



Employee Benefits Handbook

Plan Year July 1, 2020 thru June 30, 2021

Enroll Online at www.eelect.com

Enrollment ID = **103016**

Then Follow On-Screen Instructions

TABLE OF CONTENTS

Table of Contents, Eligibility and Changes	1
Meet the Walton County Board of Commissioners	2
Medical Benefit Summary	3-5
LiveHealth Online	6-9
Care & Cost Finder	10-12
Dental Benefit Summary	13
Vision Benefit Summary	14-15
Frequently Asked Questions	16
Health Care / Dependent Care Flexible Spending Account (FSA/DCA)	17-19
Group Term Life and AD&D Insurance Summary	20
Supplemental Term Life and AD&D Insurance Summary	21-22
Voluntary Short Term Disability Summary	23
Voluntary Long Term Disability Summary	24
Group Voluntary Accident Insurance Summary	25
Group Voluntary Critical Illness Insurance Summary	26
Employee Assistance Program	27
COBRA Notification / Benefit Elections and Costs / Notes	28-32

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. In the event that 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're 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.

ELIGIBILITY

Eligible Classes of Employees:

1. All Active Employees of the Employer
2. Elected and/or Appointed Officials
3. Retirees (age 62 with 20 years of service at the time of retirement)

Coverage Effective Dates:

Class 1

All Benefits: First day of the month following 30 days of full-time service

Class 2

Health/Vision/Dental: First day employee becomes an elected and/or appointed County Official

All Other Benefits: First day of the month following 30 days of becoming elected and/or appointed County Official

Class 3

Health/Vision/Dental: First day of retirement (applicable on employee only and is effective through the date the employee reaches Medicare eligibility.)

Spouses and Dependent Children:

Spouses and dependent children 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. Dependent children are eligible until the age of 26. All group health plans are now required by law to collect and supply to the Centers for Medicare Services the Social Security Numbers (SSN) of both employees and dependents on coverage. Please remember to bring this information with you to your enrollment.

CHANGES

Pre-Tax Deduction of Premiums (Section 125 Plan) - Medical, dental, vision, short term disability, long term disability, accident insurance and flexible spending account 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) 267-1351 if you have any questions regarding the open enrollment period or changes.

MESSAGE FROM CHAIRMAN LITTLE



To: All Full Time Employees
From: Chairman Little
Subject: Employee Benefits

Walton County appreciates very much the hard work and dedication of all our employees and we recognize that a quality, comprehensive benefits package is a critical component in retaining skilled and seasoned employees as well as recruiting new talent when needed.

This handbook is provided to you as a quick reference tool for information regarding many features of the various benefit plans offered to our employees. You will find answers to many of your benefit questions in this handbook as well as contact information for a variety of resources.

Thank you for all of your hard work!

Kevin Little
Chairman

BOARD OF COMMISSIONERS



Bo Warren
District 1



Mark Banks
District 2



Timmy Shelnutt
District 3



Lee Bradford
District 4



Jeremy Adams
District 5



Kirklyn Dixon
District 6

MEDICAL BENEFIT SUMMARY



Walton County offers medical coverage through Anthem BlueCross BlueShield. The plan includes a \$500 Deductible and is an Open Access POS Plan. "Open Access" means you are not required to name a primary care physician (PCP) nor obtain referrals to visit specialist physicians. The plan does offer an out-of-network benefit; however you receive the best value by staying in-network.

IN-NETWORK		OPEN ACCESS POS
Individual Annual Deductible*		\$500
Family Annual Deductible*		\$1,500
Coinsurance		Member Pays 20% / Plan Pays 80%
Individual Out-of-Pocket Maximum (includes deductible)		\$3,000
Family Out-of-Pocket Maximum (includes deductible)		\$9,000
Primary Care Physician (PCP) Copay		\$25
Specialist Physician Copay		\$50
Preventive Care Services		Member pays 0%
LiveHealth Online		\$0
Urgent Care Copay		\$35
Emergency Room Copay (Waived if admitted)		\$350 then Member Pays 20%
OUT-OF-NETWORK		
Individual Annual Deductible*		\$1,000
Family Annual Deductible*		\$3,000
Coinsurance		Member Pays 40% / Plan Pays 60%
Individual Out-of-Pocket Maximum (includes deductible)		\$9,000
Family Out-of-Pocket Maximum (includes deductible)		\$27,000
PRESCRIPTION DRUG COPAYS**		
Retail Drug - Tier 1a (30 day supply)		\$5
Retail Drug - Tier 1b (30 day supply)		\$20
Retail Drug - Tier 2 (30 day supply)		\$45
Retail Drug - Tier 3 (30 day supply)		\$90
Retail Drug - Tier 4 (Specialty Drugs) (30 day supply)		25% up to \$450 per script
Mail-Order Maintenance Drug - Tier 1a (90 day supply)		\$5
Mail-Order Maintenance Drug - Tier 1b (90 day supply)		\$20
Mail-Order Maintenance Drug - Tier 2 (90 day supply)		\$90
Mail-Order Maintenance Drug - Tier 3 (90 day supply)		\$270
Mail-Order Maintenance Drug - Tier 4 (Specialty Drugs) (30 day supply)		25% up to \$450 per script

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.

** Unless otherwise indicated in the Certificate Booklet, each retail prescription has a 30-day supply limit and each mail order maintenance prescription has a 90-day supply.

EMPLOYEE MEDICAL DEDUCTIONS	
Bi-Weekly (26 deductions per year)	
MEMBERS COVERED	Open Access POS
Employee Only	\$ 30.33
Employee + Spouse	\$ 85.59
Employee + Child(ren)	\$ 78.06
Employee + Spouse & Child(ren)	\$133.32

Finding a Provider

You can search for physicians, other health care professionals and hospitals in your network by using www.anthem.com and following these easy steps: Click on "Menu" then "Find a Doctor". You may login if you are currently registered as an online member or choose to "Search as a Guest". If you choose to search as a guest, select "Through my employer", "Georgia", "Medical" and "Blue Open Access POS". You may search by the name or specialty of the physician. Next, enter either the City and State or zip code and click on the "Search" button. From this screen you may sort the results by distance or alphabetically. Or you may contact Customer Care at 1-855-397-9267.



MEDICAL BENEFIT SUMMARY

	Open Access POS	
	In-Network	Out-of-Network
Covered Services		
Calendar Year Deductible		
Employee	\$500	\$1,000
Family	\$1,500	\$3,000
Coinsurance	Member pays 20% Plan pays 80%	Member pays 40% Plan pays 60%
Calendar Year Out-of-Pocket Maximum		
Employee	\$3,000	\$9,000
Family	\$9,000	\$27,000
<small>(Includes calendar year deductible)</small>		
<small>*Deductibles are combined for in-network and out-of-network services. Out-of-pocket maximums are added separately for in-network and out-of-network services. Maximum of three (3) per family (one for employee, one for spouse and one for all eligible children combined). The following do not apply to out-of-pocket maximums: non-covered items, plan premiums, any balance billing due to Out-of-Network services. The medical copayments on this plan will apply toward the out-of-pocket maximums.</small>		
Lifetime Maximum	Unlimited	Unlimited
Preventive Care		
Routine Preventive Care – All Ages <small>(preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits)</small>		
Well-child care, immunizations Periodic health examinations Annual gynecology examinations Prostate Screenings	Member pays 0%; no plan deductible	Member pays 40% after deductible (Deductible waived through age 5)
Physician Services		
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures)		
Primary Care Physician (PCP)* OB/GYN Specialist Physician <small>*Also applies to services rendered at Retail Health Clinics</small>	\$25 copay \$25 copay \$50 copay	Member pays 40% after deductible
Maternity Physician Services <small>Global obstetrical care (prenatal, delivery, and postpartum services)</small>	\$100 copayment <i>(first office visit only)</i> Benefits are only available to the subscriber and the spouse	Member pays 40% after deductible Benefits are only available to the subscriber and the spouse
Telemedicine Services	\$25 copay (PCP) \$50 copay (Specialist)	Member pays 40% after deductible
TeleHealth Services – LiveHealth Online Physician Visit	\$0 copay	Member pays 40% after deductible
Allergy Services <small>Office visits, testing, and the administration of allergy injections</small>	\$25 copay (PCP) \$50 copay (Specialist)	Member pays 40% after deductible
Allergy injection serum	Included in office visit copayment	
Office Surgery <small>(surgery and administration of general anesthesia)</small>	\$25 copay (PCP) \$50 copay (Specialist)	Member pays 40% after deductible
Therapy Services		
Office Therapy Services <small>Physical therapy and Occupational therapy: 30-visit benefit period maximum combined Speech therapy: 20-visit benefits period maximum Chiropractic Care/Manipulation therapy: 20-visit benefit period maximum</small>	\$15 copay \$50 copay \$15 copay	Member pays 40% after deductible
Other Therapy Services (chemotherapy, radiation therapy, cardiac rehabilitation [There is no Cardiac Rehabilitation visit max on this plan; EBH benchmark plan indicates zero max; authorization required] and respiratory / pulmonary therapy)	Member pays 0% after deductible	Member pays 40% after deductible
Advanced Diagnostic Imaging		
MRI, MRA, CT Scans and PET Scans	Member pays 0% after deductible	Member pays 40% after deductible
Emergency / Urgent Care		
Urgent Care Services	\$35 Copay	\$35 Copay Member pays 40% after copayment deductible
Emergency Room Services <small>Life-threatening illness or serious accidental injury only . The ER copayment will be waived if admitted to the Hospital</small>	Member pays 20% after \$350 Copay	Member pays 20% after \$350 Copay
Non-Emergency Use of Emergency Room	Not Covered	Not Covered

