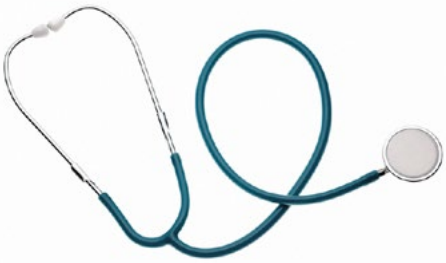


My Benefits

Benefit Summary

PAULDING COUNTY, GEORGIA
BOARD of COMMISSIONERS

2018-2019

We are pleased that you are an employee. We are proud to provide a wide array of benefits for you and your family. Paulding County Board of Commissioners pays the majority of your costs, for single or family coverage, so that participation is an affordable and important part of your working experience. The foundation for the design of the program and our cost sharing arrangement with you, our most important asset, is detailed in the following Benefits Philosophy statement.

Benefits Philosophy

Paulding County Board of Commissioners' objective is to provide the best possible benefit program at the most appropriate cost for our employees. We have an important long term objective of controlling costs so that we can continue to offer as broad an array of benefits as possible, with as little cost to you as possible, and for as long as possible.

Our commitment to you...

Our goal is to provide the best level of benefits for you and your family at the lowest possible cost. To meet this goal, we will maintain a benefits program for you and your family that will:

- Protect you and your family from severe financial hardship in the event of a catastrophic illness or injury.
- Provide you and your family financial protection in the event of death or disability.
- Provide you and your family with the information necessary to put you in more control of using the medical care options available to you and to make the medical care decisions that will provide you with the care you need, when you need it, while maximizing valuable benefit plan dollars.
- Communicate the specifics of all plan benefits through an employee benefit notebook, and keep the plan up to date and in compliance with all state and federal laws.
- A continuous review of the program to ensure it meets our objectives.

Your part...

To keep the best level of benefits at the lowest cost for you and your family, you can:

- Be the healthiest person you can be. Use information on health and wellness available to you to make good lifestyle decisions. Good decisions concerning lifestyle issues such as exercise, diet, smoking, drinking, etc., produce much healthier individuals, and much lower plan costs than bad ones!
- Educate yourself on how to consume health care wisely and effectively. Know your needs and those of your family!
- Understand how "the system" works. "Who pays for what?" "Why didn't the insurance company cover that?" Make it a point to learn about your plan through plan booklets, and the carrier's toll free numbers!
- Establish a relationship with a doctor. Ongoing care from the same doctor is a great advantage for you. It allows the doctor to learn about you and establish a history of your health. It also eliminates unnecessary repetition of procedures and will greatly reduce the chances you could be misdiagnosed.
- When you practice these habits, you improve your health and you receive better care. We all benefit from a healthier workforce and keeping costs down allows us to continue and enhance all of our benefits as we grow!

As an eligible Paulding County employee, you automatically receive these benefits:

- Basic Employee Life Insurance
- Accidental Death & Dismemberment (AD&D)
- Short Term Disability
- Long Term Disability
- Travel Aid Services
- Employee Assistance Program (for you and your Eligible Dependents)

You may elect all of the following coverages as a package:

- Medical Insurance
- Prescription Drug Plan (Rx)
- Health Advocate Support
- Medical Bill Saver and MedChoice Support
- Dental with Vision Discount Program

All enrolled dependents of Paulding County employees receive the following coverages:

- Medical Insurance
- Prescription Drug Plan (Rx)
- Health Advocate Support
- Medical Bill Saver and MedChoice Support
- Dental with Vision Discount Program
- Dependent Life Insurance for Eligible Dependents

You also have the opportunity to enroll yourself and eligible family members in the following voluntary coverages that you pay for on a payroll deduction basis:

- Vision Insurance
- Voluntary Term Life Insurance with WillPrep Services
- Medical Flexible Spending Account (FSA)
- Dependent Care Spending Account

Table of Contents

***Note**: This summary contains information we are pleased to bring you. It is important that you read all pages carefully and thoroughly. They contain information important to you and your family regarding Life, AD&D, Short and Long Term Disability, Medical/Rx, Health Advocate, Dental with Vision Discount Program, Vision, Medical FSA, and Dependent Care Spending Account.*

Please consult your certificate booklets to determine the exact terms, conditions, and scope of coverage including all exclusions and limitations. This summary is designed as a partial description of the plan being offered and in no way details all benefits, limitations, or exclusions.

