

Employee Benefits Guide

Plan Year July 1, 2026 – June 30, 2027

Spalding
Everything you need in Spalding



Enroll online at:
spaldingcounty.zevobenefits.com
Then follow on-screen instructions

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This guide 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 the guide 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 understand the benefit options available to you. If you are already covered by any of the benefit plans, you may refer to this guide throughout the year as you use your benefits. This guide also provides information regarding COBRA right and responsibilities.



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 guide 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
District 2
(Vice Chairman)



Reginald Watts
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.

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 elections 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.

Enroll Online (*Open Enrollment Only*)

How do I enroll online?

Simply follow the instructions below to confirm your new benefit elections...

Go to: spaldingcounty.zevobenefits.com

The link will take you to the login page.

- If you are a returning user, click “Log In” in the top-right corner of the screen.
- If you are enrolling for the first time, click “Get Started Now” on the middle of the page to create an account. You will then see the screen below:

The screenshot shows a web form titled "Please confirm your account". It contains four input fields: "Email address", "Password", "Last four digits of your SSN", and "Date of Birth". To the right of the "Password" field is a "Confirm password" field. A blue "Create Account" button is positioned below the "Date of Birth" field. At the bottom of the form, there is a link that says "Click here if you are having trouble confirming your account".

This will prompt you to enter an email address, the last 4 digits of your SSN and your birthdate. You will then create a password to be used for future access.

If you have issues getting logged in to the system, please call MSI Benefits Group at **770-425-1231** or 1-800-580-1629, Monday through Friday, 8:00 am – 5:00 pm.

Note: Passwords are reset Monday through Friday, 8:00 am – 5:00 pm.

Spalding County offers a 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.**

	\$1,500 OA Plus
In-Network	
Individual Calendar Year Deductible	\$1,500
Family Calendar Year Deductible	\$3,000
Co-Insurance	Member pays 20% / Plan pays 80%
Individual Benefit Period Out-of-Pocket (includes deductible)	\$6,900
Family Benefit Period Out-of-Pocket (includes deductible)	\$13,800
Lifetime Maximum	Unlimited
Preventive Care	\$0
Urgent Virtual Care Services	
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% / Plan pays 60%
Individual Out-of-Pocket	\$23,700
Family Out-of-Pocket	\$47,400
Prescription Drugs (Through Veracity)	
RX Deductible (Does not apply to generic drugs)	Single: \$300 / Family: \$600
RX Out of Pocket Max	Single: \$1,000 / Family: \$2,000
Generic	Select Pharmacies: \$5 Non-Select Pharmacies: \$20
Preferred Brands	\$45
Non-Preferred Brands	\$80
90-day prescriptions Select Pharmacies Only*	Preferred Generic: \$10 Name Brand: \$90 Non-Preferred: \$160

**Non-Select Pharmacies include CVS, Target, Walgreen’s, and Rite-Aid. All other pharmacies are considered Select.*

Employee Medical Deductions – Per Paycheck Semi-Monthly (24 / Year)	
Members Covered	\$1,500 OA POS
Employee Only	\$30.83
Employee + 1 Dependent	\$202.80
Employee + 2 or More Dependents	\$240.00



		\$1,500 OA POS	
		In-Network	Out-of-Network
Covered Services			
Benefit Period Deductible	Employee Family	\$1,500 \$3,000	\$3,000 \$6,000
Coinsurance		Member pays 20% Plan pays 80%	Member pays 40% Plan pays 60%
Benefit Period Out-of-Pocket Maximum (Includes benefit period deductible)	Employee Family	\$6,900 \$13,800	\$12,000 \$24,000
*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 (preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits)		Member pays 0% no plan deductible	Birth through age 5 PCP: Plan pays 70% after deductible Specialist: Plan pays 70% after deductible Age 6 and older PCP: Plan pays 70% after deductible Specialist: Plan pays 70% after deductible
Well-child care, immunizations Periodic health examinations Annual gynecology examinations Prostate Screenings			
Physician Services			
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures and office surgery)			
Primary Care Physician (PCP)*		\$30 copay	Plan pays 70% after deductible
Specialist Physician *Also applies to services rendered at Retail Health Clinics		\$60 copay	
Urgent Care Facility - 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 - Office visits in addition to global maternity fee. All subsequent prenatal visits, postnatal visits and physician's delivery charges		\$30 copay Plan pays 100%	Plan pays 70% after deductible
Urgent Virtual Care Services - Dedicated Virtual Providers may deliver services that are payable under other benefits, (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician). Lab services supporting a virtual visit must be obtained through dedicated labs. 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 - Allergy serum dispensed by the physician in the office. Note: Office copay does not apply if only the allergy serum is provided		\$30 copay (PCP) \$60 copay (Specialist)	Plan pays 70% after deductible
Outpatient Therapy Services			
Annual Limits: • Speech Therapy - 20 days • Occupational Therapy and Physical Therapy - 20 days • All other therapies - Includes Cognitive Therapy and Pulmonary • Rehabilitation - 20 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.		\$30 copay	Member pays 40% after deductible
Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.			
Advanced Radiological Imaging (ARI)			
Outpatient Facility		Plan pays 80% after deductible	Plan pays 60% after deductible
Physician's Services/Office Visit		\$30 copay (PCP) \$60 copay (Specialist)	Plan pays 70% after deductible