MEDICAL BENEFIT SUMMARY



Open Access POS

	In-Network	Out-of-Network
Outpatient		
Outpatient Facility Services Surgery facility/hospital charges Diagnostic x-ray and lab services Physician services (anesthesiologist, radiologist, pathologist)	Member pays 20% after deductible Member pays 20% after deductible Member pays 0% after deductible	Member pays 40% after deductible
Inpatient		
Inpatient Facility Services Daily room, board and general nursing care at semi-private room rate, ICU/CCU charges; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care Physician services (anesthesiologist, radiologist, pathologist)	Member pays 20% after deductible Member pays 0% after deductible	Member pays 40% after deductible
Other Health Care Facilities / Services		
Skilled Nursing Facility, Sub-Acute Facility • 150-day benefit period maximum	Member pays 0% after deductible	Member pays 40% after deductible
Mental Health/Substance Abuse Services (*services must be authorized by calling 1-800-292-2879) Inpatient mental health and substance abuse services* (facility fee) Inpatient mental health and substance abuse services (physician fee) Partial Hospitalization Program (PHP) and Intensive Outpatient Program(IOP)* (facility and physician fee) Office mental health and substance abuse services (physician fee) Outpatient mental health and substance abuse services (physician fee)	Member pays 20% after deductible Member pays 0% after deductible Member pays 0% after deductible \$25 Copay / \$50 Specialist Copay Member pays 20% after deductible	Member pays 40% after deductible
Home Health Care 100-visit benefit period maximum	Member pays 0% after deductible	Member pays 40% after deductible
Hospice Care Services Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% (no deductible)	Member pays 40% (no deductible)
Durable Medical Equipment <i>Included in this benefit is Hearing Aids for children up to the age of 18. Coverage is for \$3,000 per ear every 48 months.</i>	Member pays 20% after deductible	Member pays 40% after deductible
Ambulance Services (covered when medically necessary)	Member pays 0% (no deductible)	Member pays 0% (no deductible)
Prescription Drugs - Essential Essential Drug Formulary Definition: Your plan limits coverage of prescription drugs to only those listed on our Essential drug list. The Essential drug list includes selected generic and brand name drugs. A list of the drugs that are covered on the Essential drug list is available at https://www.bcbsga.com/pharmacyinformation/ . Current benefit period cost shares (copayments, coinsurance) for pharmacy benefits will apply to the plan out-of-pocket maximums. Retail and Home Delivery maintenance drug coverage is provided at one of four tier levels in accordance with the Formulary Drug List. Members must file a claim form for reimbursement when using an out-of-network pharmacy. Specialty drugs can only be obtained from a Specialty Pharmacy. 90 day supply is available at in network retail pharmacies for 3 copayments. Retail and Home Delivery maintenance drug coverage is provided at one of four tier levels in accordance with the Formulary Drug List. Members must file a claim form for reimbursement when using an out-of-network pharmacy. Specialty drugs can only be obtained from a Specialty Pharmacy.		
Retail Drugs Tier 1a (30 day supply)	\$5 copay	Member pays 40% after deductible
Retail Drugs Tier 1b (30 day supply)	\$20 copay	Member pays 40% after deductible
Retail Drugs Tier 2 (30 day supply)	\$45 copay	Member pays 40% after deductible
Retail Drugs Tier 3 (30 day supply)	\$90 copay	Member pays 40% after deductible
Retail Drugs Tier 4 (Specialty Drugs) (30 day supply)	Member pays 25%, up to \$450 maximum per prescription drug	Member pays 40% after deductible
Home Delivery Maintenance Drugs Tier 1a (90 day supply)	\$5 copay	Not Covered
Home Delivery Maintenance Drugs Tier 1b (90 day supply)	\$20 copay	Not Covered
Home Delivery Maintenance Drugs Tier 2 (90 day supply)	\$90 copay	Not Covered
Home Delivery Maintenance Drugs Tier 3 (90 day supply)	\$270 copay	Not Covered
Home Delivery Maintenance Drugs Tier 4 (Specialty Drugs) (30 day supply)	Member pays 25%, up to \$450 maximum per prescription drug	Not Covered



LiveHealth Online

What you need to know about video visits with a doctor, 24/7

What is LiveHealth Online?

LiveHealth Online lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy.*

Use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, rashes, infections, allergies or another common health condition. It's faster, easier and more convenient than a visit to an urgent care center.

Why would I use LiveHealth Online instead of going to visit my doctor in person?

LiveHealth Online isn't meant to replace your primary care doctor. It's a convenient option for care when your doctor isn't available. LiveHealth Online connects you with a doctor in minutes. Plus, you can get a LiveHealth Online visit summary from the *MyHealth* tab at livehealthonline.com to print, email or fax to your primary care doctor.

LiveHealth Online should not be used for emergency care. If you have a medical emergency, call 911 right away.

When is LiveHealth Online available?

Doctors are available 24/7, 365 days a year.

How does LiveHealth Online work?

When you need to see a doctor, simply go to livehealthonline.com or use the LiveHealth Online mobile app. Pick the state you're in and answer a few questions.

Setting up an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future, share your health history and set up online visits at times that fit your schedule.

Once connected, you can talk with the doctor as if you were in a private exam room.



How much does it cost to use LiveHealth Online?

There is no charge for LiveHealth Online visits.

Is there a LiveHealth Online app that I can download to my smartphone?

Yes, search for “LiveHealth Online” in the App Store® or on Google Play™. To learn what mobile devices are supported and get instructions, go to livehealthonline.com and select **Frequently asked questions** under the *How it works* tab.

What type of computer do I need to use LiveHealth Online?

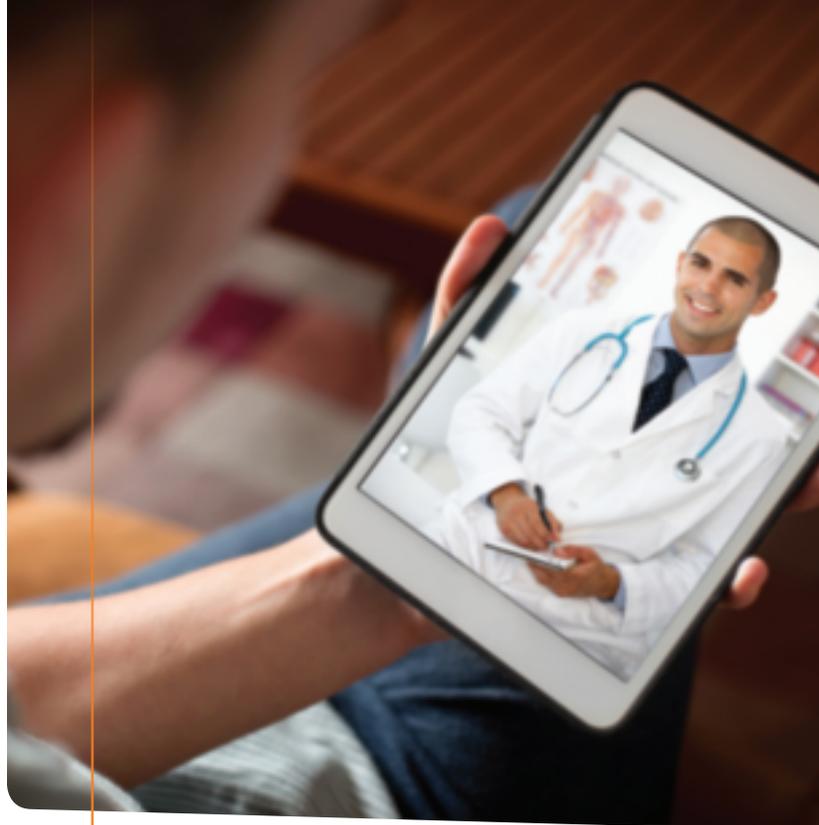
You'll need high-speed Internet access, a webcam or built-in camera with audio. To learn what computer hardware and software you need, go to livehealthonline.com and select **Frequently asked questions** under the *How it works* tab.

Do doctors have access to my health information?

It depends on whether or not you set up an account. With a LiveHealth Online account, you can allow doctors to access and review your health information from past visits. Also, to help keep track of your own health information, you can record it at livehealthonline.com. Once you sign in, go to the *MyHealth* tab and then select **Health Record**.