If there is a discrepancy between the summary and the certificate booklet, the certificate booklet prevails.

Eligibility

Timely Enrollees

Full-time hourly and salaried employees working 30 hours or more per week, *full-time firefighters* working 40 or more hours per week, and elected officials serving in office are eligible for coverage for themselves and their families on the first of the month following 30 continuous days of employment; however, new hires on January 31st and February 1st will have coverage effective March 1st.

All eligible employees receive Basic Life, AD&D with Vision Savings Program, Short Term Disability and Long Term Disability. When you enroll for other coverages for yourself or your eligible family members, you enroll in all other benefits offered, except the voluntary programs. No benefits may be elected separately and others declined, except voluntary programs.

Coverages Other than Medical/ Prescription Drug – Actively at Work

You and your family members who enroll when first eligible are considered TIMELY ENROLLEES and are covered on your eligibility date, as long as you and your family members are engaged in normal daily activities on that date. Anyone not engaged in normal daily activities will be covered first of the month following return to normal daily activities. Note: If an employee is unable to join the plan neither can the family members. If a family member cannot join the plan an employee will be able to join.

This is called an *"actively at work"* requirement. It applies to adults and children, whether employed or not. It applies to individuals in the hospital or restricted to the home, due to illness or injury.

Late Enrollees

Those who do not enroll when first eligible are Late Enrollees. An Open Enrollment Period is offered on an annual basis for employees or dependents to enroll in the benefit program, which they previously declined. These individuals must enroll during April for a May 1st effective date, to be covered during the coming plan year, unless they have recently lost coverage elsewhere or otherwise qualify for HIPAA Special Enrollment provisions.

Late Enrollees who are not Special Enrollees are subject to benefit deferral periods for Dental and Evidence of Insurability for Voluntary Supplemental Life insurance.

Special Enrollment

Late Enrollees who qualify for HIPAA (Health Insurance Portability and Accountability Act) Special Enrollment provisions are eligible for coverage:

- After an occurrence which qualifies for the Special Enrollment provision, and
- After application for a Special Enrollment is made,
- If they have otherwise met the waiting period for eligibility.

Examples of Special Enrollments are:

- *You do not cover your spouse because the spouse has coverage through his/her employer. Your spouse loses coverage due to loss of employment.* Your spouse may be subject to Special Enrollment provisions of HIPAA under our plan if applied for within 31-days of loss of coverage.
- *Coverage for a new spouse* if coverage is applied for within 31-days of marriage, subject to the conditions above.
- *Coverage for a new child if* applied for within 31-days of birth, adoption, legal guardianship, or placement for adoption.
- *In the event of a child's Medicaid or CHIP/SCHIP coverage being terminated or employee/child becoming eligible for premium assistance* the timeframe is extended to 60-days from loss or eligibility of coverage.

Termination of Coverage

Your coverage will end at midnight on the last day of the month following the date your employment with Paulding County Board of Commissioners terminates or you no longer meet the full time employee eligibility requirement.

Cost Sharing and Section 125

Section 125 Premium Conversion Plan

This section of the IRS code allows you to make contributions to health and welfare plans provided by your employer, with before tax dollars. This is accomplished by reducing your pay by the amount of the contribution. This amount will be contributed to the plan for you, but will not show as taxable income, which means your tax payments are reduced.