	\$1,500 OA POS	
	In-Network	Out-of-Network
Emergency		
Emergency Room Services Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. 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 For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists.	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient		
Inpatient Hospital Facility Services 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 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		
Inpatient Mental Health	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Mental Health - Physician’s Office	\$30 copay, and plan pays 100% after deductible	Plan pays 70% after deductible
Outpatient Mental Health - All Other Services	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Substance Use Disorder	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Substance Use Disorder - Physician’s Office	\$30 copay, and plan pays 100% after deductible	Plan pays 70% after deductible
Outpatient Substance Use Disorder - All Other Services	Plan pays 80% after deductible	Plan pays 60% after deductible
Home Health Care 100-visit benefit period maximum Note: Includes outpatient private duty nursing when approved as medically necessary.	Plan pays 100%	Plan pays 70% after deductible
Hospice Care Services		
Inpatient Facilities		
Outpatient Services Note: Includes Bereavement counseling provided as part of a hospice program	Plan pays 100% after deductible	Plan pays 70% after deductible Plan pays 70% after deductible
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 60% after deductible
Ambulance Services 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



Your Pharmacy Plan

Our pharmacy coverage copays are as follows:

RX Deductible (Does not apply to generic drugs)	Single: \$300 / Family: \$600
RX Out of Pocket Max	Single: \$1,000 / Family: \$2,000
Generic	Select Pharmacies: \$5 Non-Select Pharmacies: \$20
Preferred Brands	\$45
Non-Preferred Brands	\$80
90-day prescriptions Select Pharmacies Only*	Preferred Generic: \$10 Name Brand: \$90 Non-Preferred: \$160

*Non-Select Pharmacies include CVS, Target, Walgreen's, and Rite-Aid. All other pharmacies are considered Select.

Note: FDA Approved Weight Loss Medications available through the OneVeracity Personal Importation Program will be covered on a trial-basis only and subject to Prior Authorization approval

As your Pharmacy Benefits partner, OneVeracity handles all claims and customer service functions including Specialty and International pharmacy fulfillment.

Why Veracity? As you probably know, prescription drug costs are unpredictable, and costs are rapidly rising each year. The goal is having your best interests in mind by providing the best coverage at an affordable rate. OneVeracity is here to help make each step of your healthcare experience easier.

How to Connect

- You can reach OneVeracity 24 hours a day, 7 days a week – they're always available to take your call, even on holidays. Contact OneVeracity if you need to:
 - Locate a network pharmacy
 - Understand your pharmacy benefit
 - Get prior authorization information
- Call 888-388-8228

Member Portal Access and Benefits Management

- Register for your member portal access on or after July 1 and after you receive your ID card.
 - Register at: <https://veracity.procarerx.com/account/login>
- Use your online account to:
 - Access and/or restrict profile viewing by other family members
 - Review your prescription claims history or individual prescriptions
 - Look up a drug to identify formulary status and preferred alternatives
 - Locate pharmacies within a zip code, state, city, or county



Prescription Coverage Overview

OneVeracity

A few ways our Pharmacy program strives to save members money.

Go Generic and Save

When you choose the generic prescription versus the brand name Rx, you can save on your member cost/copay. For example, when you purchase the drug store brand of “ibuprofen” instead of the name brand “Motrin”, you still receive the same pain relief without the expensive label.

Avoid High-Cost Pharmacies

- **The following pharmacies are considered Non-Select** and will require a \$20 copay for generic drugs: CVS, Target, Walgreen’s, and Rite-Aid. You will pay a higher copay if you go to one of them.
- **Select Pharmacies:** All independent pharmacies and grocery stores are considered Select and will require only a \$5 copay.

Get your 90-day prescription filled right at your favorite Select pharmacy

You can elect to get a 90-day fill using your local Select pharmacy. Please note that this benefit is not available at the non-Select pharmacies listed above.

Use the Pharmacist Advocate Concierge for:

- **Specialty Medications**

When you are prescribed a Specialty Drug, or if you are currently on a Specialty Drug, OneVeracity will contact you to find out how we can help obtain your prescription at \$0 or Minimal Cost. If you are currently on a specialty drug, you can get started in the meantime by going to www.oneveracity.com and complete the “Enrollment Form” located at the top of the page with your information. Once completed, a OneVeracity pharmacist concierge will be in touch. If you don’t enroll in the program, you will pay 100% of the cost.

- **Personal Importation Medications (formerly known as International Medications)**

Medications that can be obtained internationally (from Canada) must also be acquired through the OneVeracity Pharmacist Concierge program. When the medications are obtained this way, the cost to you is \$0 Copay. You may still continue to fill these medications at your local retail pharmacy until you’re enrolled into the program. A OneVeracity Pharmacist Concierge will be in touch to confirm enrollment. For more information on the process and to see which drugs are considered an international type of medication, see additional information within the packet. If you don’t enroll in the program, you will pay 50% of the cost.