How long is a LiveHealth Online visit?

A typical LiveHealth Online visit with a doctor lasts about 10 minutes.



Can I get online care from a doctor if I'm traveling or in another state?

Yes, just select the state you're in under **My Location** on livehealthonline.com or with the app, and you'll only see doctors licensed to treat you in that state. Don't forget to change the state back when you get home.

What if I still have questions about using LiveHealth Online?

Send an email to customersupport@livehealthonline.com or call toll free at **1-888-548-3432**.



* Prescription availability is defined by physician judgment and state regulations. Visit the home page of livehealthonline.com to view the service map by state. LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem.

If you're a retiree or have coverage that complements your Medicare benefits, your employer sponsored health plan may not include coverage for online visits using LiveHealth Online. Check your plan documents for details. You can still use LiveHealth Online, but you may have to pay the full cost of a visit. Online visits using LiveHealth Online may not be a covered benefit for HRA and HIA+ members.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc.; HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

LiveHealth Online

Sign up today — so you're ready for a video visit when you need it



Using LiveHealth Online, you can have a private and secure video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer with a webcam. It's an easy way to get the care you need at home or on the go.

When your own doctor isn't available, use LiveHealth Online 24/7 if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or other common health condition. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if it's needed.¹

How to get started

Rather than waiting to sign up when you're not feeling well, register today so you're ready for a visit when you need one. To sign up, visit livehealthonline.com or download the free LiveHealth Online app to your mobile device. Next, you:

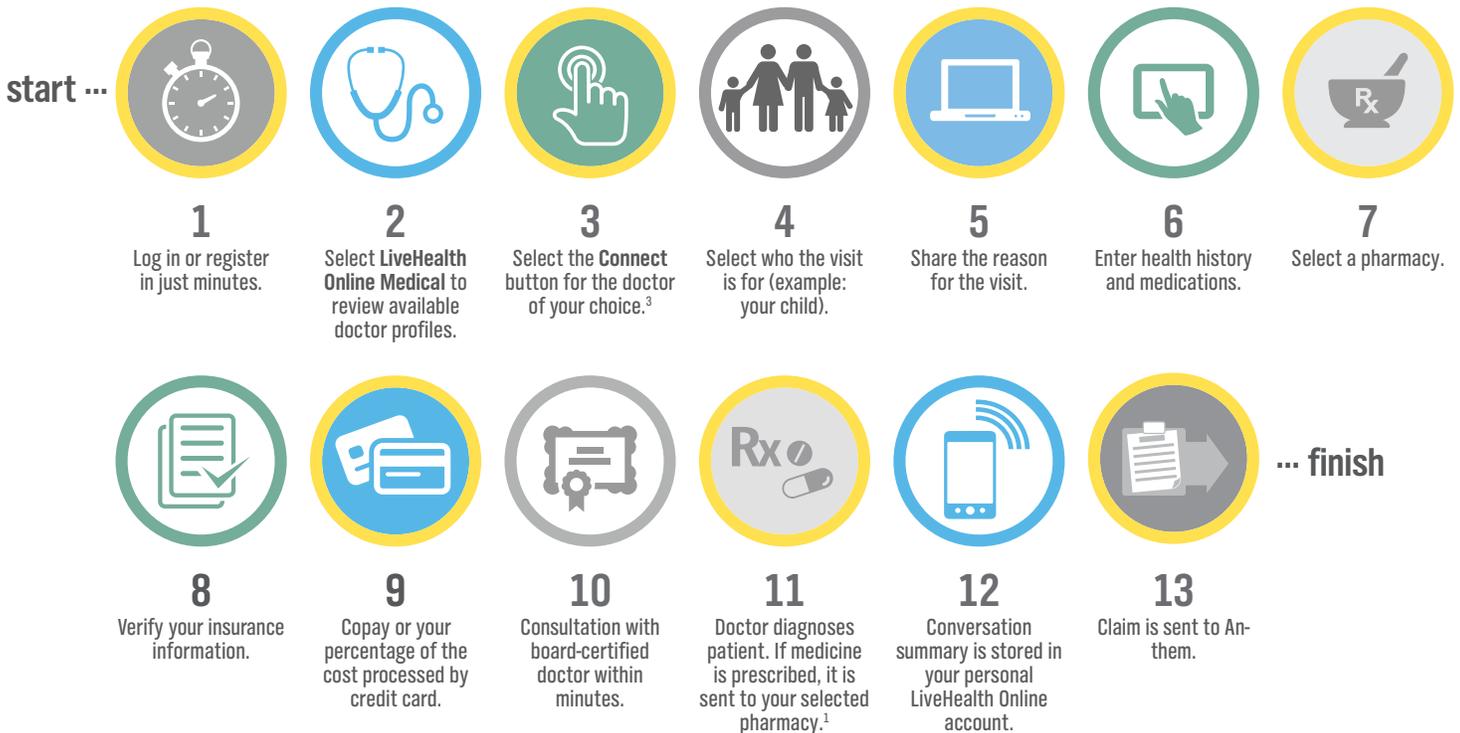
1. Choose **Sign Up** to create your LiveHealth Online account. Then enter information like your name, email address, date of birth and create a secure password.
2. Read the *Terms of Use* and check the box to agree.
3. Choose your location in the drop-down box of states.
4. Enter your birth date and choose your gender.
5. For the question "Do you have insurance?", select **Yes**. Be sure to have your Anthem member ID card handy to complete your insurance information. If you choose **No**, you can still enter your insurance information later.
6. For **Health Plan**, in the drop-down box, select **Anthem**.
7. For **Subscriber ID**, enter your identification number, which is found on your Anthem member ID card. Select **Yes** if you are the primary subscriber or **No** if you are not the primary subscriber.
8. Insert a service key if you have one. If you don't have a service key that's OK, this is optional and not required to register.
9. Select the green **Finish** button.



Your account securely stores your personal and health information

You can be confident knowing you can easily connect with doctors when you need to consult about certain conditions, share your health history, and schedule online visits at times that fit your schedule.

How to use LiveHealth Online for a video visit with a doctor



The steps to set up an appointment with a therapist using **LiveHealth Online Psychology** are very similar to seeing a doctor. You need to select **LiveHealth Online Psychology** to see available therapists and schedule an appointment.

Questions about how to use LiveHealth Online?

Call toll free at **1-888-LiveHealth (548-3432)** or email help@livehealthonline.com. If you send us an email, please include your name, email address and a phone number where we can reach you.

¹ Prescription availability is defined by physician judgment and state regulations. Visit the home page of livehealthonline.com to view the service map by state.

² Appointments subject to availability of a therapist.

³ Select a doctor licensed to practice in the state where you're physically located. If that doctor is seeing another patient, you can choose to go to an online waiting room or you can select another doctor who is available at that moment.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem.

Psychologists or therapists using LiveHealth Online cannot prescribe medications.

Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

If you're a retiree or have coverage that complements your Medicare benefits, your employer sponsored health plan may not include coverage for online visits using LiveHealth Online. Check your plan documents for details. You can still use LiveHealth Online, but you may have to pay the full cost of a visit. Online visits using LiveHealth Online may not be a covered benefit for HRA and HIA+ members.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc.; HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company, Inc. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



Need a doctor – and no surprises?

Use Care & Cost Finder

Life happens. When it does, we've got your back.

There's a lot to think about when you need care. Things like the best place to go and what's covered by your benefits. Care & Cost Finder helps you put an end to the guesswork. Included in this powerful tool is the Personalized Match* sort option. This provides customized search results based on your location, unique profile, and history to help you find the right doctor for you.

Find a doctor, check quality and compare costs all in one place – online or on the go!

You can search for doctors, pharmacies, hospitals and other health care providers in your plan at anthem.com or with the Anthem Anywhere mobile app. You'll get important facts like office location, services provided, gender, languages spoken, patient ratings and if providers have received awards for high-quality care.

Care & Cost Finder includes costs for different kinds of care. You can compare doctors and costs side by side and get an estimate of what you'll pay based on your benefits.

It's easy to find, easy to use – and all in one place.

*Personalized match is not available in Engage: Elite.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

63020MUMENABS VPOD Rev. 09/18



Ready to start using Care & Cost Finder?

Just register or log in to anthem.com today. Use the Anthem Anywhere app to get the same great information when you're on the go.

Be a smart shopper – it pays to compare

Hospital 1		Hospital 2	
Procedures			
\$3,000	Bronchoscopy	\$5,000	
\$300	Chest CT scan	\$1,000	
\$25,000	Hip replacement	\$36,000	
\$25,000	Knee replacement	\$37,000	

Sample cost comparison*

Different doctors and hospitals may charge different amounts for the same service. So shop around using the **Estimate Your Cost** tool to see costs based on your own benefits. You can also compare the quality of different procedures.

Know your costs before you get care

Go to anthem.com and log in to use the **Estimate Your Cost** tool. Search for the procedure you need and the tool will help guide you.