Considering state and federal income taxes and FICA, all employees would be in at least a 23.65% total tax bracket. Many, particularly families with two incomes, will have higher tax rates. The actual cost to you of your benefits, net of the tax savings, is provided below for a marginal tax bracket of 23.65%, as an example.

Paulding County wants all eligible employees to be able to participate in this program. Your level of contribution has been set to ensure this is the case. The per pay period cost in the following chart is for Basic Employee Life Insurance, Accidental Death & Dismemberment (AD&D), Short Term Disability, Long Term Disability, Travel Aid Services, Employee Assistance Program, Medical Insurance, Prescription Drug Plan (Rx), Health Advocate Support, Medical Bill Saver and MedChoice Support, and Dental with Vision Discount Program.

Per Pay Period	Employee Only				Employee + Family			
	Your %	Your Cost	PCBOC's %	PCBOC's Cost	Your %	Your Cost	PCBOC's %	PCBOC's Cost
Open Access POS Option								
Gross Cost	14%	$50.00	86%	$308.99	16%	$150.61	84%	$807.91
Less Tax Savings		$11.83				$35.62		
Net Cost		$38.17				$114.99		
HRA Option 1								
Gross Cost	3%	$10.00	97%	$372.00	9%	$85.61	91%	$863.89
Less Tax Savings		$2.37				$20.25		
Net Cost		$7.63				$65.36		
HRA Option 2								
Gross Cost	0%	$0	100%	$357.46	7%	$60.61	93%	$821.40
Less Tax Savings		$0				$14.33		
Net Cost		$0				$46.28		

The per pay period cost for the Vision Plan is:

Vision		
Per Pay Period	Employee Only	Family
	Your Cost	Your Cost
Gross Cost	$3.66	$7.86
Less Tax Savings	$0.87	$1.86
Net Cost	$2.79	$6.00

NOTES: The gross cost shown in these charts will be deducted from your pay. Your withholding for taxes will be reduced by your actual tax savings amount.

If you do not change your previous year's election of coverage/plan, that election carries into the new plan year. If there are any payroll deduction changes, those are made automatically and shown on your paycheck.

To change your previous year election ask Human Resources for an Enrollment/Change Form to either change your plan selection, drop coverage or add coverage for an eligible spouse or child(ren).

The law requires that Section 125 participation elections may be changed only at plan anniversary dates except for "special enrollments" discussed in the enrollment materials, or "off" anniversary employer changes in benefits or costs.

Medical Insurance

Individual Shared Responsibility

- Most Americans without minimum essential health care coverage in 2018 are subject to tax penalties. These penalties are set to expire in 2019, as of the time of this document's printing.
- Please note that Paulding County cannot provide advice on how the Affordable Care Act (ACA) will affect you and your family. You may wish to check with your tax advisor or CPA.
- For more information on the health care reform law visit:
  - ➢ www.healthcare.gov

    Suggested search: the fee for not being covered
  - ➢ www.irs.gov

    Suggested searches: questions and answers on the individual shared responsibility provision, or questions and answers on the premium tax credit

Health Insurance Exchange

- The health care reform law (the ACA) created a new type of online marketplace for purchasing health insurance coverage. The marketplace is called a Health Insurance Marketplace, or Exchange. The Exchange does not affect Paulding County's medical plan offering and you are not required to purchase insurance coverage through the Exchange.
- For most people, the next opportunity to enroll in a plan through the Exchange is November 1 for coverage beginning January 1.
- If you purchase coverage through an Exchange, you may be eligible for a federal subsidy that lowers your premiums or reduces your cost sharing. However, to receive these federal savings, you cannot be eligible for health plan coverage that is both affordable and provides "minimum value." As defined by ACA, Paulding County's plan provides affordable coverage in excess of the required minimum value for eligible employees.
- Availability of coverage through the Exchange does not affect eligibility for coverage through Paulding County's health plan. If you get coverage through an Exchange and drop Paulding County's plan, you lose Paulding County's contributions towards your coverage – on average 88% of the cost.
- For more information on the health care reform law and the Exchange visit www.healthcare.gov.