Note: Some drugs require a pre-authorization. Even if you have obtained a pre-authorization before, you may need to obtain a new one as pre-authorizations do expire.



Member Quick Reference Guide

Pharmacy Benefit Provider

OneVeracity

Phone: 888-388-8228

When to Call:

- To locate a pharmacy
- To ask a benefit question
- To get information on prior authorizations
- To get help when you are at the pharmacy and a drug is denied

90-Day Prescriptions

Maintenance Drugs

At Retail:

Select Pharmacies Only

Specialty Medications

High-Cost Drugs

Enroll at www.oneveracity.com and a OneVeracity Pharmacist Concierge will be in touch

Retail Pharmacy Network

Select Pharmacies

Advantages:

Lower Copays on Generic Prescriptions

Which are Select?

Grocery stores such as Kroger, Publix, Costco, Winn-Dixie and locally-owned neighborhood pharmacies. *Basically any pharmacy EXCEPT those that are non-Select.*

Non-Select Pharmacies

Disadvantages:

Higher Copays on Generic Prescriptions

Which are Non-Select?

CVS, Walgreens, Rite-Aid, and Target

If you have questions regarding your plan benefits, please contact OneVeracity at 888-388-8228



Specialty Medications OneVeracity Program

How to enroll in the program

1	Please check the list below of commonly prescribed specialty drugs .
2	If you or a covered member of your household are on any of the drugs listed or any other specialty medication, please start by going to www.oneveracity.com and complete the “ Enrollment Form ”
3	Be on the look out for an email from a OneVeracity Specialty Team member with next steps.
4	Complete the patient assistance application included in the email and return with any additional required documentation (i.e., 1 st two pages of your most recent 1040).

Commonly Prescribed Specialty Medications*	
Actemra	Ingrezza
Acthar	Jynarque
Adempas	Kuvan
Afinitor	Lenvima
Amjevita	Olumiant
Aubagio	Opsumit
Cosentyx	Orgovyx
Dupixent	Rebif
Envarsus XR	Rydapt
Epidiolex	Stelara
Firazyr	Taltz
Gilenya	Tobi Podhaler
Haegarda	Vumerity
Humira (biosimilars)	Zelboraf
Humira CF (biosimilars)	Zenpep
Ilaris	

**List is only a sample of the top specialty drugs and is subject to change without notice. Additional specialty drugs can be pursued beyond this list.*



Personal Importation Medications OneVeracity Program

How to enroll in the program

1	Please check the list below of commonly prescribed medications that can be sourced internationally .
2	If you or a covered member of your household are on any of the drugs listed, please start by going to www.oneveracity.com and completing the “ Enrollment Form ”.
3	Be on the look out for an email from a OneVeracity Personal Importation Team member with next steps.
4	Contact your healthcare provider to have a new prescription sent into our pharmacy partner. <i>Instructions will be included in email on how to send in new prescription.</i>

Commonly Prescribed Personal Importation Medications*

Anoro Ellipta	Imbruvica	Rexulti
Apidra	Invokamet	Rinvoq
Apidra Solostar	Isentress	Skyrizi
Arnuity Ellipta	Janumet	Silenor
Atripla	Janumet XR	Spiriva Respimat
Basaglar Kwikpen	Januvia	Tafinlar
Biktarvy	Jardiance	Tagrisso
Breo Ellipta	Juluca	Tivicay
Brilinta	Kesimpta	Toujeo Solostar
Cabometyx	Mekinist	Tradjenta
Cimzia	Myrbetriq	Trelegy Ellipta
Combivent Respimat	Omnaris	Tremfya
Descovy	Orencia	Trintellix
Dulera	Otezla	Trulicity
Eliquis	Ozempic	Victoza
Enbrel	Prezcobix	Xarelto
Entresto	Promacta	Xeljanz
Farxiga	Pulmozyne	
Fiasp	Qvar	

*List is only a sample of the top personal importations drugs and is subject to change without notice. Additional personal importation drugs can be pursued beyond this list.



HAVE YOUR ID CARD HANDY?

With myCigna, the answer is always “yes.”



Big news: You never have to worry about misplacing your ID card. It's always right there on myCigna®, whenever and wherever you need it.*

Accessing your digital ID cards is easy.



Log in to **myCigna.com** or the **myCigna App**



ID Cards

Click or tap “ID Cards”



View your card(s), as well as any dependents' card(s)**



Email cards directly to doctors



Save your digital ID cards in your Apple Wallet



Not registered on myCigna yet? It's quick and easy.

Visit **myCigna.com**® or scan the QR code to download the **myCigna App**® and register now.