For even quicker cost comparison, use the **Anthem Blue Cross and Blue Shield mobile app**.



* These rates are national averages for the services listed. Your experience may be different depending on your specific plan, the services you receive and the health care provider. Rates as of 2014.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (CompCare), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

You have choices

that can save you a lot

Estimate your health care costs and see your options

Sometimes, the cost of health care can be more than what you expect when you need a procedure, service or lab work. But when you know what your cost will be ahead of time, you can plan ahead. With our Estimate Your Cost tool, you can find out costs and compare facilities and providers based on cost and quality ratings for procedures – before you get them. It puts you in control of where and how you spend your health care dollars.

Don't pay too much

Use the Estimate Your Cost tool to **get an idea of what you'll pay** before you get a procedure.

Peace of mind comes when you plan ahead. The Estimate Your Cost tool was designed to help you feel better about where you go for care.



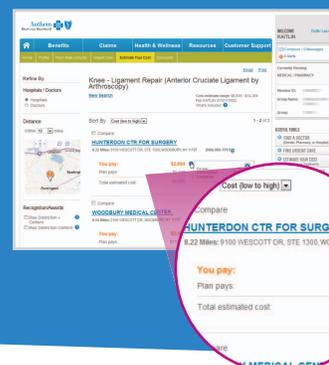
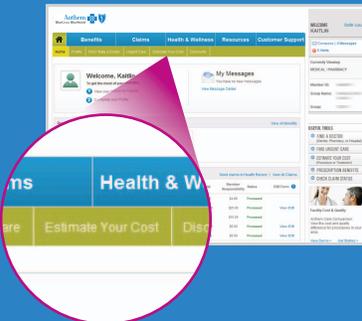
Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; Compare Care Health Services Insurance Corporation (Compare), which underwrites or administers the HMO policies; and Compare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

52985ANMENABS VPOD 11/15

The Estimate Your Cost tool is easy to use

Just follow these steps to get the information you want:

1. Log in to anthem.com.
2. Choose **Estimate Your Cost**.
3. Enter the location you want, how far you want to travel and the procedure needed. Then, choose **Search Cost Estimates**.
4. Agree to the **Terms of Use** and choose **Submit**.
5. Take a look at the list of providers in our network and the estimated costs for the procedure.



DENTAL BENEFIT SUMMARY



GENERAL INFORMATION	BASE PLAN	BUY-UP PLAN
Calendar Year Deductible Applies to Basic and Major Services Maximum of three deductibles per family No Deductible on Preventive Services	\$50 Individual \$150 Family	\$50 Individual \$150 Family
Calendar Year Maximum	\$1,000 per person	\$2,000 per person
Preventive Services Oral Evaluations/Exam (two per year) Prophylaxis/Cleaning (two per year) Topical applications of fluoride (once per year through age 18) Space Maintainers (through age 16) Dental X-rays (limitations apply) Sealants (through age 15)	100%	100%
Basic Services Fillings Oral surgery Endodontics Simple extractions Periodontic services Other visits and exams Repair of removable dentures Re-cement crowns and bridges Palliative emergency treatment Occlusal guards (one per year)	80%	80%
Major Services Inlays Crowns Bridges Dentures Denture rebase or reline Repair of fixed bridge Implants (Buy-Up Plan ONLY)	50%	50%
Orthodontic Services for dependents up to age 19	50% Lifetime Max: \$1,000	50% Lifetime Max: \$2,000
WHEN POSSIBLE, ASK YOUR PROVIDER TO REQUEST A "COST ESTIMATE" FROM ANTHEM BEFORE SERVICES ARE RENDERED!		

EMPLOYEE DENTAL DEDUCTIONS		
Bi-Weekly (26 deductions per Year)		
MEMBERS COVERED	BASE PLAN	BUY-UP PLAN
Employee Only	\$ 2.71	\$ 6.74
Employee + Spouse	\$ 5.41	\$14.52
Employee + Child(ren)	\$ 5.14	\$14.25
Employee + Spouse & Child(ren)	\$ 8.39	\$17.50

Finding a Provider

You can search for physicians, other health care professionals and hospitals in your network by using www.anthem.com and following these easy steps: Click on "Find a Doctor". You may either login if you are currently registered as an online member or choose to "Search as a Guest". If you choose to search as a guest, select "Through my employer", "Georgia", "Dental" and "Complete Dental Network" and click "Continue". You may search by the name or specialty of the provider. Next, enter either the City and State or zip code and click on the "Search" button. From this screen you may sort the results by distance or alphabetically. Or you can contact Customer Care at 1-855-397-9267.



VISION BENEFIT SUMMARY

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!



Your Blue View Vision network

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Target® Optical, JC Penney Optical, Sears Optical and Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at (866) 723-0515 with questions about vision benefits or provider locations.

Out-of-network services

Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward services and you pay the rest. (In-network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam - Each calendar year	\$10 copay; then covered in full	\$30 allowance
Eyeglass frames Each calendar year you may select any eyeglass frame and receive the following allowance toward the purchase price:	\$130 allowance then 20% off remaining balance	\$45 allowance
Eyeglass lenses (Standard) <i>Factory scratch coating included</i> <i>Polycarbonate lenses included for children under 19 years old.</i> <i>Transitions™ lenses included for children under 19 years old.</i> Each calendar year you may receive any one of the following lens options: <ul style="list-style-type: none"> Standard plastic single vision lenses (1 pair) Standard plastic bifocal lenses (1 pair) Standard plastic trifocal lenses (1 pair) 	\$20 copay; covered in full \$20 copay; covered in full \$20 copay; covered in full	\$25 allowance \$40 allowance \$55 allowance
Eyeglass lens upgrades When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass copayment applies. ¹ Please ask your provider for his/her recommendation as well as the progressive brands by tier. ² Please ask your provider for his/her recommendation as well as the coating brands by tier.	Lens Options <ul style="list-style-type: none"> UV Coating \$15 Tint (Solid and Gradient) \$15 Standard Polycarbonate \$40 Transitions™ lenses \$75 Other Photochromics \$75 Progressive Lenses¹ <ul style="list-style-type: none"> Standard \$65 Premium Tier 1 \$91 Premium Tier 2 \$97 Premium Tier 3 \$103 Standard Anti-Reflective Coating² \$45 Premium Tier 1 Anti-Reflective Coating² \$57 Premium Tier 2 Anti-Reflective Coating² \$68 Other Add-ons and Services 20% off retail price 	Discounts on lens upgrades are not available out-of-network
Contact lenses Each calendar year Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses and receive an allowance toward the cost of a supply of contact lenses. <i>Your contact lens allowance must be used at the time of initial service.</i>	<ul style="list-style-type: none"> Elective Conventional Lenses \$130 allowance then 15% off the remaining balance Elective Disposable Lenses \$130 allowance (no additional discount) Non-Elective Contact Lenses Covered in full <i>No amount over the allowance may be carried forward to subsequent materials in the same or the following calendar year.</i> 	\$105 allowance \$105 allowance \$210 allowance

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!



VISION CARE SERVICES

Contact lens fitting and follow up

A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.

- Standard contact fitting*
- Premium contact lens fitting**

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

IN-NETWORK Member Cost

Fitting and follow up visits up to \$55

10% off retail price

OUT-OF-NETWORK

Discounts not available out-of-network

Discounts - Savings on additional eyewear and accessories - After you use your initial frame or contact lens allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

BLUE VIEW VISION ADDITIONAL SAVINGS

Additional Pair of Complete Eyeglasses

Contact Lenses - Conventional
(Discount applied to materials only)

Eyewear Accessories
Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.

*Items purchased separately are discounted 20% off the retail price. Blue View Vision's Additional Savings Program is subject to change without notice.

MEMBER SAVINGS

40% discount off retail*

15% off retail price

20% off retail price

LASER VISION CORRECTION SURGERY

Glasses or contacts may not be the answer for everyone. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to SpecialOffers at anthem.com and select vision care.

USING YOUR BLUE VIEW VISION PLAN

The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

OUT-OF-NETWORK

If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt to the below fax number, email address, or mailing address. When visiting an out-of-network provider, you are responsible for payment of services and/or eyewear materials at the time of service.

To Fax: **866-293-7373**
To Email: oonclaims@eyewearspecialoffers.com
To Mail: **Blue View Vision**
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

EXCLUSIONS & LIMITATIONS

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from Blue View Vision provider. In addition, benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

EMPLOYEE VISION DEDUCTIONS

Bi-Weekly (26 deductions per Year)

MEMBERS COVERED	VISION PLAN
Employee Only	\$1.16
Employee + Spouse	\$2.32
Employee + Child(ren)	\$2.20
Employee + Spouse + Child(ren)	\$3.59



FREQUENTLY ASKED QUESTIONS

Can I keep my current doctor?

Yes, you can. But keep in mind that you get the most out of your plan if your doctor is part of the network. Some plans cover only services from network doctors, which means you pay for the full cost if you see a doctor outside the network. Other plans cover services from doctors outside the network — but your plan pays more of the cost when you see a network doctor. Be sure to check the details of your plan.