Medical/Prescription Drugs

BlueCross BlueShield of Georgia is your carrier.

The following pages include important information about the Medical/Rx plans, including summaries of how the plans work, a chart showing major plan differences, and coverage examples of different types of claims.

You have the choice of three Medical/Rx plan options. All three options are through BlueCross BlueShield of Georgia (BCBS). Please take the time to evaluate each plan option so you will be able to select the best option for you and your family.

1. **Open Access Point of Service (POS)**- a traditional type plan with copays for Office Visits. Payroll deductions: $50 for employee only and $150.61 for employees covering their family.
2. **HRA Option 1 - a higher deductible plan with a Health Reimbursement Account (HRA) set up by Paulding to help you meet the higher deductible.** Payroll deductions: $10 for employee only and $85.61 for employees covering their family.

   Employees in the HRA Option 1 rather than the **Open Access POS** will have an **annual payroll savings of**:

   - $1,040 for employee only.
   - $1,690 for employee + family.

   Approximately 420 employees participated in the HRA plans as of 12/31/17 and are holding down costs for everyone.

   - 99 have HRA account balances in excess of $2,000
   - 62 of 99 have account balances in excess of $3,000
   - 31 of 99 have account balances in excess of $5,000
   - 11 of 99 have account balances in excess of $8,000
   - 5 of 99 have account balances in excess of $10,000
3. **HRA Option 2 - a higher deductible plan than HRA Option 1, also with an account to help you meet the higher deductible.** Payroll deductions: $0 for employee only and $60.61 for employees covering their family.

Medical/Prescription Drugs *[continued]*

Some PCBOC employees have understood and participated in the HRA plan early on. Some have done their part to maintain good health to their financial benefit. **Many have HRA account balances so high**, that regardless of the medical catastrophe, they would have **no out of pocket expenses**, and **many would have lower expenses** than under the traditional POS plan **and with less out of their pay each pay period** than those in the traditional POS plan. The **HRA Option 2** allows employees with high balances to take a higher deductible in exchange for a lower payroll deduction. This plan is also for anyone who wants to have catastrophic insurance protection, at the lowest possible payroll deduction.

Employees who elect **HRA Option 2** rather than **HRA Option 1** have an annual payroll savings of:

- $260 for employee only.
- $650 for employee + family.

Employees who elect **HRA Option 2** rather than the **Open Access POS** have an annual payroll savings of:

- $1,300 for employee only.
- $2,340 for employee + family.

All three plans have the same Prescription Copays

Speak to your doctor about low cost prescription options like generics or brand name prescriptions that cost less than what you are currently taking. Call **Health Advocate** at 866-695-8622 for helpful information about what to discuss with your doctor.

How the POS plan works:

This is a traditional plan with a lower deductible than the HRA options, coinsurance once the deductible is met, and a higher premium.

How the HRA plans work:

The basic concept of the HRA is this:

- You have a first dollar Health Reimbursement Account (HRA) and receive funds based on the following plan entry dates:
  - If your benefits start date is 1/1 to 3/31 then your HRA amount is $1,000 for individual or $2,000 for family.
  - If your benefits start date is 4/1 to 6/30 then your HRA amount is $750 for individual or $1,500 for family.
  - If your benefits start date is 7/1 to 9/30 then your HRA amount is $500 for individual or $1,000 for family.
  - If your benefits start date is 10/1 to 12/31 then your HRA amount is $250 for individual or $500 for family.
- The first part of expenses in a benefit year for each member will be paid at 100% from your HRA **except for the following three items:**
  1. **In Network covered preventive/wellness care office visits which are paid at 100% in addition to your HRA**
  2. **Prescription drugs, which are paid at 100% after your copay**
  3. **Any amounts above usual and customary charges are paid by you in addition to your portion of the deductible, if you use an Out of Network provider**