Offered by Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

TIPS TO HELP YOU SAVE MONEY

Save on prescription drugs	Know where to go for care	Choose the right provider	Be proactive about your health
<ul style="list-style-type: none"> Find the complete list of covered medications on myCigna.com Use the Price a Medication tool on myCigna to compare prices and purchase mail-order prescriptions⁴ Use generics when possible Know what brand-name medications are covered in your plan Ask your doctor about a 90-day supply for your maintenance medication(s) through our home delivery pharmacy service⁵ 	<ul style="list-style-type: none"> Use an emergency room for true emergencies Don't wait: Locate an in-network convenience care clinic, sometimes found within a grocery store, or urgent care center near you, before you need it For minor medical conditions, connect with a board-certified doctor via video or phone when, where and how it works best for you. Visit myCigna.com, or call MDLIVE at 888.726.3171 to talk with a doctor 24/7.³ Don't be fooled: Some emergency rooms look like urgent care centers, so know what type of facilities are in your area 	<ul style="list-style-type: none"> Know which providers are in your network by going to myCigna.com > Find Care & Costs Choose providers who have received the Cigna Care Designation – high-performance recognition given to physicians in certain specialties who meet Cigna Healthcare quality and medical cost-efficiency standards⁶ Opt to connect with a board-certified doctor, therapist or psychiatrist via video or phone³ Use in-network national labs to help save money 	<ul style="list-style-type: none"> Get information on the cost of medications and treatments to avoid surprises Use your preventive care benefits, learn your core health numbers (blood pressure, cholesterol and blood glucose), and make use of the health improvement tools at myCigna.com

Find your way to better health.

Get more information on all the programs that are available to you.



When your plan year begins, register on **myCigna.com**.



Call the 24/7 customer service number on your ID card.



Download the **myCigna App**.⁶



1. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com. 2. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days but usually within 24 hours. 3. Cigna Healthcare provides access to virtual care through participating in-network providers. Not all providers have virtual capabilities. Cigna Healthcare also provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. All health care providers are solely responsible for the treatment provided to their patients; providers are not agents of Cigna Healthcare. Refer to plan documents for complete description of virtual care services and costs. 4. Not all preventive care services are covered, and different plans may cover different things. For example, immunizations for travel are usually not covered. See your plan materials for a complete list of covered preventive care services. 5. Internal unique provider data as of November 2022. Subject to change. 6. The program and services are provided by an independent company/entity and not by Cigna Healthcare. Program and services are subject to all applicable program terms and conditions. Program availability is subject to change. Not available to insured clients situated in NY and NJ. 7. The downloading and use of any mobile App is subject to the terms and conditions of the App and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply. 8. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information. 9. For legacy clients that have a non-zero preventive care benefit, customers' preventive benefit will be applied when receiving a virtual wellness screening. 10. As allowable by law. For medications administered by a health care provider, Accredo will ship the medication directly to your doctor's office. 11. You'll see your first order in the myCigna App or website once Accredo ships it. 12. Standard shipping costs are included as part of your prescription plan. 13. The ability to refill prescriptions by text is only available for certain medications. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, simply reply to their welcome text to get started. Standard text messaging rates apply. 14. Prices shown on myCigna are not a guarantee. Coverage falls under your plan terms and conditions. Visit myCigna for more information. 15. Not all plans offer coverage for 90-day prescriptions. 16. Patient experience, quality designations, cost-efficiency and other ratings found in Cigna Healthcare's online provider directories are a partial assessment of quality and should not be the only basis for decision-making (as such measures have a risk of error). They are not a guarantee of the quality of care that will be provided to individual patients. Individuals are encouraged to consider all relevant factors and talk with their physician about selecting a health care facility. Providers are solely responsible for any treatment provided and are not agents of Cigna Healthcare.

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. For costs and details of coverage, contact a Cigna Healthcare representative.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Express Scripts, Inc., or their affiliates.

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care¹ from MDLIVE.[®]



It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE[®]

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost² to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities³

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology⁴

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours



3 easy steps to connect to care

Virtual care visits are convenient and easy.
To schedule an appointment:



Access MDLIVE by logging into myCigna.com and clicking on “Talk to a doctor.” You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)



Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE



Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.



Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®



1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost \$0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, or its affiliates. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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**MRI CT Ultrasound X-ray Bone Density
Nuclear Medicine PET Imaging**

Know the Costs® (KTC) is a radiology benefit service that allows you to obtain certain outpatient radiology imaging at **No Cost** to you.

How to Use Your Benefit

- If your doctor orders imaging, be sure to tell them you have the KTC radiology benefit and you want to use your benefit.
- Contact KTC before scheduling an imaging appointment to ensure you schedule with a KTC facility or to locate a participating KTC facility.
- Don't present your health insurance card, only your KTC card with KTC Policy number.
- When completing registration paperwork, list KTC as your primary insurance.
- If the imaging provider bills your insurance, we may be unable to reverse the filing.

How to Reach us:

- **KnowTheCosts.com**, under the "Contact" tab. Questions submitted using the online contact form will be responded to same business day, unless requests are made after hours. Those requests will be returned the following day.
- By phone at 833-KTC-4YOU



Call Know the Costs® BEFORE Scheduling Outpatient Imaging

Nothing is more important than your family.

Learn the **who, what, why & how** of your **Life Advisor EAP!**



WHO CAN USE THE EAP?

Spouses, live-in significant others, & dependents through the age of 26.