To find out if your doctor is in our network, or to find a new doctor or pharmacy in our network, go to our **Find a Doctor** tool on www.anthem.com. You can search by specialty and check a doctor's training, certifications and member reviews. Be ready to enter your plan name to view the network that serves your plan. You can also use **Find a Doctor** on your smartphone.

If I receive a bill from a doctor or hospital that I don't think I owe, what should I do?

Contact Anthem and make sure the claim has been filed with them and you have been sent from Anthem the medical explanation of benefits (EOB). If the claim has not been filed contact your medical provider and request they file the claim with Anthem. If Anthem did receive the claim and you feel the claim was not processed correctly, please fax the EOB or the bill you received from your medical provider to **MSI Benefits Group**, Fax: 770-425-4722 and/or call them at 770-425-1231 for assistance.

What prescription drugs are covered?

Your plan limits coverage of Prescription Drugs to only those listed on the Anthem Essential Drug List. The Essential Drug List includes selected Generic and Brand Name Drugs. A list of the drugs that are covered on the Essential Drug List is available at: <https://www11.anthem.com/pharmacyinformation/>.

Is preventive care covered?

Yes, preventive care from a network provider is covered at 100%. It's very important to take care of your health with regular checkups even when you feel fine. So talk to your doctor about screenings and immunizations that you may need to protect your health.

Do I have health and wellness benefits with my plan?

Yes, Anthem health rewards (Get Strong). It's true that good health is its own reward. But getting something extra feels good, too. That's how Anthem Health Rewards works. It rewards you for taking part in employer-sponsored health and wellness programs. This guide lists the programs and activities you can participate in to:

- Earn rewards
- Learn about reward amounts
- Learn how you can get rewards

When you complete your first healthy activity, you'll get the Health Rewards card. It's a reloadable card you can use anywhere major credit cards are accepted. As you earn more rewards, they'll be automatically deposited into your rewards account and available to spend using your Health Rewards card.

It's easy to get started. Here's how:

1. Register or log in at www.anthem.com.
2. Once you're logged in, go to the *Health & Wellness* section.
3. Select **Get My Rewards**.

You'll be taken to the Anthem Health Rewards site, where you can view activities and start earning rewards. See inside to learn more.

How can my plan help me save money?

You'll save money every time you go to a doctor in network — they've agreed to charge lower rates for Anthem members. But we'll also help save you money before you go to the doctor. At www.anthem.com, you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products.

Home Delivery Pharmacy — You can save money and time by having your prescriptions delivered to your home. Learn how to get started with Home Delivery.

Site of Service — If your plan includes Site of Service, you can get quality care for less money when you choose a freestanding, independent X-ray provider, ambulatory surgery center or lab from our network.

Care & Cost Finder — Find a doctor, check quality and compare costs all in one place - online or on the go! Care & Cost Finder includes costs for different kinds of care. You can compare doctors and costs side by side and get an estimate of what you'll pay based on your benefits.

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.

Walton County's FSA expense reporting period is July 1, 2020 through June 30, 2021.

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 Maximum Election: \$2,750 (\$105.76 / 26 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.

IMPORTANT RULES

You will be allowed to carry over up to \$500 of your account balance into the next plan year. The IRS requires that any unused portion of your account balance above \$500 remaining at the end of the year is forfeited. It is important to estimate your expenses carefully. The "grace period" after the end of the plan year to submit all expenses incurred during the preceding year is decided by your employer. If you were enrolled in an FSA and would like to continue that election, you must re-enroll every year. Be sure to retain documentation from the provider should substantiation of your claim be required.

THE HEALTHEQUITY VISA

The HealthEquity Visa® Program provides a way to immediately access the funds in your Flexible Spending Account. The card may be used at eligible merchants to pay for eligible expenses under your FSA. Remember, IRS regulations strictly govern the use of these cards, and YOU are solely liable for its use.

ONLINE ACCOUNT ACCESS

Active participants holding a HealthEquity Visa® may track their FSA status online. Log onto www.mytheequity.com, click on "My Money" then "Reimbursement Account Detail".

FLEXIBLE SPENDING ACCOUNT ELIGIBLE / INELIGIBLE EXPENSES

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 mastectomy 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>	<ul style="list-style-type: none"> • Babysitting, childcare, and nursing services for a normal, healthy baby • Controlled substances without a prescription • Cosmetic surgery • Dancing lessons • Diaper services • Electrolysis or hair removal • Funeral expenses • Hair transplant • Health club dues • Health coverage tax credit • Household help • Illegal operations and treatments • Insurance premiums (for example, HMO premiums, Employer sponsored health insurance plan premiums) • Maternity clothes • Medical savings account (MSA)/health saving account (HSA) contributions • Medicare B and D premiums • Nutritional supplements • Over-the-counter medications • Personal use items • Swimming lessons • Teeth whitening • Veterinary fees • Weight-loss program not part of specific disease treatment

Your HealthEquity Member Portal

Access Account Information and Helpful Health Care Financial Service Tools

To log in to your HealthEquity member portal:

- » **Go to www.myhealthequity.com.**
- » **Type in your username and password.**
- » **If you have never logged in before, select that you are logging in for the first time as a member.** Be prepared to enter your first and last name, the last four digits of your Social Security number, birth date, and the ZIP code of your current residence. This information is used to identify you as the actual account holder.
- » **HealthEquity's expert specialists are standing by 24/7/365 to answer your questions** about anything and everything related to your HealthEquity accounts. If you have any questions regarding how to log in or how to best use your accounts, please contact HealthEquity at 877-583-4257.

Your HealthEquity portal allows you to:

- Check your account balance in real time.
- Compare the cost of treatments and providers within a specific ZIP code using the HealthEquity medical pricing tool.
- Check to see if your prescription has a generic alternative or less expensive substitute using the prescription drug pricing tool.

Finding Fast Answers on Your HealthEquity Member Portal:

Need to:	Click on:
Check balance	My Money , then Account Balance
Check the status of a claim	My Money , then Reimbursement Account Detail
Change password and username	My Profile , then Login Settings
Update personal information	My Profile , then Personal Information

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
<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





BASIC LIFE and AD&D INSURANCE

Below is a brief description of Walton County’s group life insurance coverage underwritten by **OneAmerica**. **Walton County pays 100% of the cost for your Basic Life and AD&D insurance.** The summary highlights some of the features of the Group Policy, but it is not intended to be a detailed description of coverage. The certificate will contain more detailed information, including the full text of the definitions, exclusions, limitations, reductions and terminating events that apply to the Group Policy. Only the Master Policy contains all the controlling terms and provisions of coverage.



All Full-Time Employees

Basic Life and Accidental Death and Dismemberment (AD&D) Amount: \$25,000

While insured under the Policy, if the Employee has an accident which results in a specified loss, OneAmerica will pay the amount for such loss; provided the loss occurs within 365 days of the accident and OneAmerica receives acceptable proof of loss.

Reduction Schedule

Coverage will reduce upon reaching certain ages as follows:

Employee’s age when reduction occurs	65	70
Percent of Life Amount Remaining	65%	50%

Accelerated Life Benefit

If you are permanently and totally disabled and are diagnosed with a terminal condition and are eligible for benefits under this section, you may apply for payment of the Accelerated Life Benefit. The amount of Accelerated Life Benefit available is shown in the certificate, unless any portion of your life amount has already been paid. The amount of Accelerated Life Benefit available will then be based on the amount remaining after payment of any portion of the Life Amount. Benefits will be paid in one lump sum to you.

Waiver of Premium for Total Disability

OneAmerica will waive further premium payments for the Employee’s Life Amount if the Employee becomes Totally Disabled before age 60 while insured under the Policy, and remains continuously Totally Disabled for 9 months, and submits proof of Total Disability. There is a 24-month limitation on Waiver of Premium if the Total Disability is due to a Mental Illness and/or Drug and Alcohol abuse.

Conversion

If the Employee’s Life Insurance or a portion of it ceases, the Employee may apply for an individual life insurance conversion policy without evidence of insurability. The coverage amount of the individual life insurance conversion policy shall not exceed the amount of life insurance that ceases because of loss of eligibility for coverage under the policy minus the amount of any group life coverage for which You become eligible within 31 days of termination.

Actively at Work

Your life insurance policy will terminate if you have not been ACTIVELY AT WORK within the last **12 months**. To continue coverage you must elect a portability or conversion option within 30 days of your coverage terminating.

**Basic Life Insurance and AD&D certificate available upon request*

Life Insurance Amount:

Employee: Increments of \$10,000 to a maximum of \$500,000.
Not to exceed five times annual base salary.

Spouse: Increments of \$5,000 to a maximum of \$250,000.
 (Spouse benefits terminate at age 70)

Child: \$10,000

Guaranteed Issue Amounts

Employee: \$250,000

Spouse: \$ 20,000

Child: \$ 10,000



Accidental Death and Dismemberment (AD&D): Matches Life Amount

AD&D insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable. The benefit amount is equal to the life amount elected by you. Cost included in the rates below.