In Network

- If your claims exceed your HRA balance, the remaining portion of the deductible is paid by you up to the claim amount. After the deductible is met, the plan pays 90% In Network and you pay 10% of covered charges plus any prescription drug copays until you reach your maximum coinsurance and copay out of pocket amount for the calendar year, which is $3,000 In Network per individual.
- If you exceed your HRA, and reach your maximum portion of the deductible and coinsurance, all other covered expenses are paid at 100% for the remainder of the calendar year.
- The majority of HRA members will not use 100% of their HRA and will not get into their deductible.
- The purpose of the HRA is to put healthcare consumers in more control of the healthcare consumption process.
- **How does it benefit you by being more in control?** The portion of the HRA that is not used in a calendar year rolls to the next year. For example, if you have employee only coverage and use only $250 in covered medical expenses, you roll over your $750 balance ($1,000 - $250 = $750). Then, for the next calendar year, your HRA is valued at $1,750 ($750 rollover + $1,000 for the new calendar year). The unused portion continues to roll over, year after year.

Medical/Prescription Drugs *[continued]*

Summary of Benefits

You have the choice of three plans, the **Open Access POS**, **HRA Option 1** or the **HRA Option 2**.

Benefits Comparison	Open Access POS		HRA Option 1		HRA Option 2	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Health Reimbursement Accounts*						
Individual	N/A		**$1,000**		**$1,000**	
Family	N/A		**$2,000**		**$2,000**	
Calendar Year Deductible						
Per Individual	$1,500	$3,000	$2,000	$4,000	$3,000	$6,000
Family Maximum	$3,000	$6,000	$4,000	$8,000	$6,000	$12,000
Coinsurance	80%	60%	90%	70%	90%	70%
Coinsurance is the percentage of costs you share with the insurance company after you meet any remaining portion of your deductible. For those in an HRA option, your HRA helps you meet the deductible and depending on your HRA balance, coinsurance too.						
Calendar Year Out of Pocket Maximum Due to Coinsurance and Copays						
Per Individual	$1,500	$3,000	$3,000	$6,000	$3,000	$6,000
Family Maximum	$3,000	$6,000	$6,000	$12,000	$6,000	$12,000
Total Calendar Year Out of Pocket Maximum (Deductible + Coinsurance + Copays)						
Per Individual	$3,000	$6,000	$5,000	$10,000	$6,000	$12,000
Family Maximum	$6,000	$12,000	$10,000	$20,000	$12,000	$24,000
Lifetime Maximum *(except for certain internal policy limits)*	Unlimited		Unlimited		Unlimited	

*HRA's are prorated quarterly:
If your benefits start date is 4/1 to 6/30 then your HRA amount is $750 for individual or $1,500 for family.
If your benefits start date is 7/1 to 9/30 then your HRA amount is $500 for individual or $1,000 for family.
If your benefits start date is 10/1 to 12/31 then your HRA amount is $250 for individual or $500 for family.

Comparison: Calendar Year Deductible Plus Out-of-Pocket Maximum — Net of Premium Savings and Paulding County HRA Contribution

Deductible Plus Coinsurance Out of Pocket, Less Premium Savings and Paulding County HRA Contribution*						
	Open Access POS		HRA Option 1		HRA Option 2	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Per Individual	$3,000	$6,000	$2,960	$7,960	$3,700	$9,700
Family Maximum	$6,000	$12,000	$6,310	$16,310	$7,660	$19,660

*Please see pages 5-6 and 16 for details about premium savings and HRA contributions.

