided free of charge. Our specialist will work with you to restore your financial identity to its pre-theft status.

- **Tobacco Cessation (Online and Coaching).**
  - **Online:** The EAP offers a free 10 session, online training program which will help you learn how to break the tobacco habit.
  - **Coaching:** Tobacco cessation coaching is a free service provided via telephone or through instant Messaging on the EAP website.

- **Child and Elder Care Resources and Information.** You and your household members can get information on child and elder care resources such as day care, in home services, adult day care, support groups and more by contacting the EAP.

- **EAP Website.** www.anthemeap.com provides access to a variety of resources to help you balance the demands of home and work. Log on to the web for articles, guides, interactive tools, self-assessments, financial/legal resource and more.

Contact with BSBSGA EAP is confidential. Our representatives answer calls 24 hours a day, seven days a week. We recommend that you place this letter with your household resources so you'll have our number handy if you ever need it. There are no limitations on how often you can call.

**EAP toll free number: 1-800-865-1044**

**You can also visit our website at:**

**www.anthemeap.com**

**Log in: Spalding County**

# CONTINUATION COVERAGE RIGHTS UNDER COBRA

## SPALDING COUNTY HEALTH PLAN

**Introduction**

You are receiving this notice because you have recently become eligible or will soon become eligible under the **Spalding County** health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

**What is COBRA Continuation Coverage?**

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

**When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice **in writing** to:
**Spalding County, Miles Neville, P.O. Box 1087, Griffin, GA 30224.**

# CONTINUATION COVERAGE RIGHTS UNDER COBRA

**How is COBRA Coverage Provided?**

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

***Disability extension of 18-month period of continuation coverage***

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

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

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

**If You Have Questions**

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

**Keep Your Plan Informed of Address Changes**

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

**Plan Contact Information**

Information about the plan and COBRA continuation coverage can be obtained on request from:

**Spalding County**
**Miles Neville**
**P.O. Box 1087**
**Griffin, GA 30224**
**Phone: 770-467-4221**

# BENEFIT ELECTIONS and COSTS

**You may use this form to record your benefit elections and costs**

| Type of Benefit | Benefit Plan | Coverage Level / Covered Amount | Employee Cost | Employer Cost |
|---|---|---|---|---|
| **Medical** | | | | |
| **Dental** | | | | |
| **Vision** | | | | |
| **Basic Term Life and AD&D Insurance** | Enrolled | | | |
| **Supplemental Term Life and AD&D Insurance** | | | | |
| **Spousal Term Life and AD&D Insurance** | | | | |
| **Dependent Life Insurance** | | | | |
| **Short Term Disability** | | | | |
| **Long Term Disability** | | | | |
| **Flexible Spending Account (FSA)** | | | | |
| **Dependent Care Flexible Spending Account (DCA)** | | | | |
| | | **Total Per Pay Cost:** | | |
| | | **Total Annual Cost:** | | |

# NOTES

# IMPORTANT CONTACT INFORMATION

**SPALDING COUNTY**
Kryia Williams
Tel: 770-467-4231
**www.spaldingcounty.com**

**MEDICAL PLANS**
Cigna
Tel: **1 (800) 244-6224**

**DENTAL PLAN**
Cigna
Tel: **1 (800) 244-6224**

**VISION PLAN**
Davis Vision
Tel: 800-999-5431
**www.davisvision.com**
control code: 2321

**MSI BENEFITS GROUP, INC.**
Administrative Contact
Tel: 770-425-1231
Fax: 770-425-4722
**Email: helpme@msibg.com**
**www.msibg.com**

**To view copies of all certificates of coverage and plan documents go to:**
**www.msibg.com**

Click on "Employee" at the top right of the page

Username: **spaldingEE**
Password: **Benefits123**

**LIFE INSURANCE**
Anthem Life
Tel: 800-851-8544
**www.anthem.com**

**SHORT / LONG TERM DISABILITY**
Anthem Life
STD - Tel: 800-232-0113
LTD - Tel: 800-851-8544
**www.anthem.com**

**FLEXIBLE SPENDING ACCOUNT (FSA)**
**DEPENDENT CARE ACCOUNT (DCA)**
Cigna
Tel: **1 (800) 244-6224**

*Presented to you by MSI Benefits Group*

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