WHAT IS THE EAP BENEFIT? ★

The EAP is **convenient, easy to access, 100% confidential and free of cost for:** Counseling, life coaching, 24/7/365 crisis line, work-life resources, legal/financial consultations, online portal ► [LifeAdvisor.com](https://www.lifeadvisor.com)

21+%

21.4% of U.S. adults have experienced a mood disorder at some point in their lives.

Families & couples who have attended therapy sessions = high levels of patient satisfaction.



14+%

14.3% of adolescents have experienced some type of mood disorder.

After working with a marriage/family therapist, 93% had more effective problem solving tools.

93%

WHY IS THIS IMPORTANT? ♥

TO ADDRESS: Anxiety, Depression, Stress, Anger, Substance Abuse & Non-Substance Use Addictions, Domestic Violence, Couples and Family Counseling, Motivational Coaching, Parenting & Co-Parenting, Caring for Aging Parents, Grief & Loss, Work Issues, Legal & Financial Concerns—**AND MORE!**

How can I use the EAP?

Anyone who has the benefit—employee or family members, can contact us.

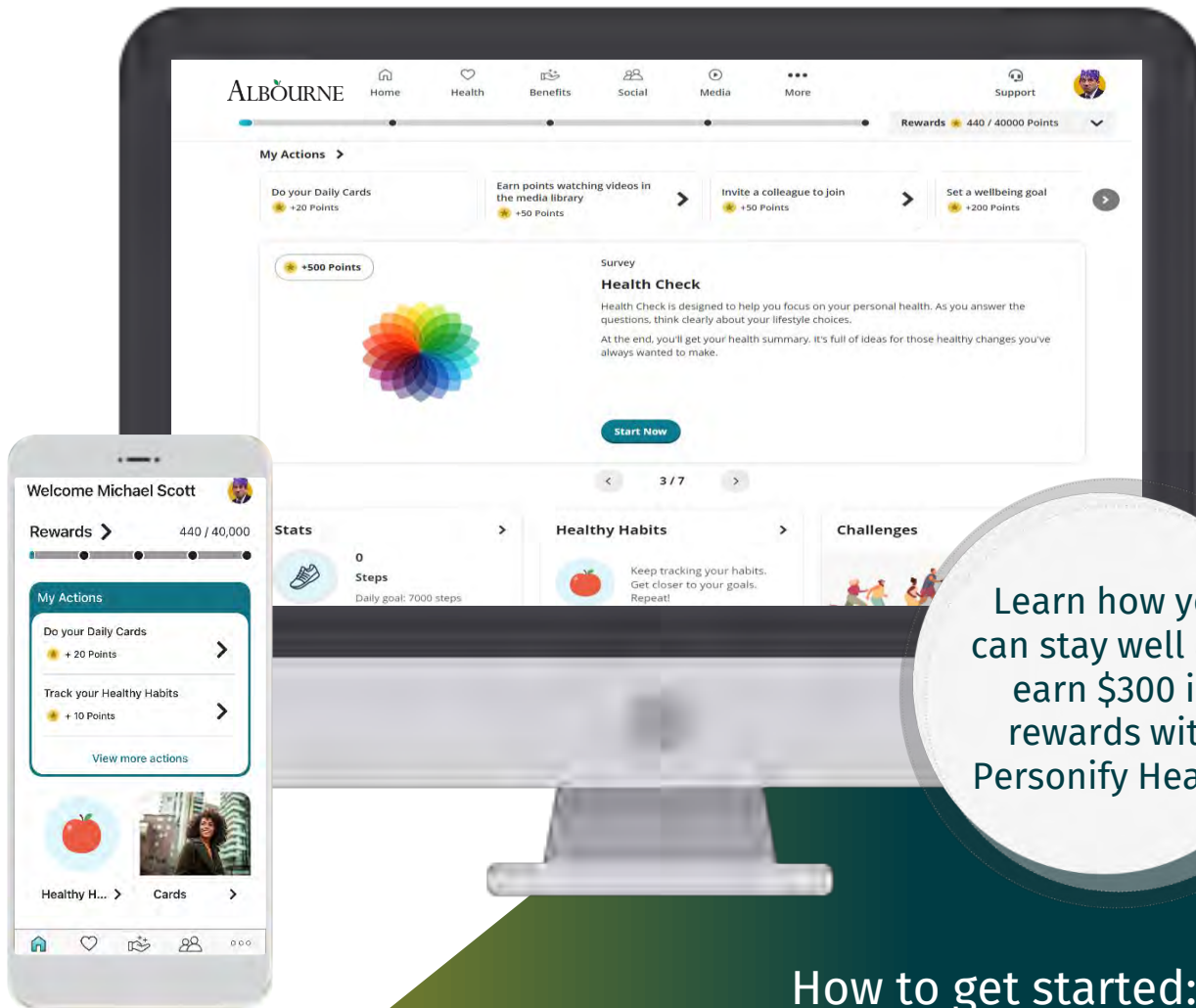
The employee does not have to be present: **CALL US ► 800.448.8326**

Provide the **company name & site location** where the person with the EAP benefit works.