Medical/Prescription Drugs *[continued]*

Your Plan Pays

Your Plan Pays	Open Access POS		HRA Option 1		HRA Option 2	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Preventive Care	100%	60% after Deductible	100%	70% after Deductible	100%	70% after Deductible
Preventive Care means you have no symptoms or diagnosis. For example, a true physical or annual well woman exam is Preventive Care. If you have borderline high blood pressure and are seen by your doctor every 6 months to check your blood pressure that is not Preventive Care. Be sure to consult your physician about your specific preventive care needs, and call BCBS or Health Advocate with any questions.						
Common Services						
Primary Care Office Visit	100% after $25 Copay	60% after Deductible	90% after Deductible	70% after Deductible	90% after Deductible	70% after Deductible
Specialist Office Visit	100% after $50 Copay	60% after Deductible	90% after Deductible	70% after Deductible	90% after Deductible	70% after Deductible
LiveHealth Online Visit* *(see p. 15 for information)*	100% after $15 Copay	NA*	90% after Deductible	NA*	90% after Deductible	NA*
Diagnostic Lab & X-Ray	100%	60% after Deductible	90% after Deductible	70% after Deductible	90% after Deductible	70% after Deductible
Emergency Room	100% after $300 Copay	100% after $300 Copay	90% after Deductible	90% after Deductible	90% after Deductible	90% after Deductible
Ambulance	80% after Deductible	80% after Deductible	90% after Deductible	90% after Deductible	90% after Deductible	90% after Deductible
Urgent Care	100% after $75 Copay	60% after Deductible	90% after Deductible	70% after Deductible	90% after Deductible	70% after Deductible
Complex Lab, MRI, PET, CT, MRA Nuclear Medicine	80% after Deductible	60% after Deductible	90% after Deductible	70% after Deductible	90% after Deductible	70% after Deductible
Hospital Inpatient	80% after Deductible	60% after Deductible	90% after Deductible	70% after Deductible	90% after Deductible	70% after Deductible
Outpatient	80% after Deductible	60% after Deductible	90% after Deductible	70% after Deductible	90% after Deductible	70% after Deductible

*The LiveHealth Online site only lists credentialed network providers as options to be seen during the online visit, and out of network providers are not available.

Medical/Prescription Drugs *[continued]*

Prescription Drug Copays

Prescription Drug Copays	Open Access POS		HRA Option 1		HRA Option 2	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Tier 1 (up to 31-day supply)	$15 Copay	Reimbursed up to what BCBS would have paid in-network minus in-network copays	$15 Copay	Reimbursed up to what BCBS would have paid in-network minus in-network copays	$15 Copay	Reimbursed up to what BCBS would have paid in-network minus in-network copays
Tier 2 (up to 31-day supply)	$40 Copay		$40 Copay		$40 Copay	
Tier 3 (up to 31-day supply)	$60 Copay		$60 Copay		$60 Copay	
Mail Order for Maintenance Medications (up to a 90-day supply)	2.5x Copays listed above	N/A	2.5x Copays listed above	N/A	2.5x Copays listed above	N/A

Why use Mail Order?

It saves you money! Using the $15 copay for one 31-day Tier 1 prescription twelve times a year costs you $180. Using the mail order 2.5x copay ($15 x 2.5 = $37.50) for a 90-day generic prescription four times a year costs you $150. A SAVINGS OF $30! Using Tier 2 prescriptions through mail order saves up to $80 per year. A family using five Tier 2 maintenance drugs realizes total savings for the entire year of $400!

It also saves you time! No more trips to the pharmacy for maintenance drugs.

Follow these steps to enroll in the Mail Order Program:

1. Request a 90-day prescription, refillable for 12 months, from your physician.
2. Before you place your fist order, make sure you have at least a 2-week supply on hand, or get a 31-day fill from your local pharmacy. This should prevent you from running out of medication before your mail order arrives.
3. Call BCBS at the Home Delivery Prescription number 866-281-4654 for instructions for your physician to submit the prescription directly to the mail order pharmacy. Or if you want to submit the prescription, log in to the BCBS website (POS Members: bcbsga.com, HRA Members: anthem.com) and download a mail order form.