Benefit Reduction Schedule:

Coverage will reduce upon reaching certain ages as follows:

Employee's Age when reduction occurs	65	70
Percent of Life Amount Remaining	65%	50%

Dependent life insurance coverage will follow the same reduction schedule as the employee's coverage. Reducing age will be based on employee's age. Dependent spouse coverage does terminate on events such as the spouse reaching age 70.

Accelerated Life Benefit (ALB):

If you are permanently and totally disabled and are diagnosed with a terminal condition and are eligible for benefits under this section you may apply for payment of the Accelerated Life Benefit of 25%, 50%, or 75% of the life amount. This benefit is available on life amounts of \$10,000 or more. The maximum payment is limited to 25%, 50%, or 75% of the life amount shown; however, OneAmerica will not issue an amount less than \$2,500.

Portability:

To continue coverage You must submit written application and the required amount of premium to OneAmerica within 31days of the date coverage terminated under the policy. Failure to pay the required amount of premium to OneAmerica timely will terminate any coverage under the policy at the end of the period for which the premium has been received. OneAmerica reserves the right to charge an administrative fee to cover administrative expenses.

Conversion:

If Your coverage or a portion of it, terminates because You are no longer eligible for coverage under the policy You may apply for an individual life insurance conversion policy without evidence of insurability. The coverage amount of the individual life insurance conversion policy shall not exceed the amount of life insurance that ceases because of loss of eligibility for coverage under the policy minus the amount of any group life coverage for which You become eligible within 31 days of termination.



SUPPLEMENTAL TERM LIFE and AD&D INSURANCE

EMPLOYEE LIFE OPTIONS				BI-WEEKLY DEDUCTIONS (26 / Year)					
AGE	< 29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
\$10,000	\$0.47	\$0.52	\$0.67	\$0.88	\$1.45	\$2.22	\$3.98	\$5.33	\$8.58
\$20,000	\$0.93	\$1.03	\$1.35	\$1.75	\$2.90	\$4.45	\$7.96	\$10.65	\$17.16
\$30,000	\$1.40	\$1.55	\$2.02	\$2.63	\$4.35	\$6.67	\$11.94	\$15.98	\$25.74
\$40,000	\$1.86	\$2.07	\$2.70	\$3.51	\$5.80	\$8.90	\$15.91	\$21.30	\$34.32
\$50,000	\$2.33	\$2.58	\$3.37	\$4.38	\$7.25	\$11.12	\$19.89	\$26.63	\$42.90
\$60,000	\$2.80	\$3.10	\$4.04	\$5.26	\$8.70	\$13.35	\$23.87	\$31.96	\$51.48
\$70,000	\$3.26	\$3.62	\$4.72	\$6.14	\$10.14	\$15.57	\$27.85	\$37.28	\$60.06
\$80,000	\$3.73	\$4.14	\$5.39	\$7.02	\$11.59	\$17.80	\$31.83	\$42.61	\$68.64
\$90,000	\$4.20	\$4.65	\$6.06	\$7.89	\$13.04	\$20.02	\$35.81	\$47.94	\$77.22
\$100,000	\$4.66	\$5.17	\$6.74	\$8.77	\$14.49	\$22.25	\$39.78	\$53.26	\$85.80
\$110,000	\$5.13	\$5.69	\$7.41	\$9.65	\$15.94	\$24.47	\$43.76	\$58.59	\$94.38
\$120,000	\$5.59	\$6.20	\$8.09	\$10.52	\$17.39	\$26.70	\$47.74	\$63.91	\$102.96
\$130,000	\$6.06	\$6.72	\$8.76	\$11.40	\$18.84	\$28.92	\$51.72	\$69.24	\$111.54
\$140,000	\$6.53	\$7.24	\$9.43	\$12.28	\$20.29	\$31.14	\$55.70	\$74.57	\$120.12
\$150,000	\$6.99	\$7.75	\$10.11	\$13.15	\$21.74	\$33.37	\$59.68	\$79.89	\$128.70
\$200,000	\$9.32	\$10.34	\$13.48	\$17.54	\$28.98	\$44.49	\$79.57	\$106.52	\$171.60
\$250,000	\$11.65	\$12.92	\$16.85	\$21.92	\$36.23	\$55.62	\$99.46	\$133.15	\$214.50
\$300,000	\$13.98	\$15.51	\$20.22	\$26.31	\$43.48	\$66.74	\$119.35	\$159.78	\$257.40
\$400,000	\$18.65	\$20.68	\$26.95	\$35.08	\$57.97	\$88.98	\$159.14	\$213.05	\$343.20
\$500,000	\$23.31	\$25.85	\$33.69	\$43.85	\$72.46	\$111.23	\$198.92	\$266.31	\$429.00

SPOUSE LIFE OPTIONS (Based on Spouse's Age)				BI-WEEKLY DEDUCTIONS (26 / Year)					
AGE	< 29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
\$5,000	\$0.23	\$0.26	\$0.34	\$0.44	\$0.72	\$1.11	\$1.99	\$2.66	\$4.29
\$10,000	\$0.47	\$0.52	\$0.67	\$0.88	\$1.45	\$2.22	\$3.98	\$5.33	\$8.58
\$15,000	\$0.70	\$0.78	\$1.01	\$1.32	\$2.17	\$3.34	\$5.97	\$7.99	\$12.87
\$20,000	\$0.93	\$1.03	\$1.35	\$1.75	\$2.90	\$4.45	\$7.96	\$10.65	\$17.16
\$25,000	\$1.17	\$1.29	\$1.68	\$2.19	\$3.62	\$5.56	\$9.95	\$13.32	\$21.45
\$30,000	\$1.40	\$1.55	\$2.02	\$2.63	\$4.35	\$6.67	\$11.94	\$15.98	\$25.74
\$35,000	\$1.63	\$1.81	\$2.36	\$3.07	\$5.07	\$7.79	\$13.92	\$18.64	\$30.03
\$40,000	\$1.86	\$2.07	\$2.70	\$3.51	\$5.80	\$8.90	\$15.91	\$21.30	\$34.32
\$45,000	\$2.10	\$2.33	\$3.03	\$3.95	\$6.52	\$10.01	\$17.90	\$23.97	\$38.61
\$50,000	\$2.33	\$2.58	\$3.37	\$4.38	\$7.25	\$11.12	\$19.89	\$26.63	\$42.90
\$55,000	\$2.56	\$2.84	\$3.71	\$4.82	\$7.97	\$12.24	\$21.88	\$29.29	\$47.19
\$60,000	\$2.80	\$3.10	\$4.04	\$5.26	\$8.70	\$13.35	\$23.87	\$31.96	\$51.48
\$65,000	\$3.03	\$3.36	\$4.38	\$5.70	\$9.42	\$14.46	\$25.86	\$34.62	\$55.77
\$70,000	\$3.26	\$3.62	\$4.72	\$6.14	\$10.14	\$15.57	\$27.85	\$37.28	\$60.06
\$75,000	\$3.50	\$3.88	\$5.05	\$6.58	\$10.87	\$16.68	\$29.84	\$39.95	\$64.35
\$100,000	\$4.66	\$5.17	\$6.74	\$8.77	\$14.49	\$22.25	\$39.78	\$53.26	\$85.80
\$125,000	\$5.83	\$6.46	\$8.42	\$10.96	\$18.12	\$27.81	\$49.73	\$66.58	\$107.25
\$150,000	\$6.99	\$7.75	\$10.11	\$13.15	\$21.74	\$33.37	\$59.68	\$79.89	\$128.70
\$200,000	\$9.32	\$10.34	\$13.48	\$17.54	\$28.98	\$44.49	\$79.57	\$106.52	\$171.60
\$250,000	\$11.65	\$12.92	\$16.85	\$21.92	\$36.23	\$55.62	\$99.46	\$133.15	\$214.50

DEPENDENT LIFE	BI-WEEKLY DEDUCTIONS (26 / Year)
	\$10,000 - \$1.17

VOLUNTARY SHORT TERM DISABILITY



Below is a brief description of the Voluntary Short Term Disability insurance coverage. 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 provided at a later date, will contain more detailed information, including the full text of the definitions, exclusions, limitations, reductions and terminating events that apply to the Policy.



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. Short term disability is calculated from your basic annual earnings, not including overtime, bonuses or any other form of pay. Walton County offers 2 short term disability plans to eligible employees; you may only enroll in one plan. **Plan 1 includes a 14 day elimination period while Plan 2 includes a 30 day elimination period before any benefit commences.**

Eligibility

All Active Full-Time Employees working 30 hours or more per week.

Pre-Existing Condition Limit

You may not be eligible for benefits if you have received treatment for a condition within the past 3 months until you have been covered under a plan for 12 months.

Portability

You may be able to port your coverage if you have been covered under the policy for 12 months and terminate due to reasons other than disability, retirement, or leave of absence.