Call us for **confidential, professional—problem solving services!**

IT'S YOUR TIME TO THRIVE.

The Personify Health wellbeing program gives you the tools to get active, get healthy, and get rewarded.



Learn how you can stay well and earn \$300 in rewards with Personify Health!

How to get started:

- ➔ Register for your Personify account at join.personifyhealth.com/spaldingcounty
- ➔ **Download the Personify mobile app** for iOS and Android. Plus, the first time you log in you'll earn bonus points!
- ➔ **Connect an activity tracker** to get credit for your steps, active minutes, and sleep. We sync with many devices and apps (Max Go, Fitbit, Apple Health, S Health, etc.)
- ➔ **Upload a profile picture and add friends.**
- ➔ **Set your interests** to get personalized daily tips to help you eat healthy, get active, reduce stress, sleep well, and more.

Your Rewards

It's easy to earn points by making healthy decisions. You'll have the opportunity to earn up to \$300 Rewards Cash this year by participating in the program, earning points, and achieving levels! Here is how your points will translate into rewards:



Earn up to \$300 Rewards Cash per year!

	Level 1	Level 2	Level 3	Level 4
POINTS	6,000	20,000	45,000	68,000
REWARDS	\$25 Rewards Cash	\$75 Rewards Cash	\$100 Rewards Cash	\$100 Rewards Cash

How to Earn Points

go to your Reward page to see all of the ways to earn points

Activity

Upload steps from your activity tracker (Max Go, Fitbit, Apple Health, S Health, Google Fit, etc.)

DAILY	(up to 140 Points/day)	Per 1,000 steps	10 Points
		15 or more active minutes	70 Points
		30 or more active minutes	100 Points
		45 or more active minutes	140 Points
MONTHLY		20-Day Triple Tracker (moderate activity)	400 Points
		20-Day Triple Tracker (high activity)	500 Points

Nutrition & Sleep

DAILY	Calorie Tracking	20 Points
	Track sleep manually	10 Points
	Track sleep nightly via a device	20 Points
	Sleep > 7 hours in a night	50 Points

Self Tracking

DAILY	Track your healthy habits (up to 30 Points/Day)	10 Points
MONTHLY	Track healthy habits 10 days in a month	200 Points
	Track healthy habits 20 days in a month	300 Points

Cards

DAILY	Complete daily tip card (2/day)	20 Points
MONTHLY	Complete 10 daily cards in a month	100 Points
	Complete 20 daily cards in a month	200 Points

Challenges

MONTHLY	Create a personal challenge	50 Points
	Join a personal challenge	100 Points
	Join the Company Challenge	100 Points

Journeys

DAILY	Complete a step	15 Points
QUARTERLY	Complete a Journey	250 Points

More!

ONE-TIME	Complete registration	100 Points
	Add a profile picture	100 Points
	Connect activity device	200 Points
	First 5 friends	250 Points
	First login to mobile app	250 Points
YEARLY	Complete the Health Check Survey	500 Points
	Complete the Nicotine Free Agreement	250 Points
	Set a wellbeing goal	200 Points
QUARTERLY	Set interests	100 Points



Sign up now at join.personifyhealth.com/spaldingcounty
 Already a member? Login at login.personifyhealth.com
Questions? Contact Member Services at 888-671-9395





**Earn
250 points
for your first
login to the
mobile app.**

Mobile app

Keep on tracking, no matter where you are.

The fun doesn't stop when you leave work. Keep challenging your coworkers (and yourself) to get healthier, whether you're at home, headed to the gym or between meetings. Our mobile app has all the same great features as the website—and even more convenience.

Download the app to get started



You can sign in with your existing username and password or select **Create Account.**

Have questions? We're here to help.

- Check out zendesk.personifyhealth.com
Live chat: Monday–Friday, 2 am–9 pm ET
- Give us a call: 888-671-9395
Monday–Friday, 8 am–9 pm ET
- Send us an email: support@personifyhealth.com

With the Personify Health app you can:

Get healthy tips

Complete your Daily Cards and explore new ways to eat better and improve your sleep with the Nutrition Guide and Sleep Guide. Try Journeys® to take small steps that lead to healthy habits.

Compete in challenges

Rally your coworkers for the latest company step challenge! Or gather a small group of coworkers or friends, and challenge one another to start a new healthy habit.

Track your progress

- Record your steps and other activities.
- Check your status and milestones.
- Track your Healthy Habits.

Sync your activity

Automatically sync information from another device or app to your Personify Health app—and earn even more!



Don't miss out!

To get the most out of your mobile experience, **go to your phone's settings and turn on notifications** for your Personify Health app.