COMPARISON	PLAN 1	PLAN 2
Benefits:	60% of Weekly Earnings	60% of Weekly Earnings
Day Injury Benefit Commences:	15th Day	31st Day
Day Sickness Benefit Commences:	15th Day	31st Day
Maximum Benefit Period (including waiting period):	26 Weeks	26 Weeks
Maximum Benefit:	\$1,500 Weekly	\$1,500 Weekly
Maternity Coverage:	Same as Any Other Disability	Same as Any Other Disability
Coverage Basis:	Non-Occupational	Non-Occupational
Continuation/Sick Leave Offsets:	Cannot Exceed 100% of Normal Earnings	Cannot Exceed 100% of Normal Earnings

How to calculate your individual premium: To calculate your per-paycheck cost for this coverage, complete the calculations below using the rate table below.

$$\frac{\text{Basic Annual Earnings}}{52} = \text{Weekly Salary} \times \frac{60\%}{\text{Benefit \%}} = \text{Your Weekly Benefit}$$

$$\frac{\text{Your Weekly Benefit}}{10} = \text{Your Rate} \times \text{Your Rate} = \text{Your Monthly Cost}$$

(see rates below)

$$\text{Your Monthly Cost} \times 12 = \text{Annual Cost} \div \frac{26}{\# \text{ Paychecks per Year}} = \text{Cost per Paycheck*}$$

AGE	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
PLAN 1	\$0.61	\$0.58	\$0.54	\$0.54	\$0.60	\$0.67	\$0.80	\$0.97	\$1.10	\$1.21
PLAN 2	\$0.42	\$0.39	\$0.38	\$0.38	\$0.41	\$0.46	\$0.55	\$0.66	\$0.75	\$0.82



VOLUNTARY LONG TERM DISABILITY

Long Term Disability Insurance is designed to provide income protection in the form of a monthly benefit during periods of disability occurring as a result of a covered accident or sickness. Coverage is not to provide direct payment for hospital, medical-surgical or major medical expenses. Instead, approved payments are made directly to you when you are not able to work. Disability means that, during an own-occupational period, an employee is unable to perform all material and substantial duties of his or her regular occupation, which results in at least a 20 percent loss in pre-disability earnings. During any-occupational period, an employee is unable to perform the material and substantial duties of any gainful occupation, which results in at least a 40 percent loss in pre-disability earnings. The employee must also be receiving regular care from a physician for the illness or injury.

Eligibility

All active full time employees working 30 or more hours per week.

Benefit Amount

60% of your basic monthly income. The benefit amount is the payment an employee will receive should he or she become disabled as provided under the policy.

Elimination Period

180 days. The elimination period is how long an employee must be disabled before benefits begin.

Maximum Benefit

\$5,000 / month

Pre-Existing Conditions

You may be eligible for benefits if you have received treatment for a condition within the past 3 months until you have been covered under this plan for 12 months.

Survivor Benefit

If the Employee dies and had been receiving a monthly benefit under this contract for 180 or more days, his or her eligible survivor (spouse or children) will receive a lump sum amount equal to 3 times his or her gross monthly benefit. However, if disability had continued for 12 or more consecutive months while the Employee was receiving a monthly benefit, the survivor benefit will be payable monthly for a period of one year in an amount equal to 60% of the Employee's last gross monthly benefit. This benefit will be paid in lieu of the 3-month benefit.

How to calculate your individual premium: To calculate your per-paycheck cost for this coverage, complete the calculations below using the rate table below.

$$\frac{\text{Annual Salary}}{\div 12} = \text{Monthly Salary} \div 100 = \text{Your Rate (see table below)} \times \text{Monthly Salary} = \text{Monthly Cost}$$

$$\text{Monthly Cost} \times 12 = \text{Annual Cost} \div 26 = \text{Bi-weekly Cost* (per pay period)}$$

* Final cost may vary slightly due to rounding.

AGE	RATE
0-19	0.08
20-24	0.13
25-29	0.16
30-34	0.25
35-39	0.37
40-44	0.54

AGE	RATE
45-49	0.80
50-54	1.12
55 +	1.45

VOLUNTARY GROUP ACCIDENT INSURANCE



Do you know how much a trip to the emergency room could cost you?

An accident insurance plan provides benefits to help cover the costs associated with unexpected bills. You don't budget for accidents if you're like most people. When a covered accident occurs, the last thing on your mind is the charges that may be accumulating while you're at the emergency room, including:

- The ambulance ride
- Surgery and anesthesia
- Wheelchairs
- Bandages
- Use of the emergency room
- Stitches
- Crutches
- Casts

You get the picture. These costs add up – fast. You hope they never happen, but at some point you may take a trip to your local emergency room. If that comes, wouldn't it be nice to have an insurance plan that pays benefits regardless of any other insurance you have? This group accident plan does just that. Below is a brief description of the group accident insurance, detailed brochures are available upon request.

PLAN FEATURES		Benefits available for spouse and/or dependent children.	
24-Hour coverage.		Benefits for both inpatient and outpatient treatment of covered accidents.	
No limit on the number of claims.		Guaranteed Issue – No underwriting required to qualify for coverage.	
Supplements and pays regardless of any other insurance programs.			
PLAN BENEFITS			
ACCIDENTAL DEATH AND DISMEMBERMENT		MAJOR INJURIES	
Accidental Common Carrier Death (Plane, Train, Boat or Ship)	\$100,000	Fractures (closed reduction*)	
Accidental Death	\$50,000	Hip/Thigh	\$4,000
Double Dismemberment	\$25,000	Vertebrae (except processes)	\$3,600
Single Dismemberment	\$12,500	Pelvis	\$3,200
Loss of One or More Fingers or Toes	\$1,250	Skull (depressed)	\$3,000
Partial Amputation of Fingers or toes (including at least one joint)	\$100	Leg	\$2,400
HOSPITAL BENEFITS		Forearm/Hand/Wrist	\$2,000
Paralysis (Quadriplegia)	\$10,000	Shoulder blade/Collar bone	\$1,600
Hospital Admission	\$1,000	Lower Jaw (Mandible)	\$1,600
Hospital Intensive Care (per day)	\$400	Skull (Simple)	\$1,400
Hospital Confinement (per day)	\$200	Upper Arm/Upper Jaw	\$1,400
Medical Fees	\$125	Facial bones (except teeth)	\$1,200
SPECIFIC INJURIES		Vertebral Processes	\$800
Burns	\$100-\$20,000	Coccyx/Rib/Finger/Toe	\$320
Lacerations	\$25-\$400	Complete Dislocations (closed reduction*)	
Ruptured Disc	\$100-\$400	Hip	\$3,000
Tendons/Ligaments	\$400-\$600	Knee (not knee cap)	\$1,950
Torn Knee Cartilage	\$100-\$400	Shoulder	\$1,500
Eye Injuries	\$50-\$250	Foot/Ankle	\$1,200
Coma (lasting 30 days or more)	\$10,000	Hand	\$1,050
Concussion	\$200	Lower Jaw	\$900
Emergency Dental Work	\$50-\$150	Wrist	\$750
ADDITIONAL BENEFITS		Elbow	\$600
Internal Injuries	\$1,000	Finger/Toe	\$240
Air Ambulance	\$1,000	* If Fracture/Dislocation requires open reduction benefit will be double the amount shown.	
Prosthesis	\$500		
Transportation	\$150-\$300		
Exploratory Surgery	\$250		
Ambulance	\$200		
Blood/Plasma	\$100		
Appliances	\$100		
Family Lodging Benefit	\$100		
Wellness Benefit (after 12 month waiting period)	\$50		
Accident Follow-up Treatment	\$30		
Physical Therapy	\$30		

EMPLOYEE DEDUCTIONS	
Bi-Weekly (26 deductions per Year)	
MEMBERS COVERED	COST
Employee Only	\$ 9.07
Employee + Spouse	\$13.60
Employee + Child(ren)	\$15.90
Employee + Spouse & Child(ren)	\$20.43

Critical Illness Insurance

pays benefits if an insured person is diagnosed with one of the specified critical illness if: 1) The date of diagnosis is after the waiting period; and 2) the date of diagnosis is while this policy and is in force; and 3) you are confined to a hospital as a result of the specified critical illness and charged for room, board and other applicable charges; and 4) it is not excluded by name or specific description in the policy.

PLAN BENEFITS

FIRST OCCURRENCE BENEFIT After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts available from \$5,000 to \$50,000. Spouse coverage is also available in benefit amounts up to \$25,000. If you are deemed ineligible due to a previous medical condition you still retain the ability to purchase spouse coverage.

ADDITIONAL OCCURRENCE BENEFIT If an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered critical illnesses. Occurrences must be separated by at least 6 months.

RE-OCCURRENCE BENEFIT If an insured collects full benefits for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months or for cancer, 12 months treatment free. Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless the insured has gone treatment free for 12 months

50% CHILD COVERAGE AT NO ADDITIONAL COST Each dependent child is covered at 50 percent of the primary insured amount at no additional charge.

\$50 HEALTH SCREENING BENEFIT (EMPLOYEE AND SPOUSE) After the 30 day waiting period, an insured may receive a maximum of \$50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under your certificate. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the certificate remains in force. This benefit is payable for the covered Employee and Spouse. This benefit is not paid for dependent children.

Covered health screening test include: mammography, colonoscopy, pap smear, breast ultrasound, chest x-ray, PSA (blood test for prostate cancer), stress test on a bicycle or treadmill, and bone marrow testing, CA 15-3 (blood test for breast cancer), CA 125 (blood test for ovarian cancer), CEA (blood test for colon cancer), Flexible sigmoidoscopy, Hemocult stool analysis, Serum protein electrophoresis (blood test for myeloma), Thermography, Fasting blood glucose test, Serum cholesterol test to determine level of HDL and LDL.

PRE-EXISTING CONDITION LIMITATION means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in the insured receiving medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

COVERED SPECIFIC CRITICAL ILLNESSES:	
Cancer (Internal/Invasive)	100%
Heart Attack (Myocardial Infarction)	100%
Stroke (Apoplexy or Cerebral Vascular Accident)	100%
Major Organ Transplant	100%
Renal Failure (End Stage)	100%
Carcinoma In Situ	25%
Coronary Artery Bypass Surgery	25%

NOTE: If a benefit is paid for carcinoma in situ, the internal cancer benefit will be reduced by 25%. If a benefit is paid for coronary artery bypass surgery, the heart attack benefit will be reduced by 25%. All covered conditions are subject to the definitions found in your certificate.

EMPLOYEE DEDUCTIONS

Bi-Weekly (26 deductions per Year)

Employee Rates										
Ages	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
17-29	\$1.81	\$2.80	\$3.79	\$4.78	\$5.78	\$6.77	\$7.76	\$8.75	\$9.75	\$10.74
30-39	\$2.66	\$4.50	\$6.35	\$8.20	\$10.04	\$11.89	\$13.74	\$15.58	\$17.43	\$19.27
40-49	\$4.87	\$8.94	\$13.00	\$17.06	\$21.12	\$25.18	\$29.24	\$33.30	\$37.37	\$41.43
50-59	\$8.01	\$15.21	\$22.41	\$29.61	\$36.81	\$44.01	\$51.21	\$58.41	\$65.61	\$72.81
60-69	\$12.35	\$23.89	\$35.43	\$46.97	\$58.50	\$70.04	\$81.58	\$93.12	\$104.66	\$116.20
Spouse Rates (based on age of spouse)										
Ages	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000	
17-29	\$1.81	\$2.30	\$2.80	\$3.30	\$3.79	\$4.28	\$4.78	\$5.28	\$5.78	
30-39	\$2.66	\$3.58	\$4.50	\$5.43	\$6.35	\$7.27	\$8.20	\$9.12	\$10.04	
40-49	\$4.87	\$6.90	\$8.94	\$10.97	\$13.00	\$15.03	\$17.06	\$19.09	\$21.12	
50-59	\$8.01	\$11.61	\$15.21	\$18.81	\$22.41	\$26.01	\$29.61	\$33.21	\$36.81	
60-69	\$12.35	\$18.12	\$23.89	\$29.66	\$35.43	\$41.20	\$46.97	\$52.74	\$58.50	



Walton County Employee Assistance Program

What is the EAP?

- Confidential, Professional Counseling Services
- Access to 24/7 Problem Evaluation
- Brief Counseling (Up to 5 Face-to-Face Sessions per issue)
- Unlimited Telephonic Support
- LifeHub Online Work-Life Resources (more info. below)
- For You and Your Family Members
- No Cost to You or to Your Family Members

What kinds of problems does the EAP Cover?

- Drug/Alcohol Abuse
- Stress Problems
- Supervisor Assistance
- Budgeting Concerns
- Parenting Problems
- Marital/Family Problems
- Work Conflicts
- Eldercare Concerns
- Smoking Cessation
- Other Personal Concerns

How do I contact the EAP?

Step 1: Call The HELP LINE: Toll Free at 800.728.9444

Step 2: An EAP Counselor will assist you with your concern. In order to best serve you, they will request some personal information, e.g. your name, telephone number, your company, etc. and ask if you would prefer to see a counselor near work or home.

Step 3: The EAP Counselor will connect you to the counselor and arrange a convenient confidential appointment time.

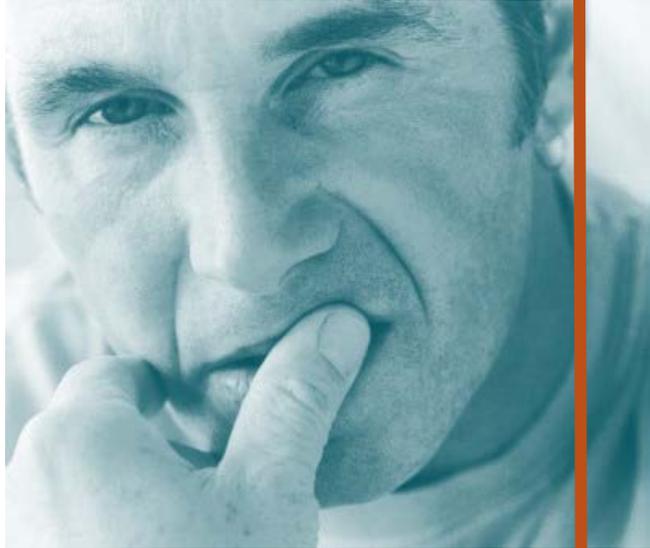
A Message to Our Employees

Walton County believes that a successful company is built upon the productivity of healthy employees. The EAP is a resource that can assist you or a family member when needed. If you are experiencing a problem please do not hesitate to call the EAP.

800.728.9444

LifeHub™ is your online life management tool for you and your family members, which is available 24/7. LifeHub offers ten life management hubs to which you can return to over and over, to improve the quality of your personal and professional lives. Resources offered are self-help assessments, articles, financial calculators, and much more.

To use these services, register confidentially at <http://new.lifehub.com/register/waltoncty>



CONTINUATION COVERAGE RIGHTS UNDER COBRA

WALTON COUNTY HEALTH PLAN

Introduction

You are receiving this notice because you have recently become eligible for the Walton 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 30 days after the qualifying event occurs. You must provide this notice **in writing to: Walton County, Human Resources Department, 303 South Hammond Drive, Suite 331, Monroe, GA 30655.**

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:

**Walton County
Human Resources Department
303 South Hammond Drive, Suite 331
Monroe, GA 30655
770-267-1329**

BENEFIT ELECTIONS and COSTS

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

Type of Benefit	Benefit Plan	Coverage Level / Coverage Amount	Deduction Amount
Medical			
Dental			
Vision			
Flexible Spending Account (FSA)			
Dependent Care Account (DCA)			
Basic Life and AD&D Insurance	Enrolled		\$0.00
Supplemental Term Life and AD&D Insurance			
Spousal Term Life and AD&D Insurance			
Dependent Life and AD&D Insurance			
Voluntary Short Term Disability			
Voluntary Long Term Disability			
Aflac Group Accident			
Aflac Employee Critical Illness			
Aflac Spouse Critical Illness			
Total Per Pay Cost:			
Total Annual Cost:			

IMPORTANT CONTACT INFORMATION

WALTON COUNTY

Human Resources
Andrea Taylor
Tel: 770-267-1351

andrea.taylor@co.walton.ga.us

MEDICAL / DENTAL / VISION PLANS

Anthem BlueCross and BlueShield
Medical Customer Service

Tel: 855-397-9267

Mental Health/Substance Abuse

Tel: 800-292-2879

Anthem COBRA Department

Tel: 866-800-2272

Dental Customer Service

Tel: 877-604-2158

Vision Customer Service

Tel: 866-723-0515

www.anthem.com

LIFE INSURANCE

One America

Tel: 800-553-5318

www.oneamerica.com

DISABILITY INSURANCE

One America

Tel: 855-517-6365

www.oneamerica.com

MSI BENEFITS GROUP, INC.

Administrative Contact

Tel: 770-425-1231 / 800-580-1629

Fax: 770-425-4722 / 800-580-2675

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: **waltonEE**

Password: **Benefits123**

ACCIDENT / CRITICAL ILLNESS

Aflac Group

Tel: 800-433-3036

www.aflacgroup.com

FLEXIBLE SPENDING ACCOUNT (FSA)

DEPENDENT CARE ACCOUNT (DCA)

HealthEquity

Tel: 877-583-4257

Fax: 801-407-1792

www.myhealthequity.net



Presented to you by MSI Benefits Group

*MSI Benefits Group
245 TownPark Drive, Suite 100
Kennesaw, GA 30144
Tel: 770-425-1231 / 800-580-1629
Fax: 770-425-4722 / 800-580-2675
Email: helpme@msibg.com
www.msibg.com*