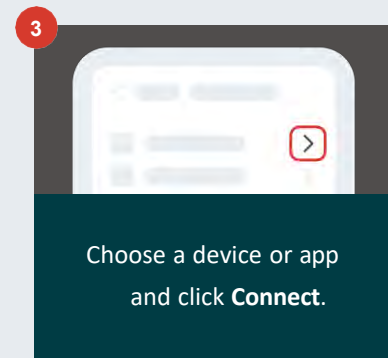
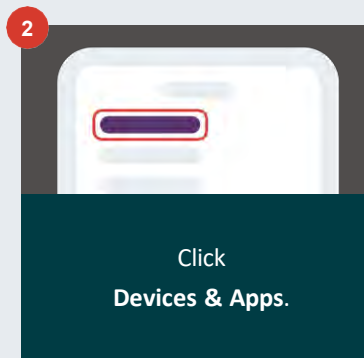
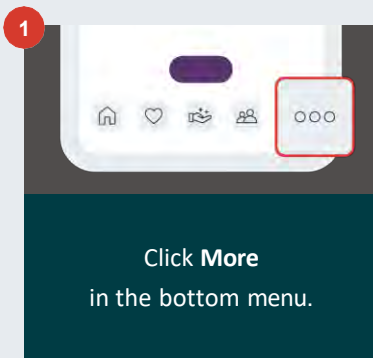
You'll get encouraging reminders and learn about upcoming opportunities like team challenges and more.



Syncing is the simple process of uploading information from an activity tracker to the mobile app, so it's all in one place. **Be sure to sign in to your Personify Health app at least once every 14 days so your data syncs and counts toward your activity goals.**

Connect a device or app

Download the Personify Health app, then follow these easy steps:



Dental Benefits	In-Network	Out-of-Network
Calendar year Maximum Class I, II and III, IX Expenses	\$1,500	\$1,500
Calendar Year Deductible • Per Individual • Per Family	\$50 \$150	\$50 \$150
Class I Expenses - Preventive & Diagnostic Care • Oral Exams • Non-routine X-Rays • Routine Cleaning (4 per year) • Routine X-Rays • Fluoride Application • Sealants • Perio Cleaning/Maintenance	100% No Deductible	100% No Deductible
Class II Expenses - Basic Restorative Care • Fillings • Emergency Care to Relieve Pain • Oral Surgery, Simple Extractions • Minor Periodontics • Root Canal Therapy / Endodontics • Major Periodontics • Anesthetics • Oral Surgery, All Except Simple Extractions • Surgical Extraction of Impacted Teeth • Space Maintainers (limited to non-orthodontic treatment)	80% After Deductible	80% After Deductible
Class III Expenses - Major Restorative Care • Crowns / Inlays / Onlays • Implants • Dentures • Bridges • Relines, Rebases and Adjustments • Repairs, Bridges Crowns and Inlays • Repairs - Dentures	50% After Deductible	50% After Deductible
Class IV Expenses - Orthodontia • Coverage for eligible children only • Lifetime Maximum	50%, No Ortho Deductible \$1,000	50%, No Ortho Deductible \$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 Paycheck Semi-Monthly (24 / Year)	
Members Covered	Employee Cost
Employee Only	\$0.00
Employee + One Dependent	\$14.95
Employee + 2 or More Dependents	\$29.88



Coverage	In-Network Benefit*	Out-of-Network Benefit	Frequency Period**
Exam Copay	\$10 copay	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after copay	Up to \$45	12 months
Eyeglass Lenses Allowances: (once per frequency period)			
• Lenses	\$10 copay		
• Single Vision	Covered 100% after copay	Up to \$32	12 months
• Lined Bifocal	Covered 100% after copay	Up to \$55	12 months
• Lined Trifocal	Covered 100% after copay	Up to \$65	12 months
• Lenticular	Covered 100% after copay	Up to \$80	12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period)			
• Elective	Up to \$130	Up to \$105	12 months
• Therapeutic	Covered 100%	Up to \$210	12 months
Frame Retail Allowance (once per frequency period)	Up to \$130	Up to \$71	24 months

*Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

**Your Frequency Period begins on January 1 (Calendar year basis)

Definitions:

Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).

Coinsurance: the percentage of charges Cigna will pay. You are financially responsible for the balance.

Allowance: the maximum amount Cigna will pay. You are financially responsible for any amount over the allowance.

Materials: eyeglass lenses, frames, and/or contact lenses.

To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders. If you use other discounts and/or promotions instead of this vision coverage or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes*:**

- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
- Polycarbonate lenses for children under 18 years of age
- Oversize lenses
- Rose #1 and #2 solid tints
- Minimum 20% savings on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults) all tints/photochromic (glass or plastic)
- Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;
- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

***Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.

Employee Vision Deductions — Per Paycheck Semi-Monthly (24 / Year)	
Members Covered	Employee Cost
Employee Only	\$0.00
Employee + One Dependent	\$2.81
Employee + 2 or More Dependents	\$6.30



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.



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 your 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

Below is a description of the Voluntary Short-Term Disability insurance coverage underwritten by The Standard. 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. If your weekly salary exceeds \$1,767, then use \$1,767 as your weekly salary in the calculation. **Please note that your final cost may vary slightly due to rounding.**

Annual Salary	÷ 52 =	Weekly Salary	x	60%	=	Your Weekly Benefit
Your Weekly Benefit	÷ 10 =		x	Your Rate (see table)	=	Your Monthly Cost
Your Monthly Cost	x 12 =	Annual Cost	÷	24	=	Cost per Paycheck

Rates Based on Age								
<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



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. Deductible sources of income include any salary continuation, worker’s compensation, social security off-set or employer retirement benefits. 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 (3/6/12): 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. **Please note that your final cost may vary slightly due to rounding.**

$$\begin{array}{rcccl}
 & \div 100 = & & \times & = \\
 \hline
 \text{Annual Salary} & & & \text{Your Rate (see table)} & \text{Annual Cost} \\
 \\
 & \div & 24 & = & \\
 \hline
 \text{Annual Cost} & & \text{Paychecks per Year} & & \text{Cost per Paycheck}
 \end{array}$$

Rates Based on Age								
<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



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 through June 30.



There are two types of Flexible Spending Accounts: Healthcare FSA and 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:** \$3,400 (\$141.67 / 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:

- \$7,500 per family per year
- \$3,750 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 only be allowed to carry up to **\$680** for subsequent years as the IRS requires that any unused portion of your account balance above \$680 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.

Eligible Expenses	Ineligible Expenses
<p>Medical Expenses</p> <ul style="list-style-type: none"> • Acupuncture • Alcoholism treatment • Ambulance • Artificial limbs • Autoette/wheelchair • Bandages • Breast reconstruction Surgery (following masectomy from cancer) • Birth control pills • Braille book and magazines • Chiropractor • Christian science Practitioner • Crutches • Diagnostic services • Disabled dependent medical care • Drug addiction treatment • Drugs and medicines • Fertility treatment • Guide dog • Hearing aids • Home care • Hospital services • Laboratory fees • Lead based paint removal • Maternity care & related services • Meals for inpatient • Medical information plan • Medical services (i.e. physician, surgeon, etc.) • Nursing home • Nursing services • Operations 	<ul style="list-style-type: none"> • Organ donor’s medical expenses • Osteopath • Oxygen • Prosthesis • Psychoanalysis • Psychologist • Special education • Sterilization • Stop-smoking programs • Surgery • Telephone/television for hearing-impaired • Therapy • Transplants • Transportation for medical care • Vasectomy • Weight-loss program (specific disease diagnosed by doctor) • Wheelchair • Replacement hair lost due to illness • X-ray <p>Dental expenses</p> <ul style="list-style-type: none"> • Artificial teeth • Dental treatment <p>Eye care expenses</p> <ul style="list-style-type: none"> • Eyeglasses • Contact lenses • Prescription sunglasses • Eye examinations • Eye surgery (for example, LASIK) • Optometrist <p>*Please Note: Over the Counter Medications are not an eligible expense.</p>

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



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
<ul style="list-style-type: none"> • Babysitter inside or outside household • Before and after school or extended day programs • Custodial childcare or eldercare expenses • Day camps • Daycare centers • Household employee whose services include care of a qualifying person • Late pick-up fees • Looking-for-work expenses • Nanny expenses • Preschool/nursery school for pre-kindergarten • Sick-child care center • Summer day camps 	<ul style="list-style-type: none"> • Educational/tuition expenses • Expenses paid to child of participant • Field trip expenses • Food, clothing education or entertainment expenses • Household services • Incidental expenses • Overnight camps • Payments for care while on a leave of absence, or while on maternity, or other medical leave • Payments for care while you are on vacation or due to illness • Payment for services not yet provided • Payments for care where you are not the custodial parent



Introduction

This notice is being provided because you are offered coverage under a group health plan through the Spalding County. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences a second qualifying event during the initial 18 months of COBRA coverage, your spouse and dependent children may receive up to an additional 18 months - for a maximum of 36 months - provided the Plan is properly notified. This extension applies if the employee dies, becomes entitled to Medicare, divorces or legally separates, or if a dependent child loses eligibility, and only if the second event would have caused a loss of coverage had the first event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information:

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

QR CODE
WILL BE
GENERATED
ONCE GUIDE
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Scan the QR code to
download and save a copy
of this benefits guide.

Contacts

Spalding County

Kyria Williams

Tel: 770-467-4231

www.spaldingcounty.com

Medical Plans

Cigna

Tel: 1 (800) 244-6224

www.cigna.com

Pharmacy Plan

OneVeracity

Tel: 1 (888) 388-8228

www.oneveracity.com

Radiology Savings Program

Know the Costs

Tel: 1 (833) 582-4968

www.knowthecosts.com

Employee Assistance Program (EAP)

Ulliance

Tel: 1 (800) 448-8326

www.LifeAdvisor.com

Dental Plan

Cigna

Tel: 1 (800) 244-6224

www.cigna.com

Vision Plan

Cigna

Tel: 1 (800) 244-6224

www.cigna.com

Life Insurance

The Standard

Tel: 800-628-8600

www.standard.com

Disability Insurance

The Standard

STD Tel: 800-368-2859

LTD Tel: 800-368-1135

www.standard.com

Flexible Spending Accounts

Cigna

Tel: 1 (800) 244-6224

To view copies of all certificates of coverage and Plan documents, go to: www.msibg.com
then click on 'Client Portal' at the top right of the page and enter the login below:

Username: spaldingEE

Password: Benefits123



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