If you have questions about enrolling in the mail order program, call the Home Delivery Prescription number (POS and HRA Members: 866-281-4654), or contact Health Advocate for assistance at 866-695-8622.

Special Note about Compound Medications

Compound medications are made by a pharmacist who mixes drugs into a specific dosage form, strength, or formulation that is not commercially available, and they are not pre-packaged; they are made up of individual chemicals combined together at the retail pharmacy.

BCBS covers compound medications when:

- A commercially available dosage form of a medically necessary medication is not available,
- All the ingredients of the compound drug are FDA approved,
- It requires a prescription to dispense, and
- It is not essentially the same as an FDA approved product from a drug manufacturer.

Prior authorization may be required for a compound medication. Call BCBS at the number on your ID card if you have any questions about a compound medication prescription:

- POS: 855-397-9269
- HRA: 855-889-5682.

Medical/Prescription Drugs *[continued]*

Coverage Examples: Based on Employee Only Coverage Election

Note: These are examples only, actual claims will vary. These examples are not intended to predict your actual costs. Instead, they are intended to help you understand the three plan options by comparing the coverage they provide and the difference in annual premium costs.

These examples are for In Network claims and example costs shown are after the network negotiated discount.

These examples assume each is the first claim of the year. Subsequent years could have higher HRA balances, due to rollover of prior year(s) unused amounts. The HRA is an annual, not per claim, amount. Examples show employee only coverage with a $1,000 HRA. Employees with family coverage receive a $2,000 HRA if enrolled as of January 1 or during the first quarter of the calendar year.

Based on Employee Only Coverage	Open Access POS	HRA Option 1	HRA Option 2
Office Visit Copay - Non Specialist	$25	N/A	N/A
Deductible	$1,500	$2,000	$3,000
BCBS Coinsurance Percentage	80%	90%	90%
Coinsurance Out of Pocket Maximum	$1,500	$3,000	$3,000
HRA	N/A	$1,000 first dollar	$1,000 first dollar
		$1,000 net deductible	$2,000 net deductible

Example 1: Two Office Visits (Non-Preventive Care), lab work associated with one visit

Based on Employee Only Coverage	Open Access POS	HRA Option 1	HRA Option 2
Primary Care Cost of Visit 1	$100	$100	$100
Copay	$25	N/A	N/A
Paid by Plan for Office Visit 1	$75	$100	$100
Primary Care Cost of Visit 2	$100	$100	$100
Copay	$25	N/A	N/A
Paid by Plan for Office Visit 2	$75	$100	$100
Lab work	$125	$125	$125
Deductible Paid by Employee	$0	$0	$0
Paid by Plan for Lab work	$125	$125	$125
		Paid by HRA	
Out of Employee's Pocket	$50	$0	$0
***Additional* Annual Payroll Deduction for Plan Compared to Lower Cost HRA**	$1,300	$260	$0
Total Out of Pocket	$1,350	$260	$0

	$1,000	Beginning HRA Balance
-	$100	Subtract Cost of Office Visit 1 up to HRA Balance
=	$900	Remaining HRA Balance
-	$100	Subtract Cost of Office Visit 2 up to HRA Balance
=	$800	Remaining HRA Balance
-	$125	Subtract Cost of Lab Work up to HRA Balance
=	$675	Remaining HRA Balance

Medical/Prescription Drugs *[continued]*

Coverage Examples: Based on Employee Only Coverage Election *[continued]*

Example 2: Seven Day Inpatient Hospital Stay

Based on Employee Only Coverage	Open Access POS	HRA Option 1	HRA Option 2
Cost of Stay	$50,000	$50,000	$50,000
HRA	N/A	$1,000	$1,000
Remaining Claim	$50,000	$49,000	$49,000
Deductible Paid by Employee	$1,500	$1,000	$2,000
Remaining Claim	$48,500	$48,000	$47,000
Coinsurance Paid by Employee	$1,500	$3,000	$3,000
Total Paid by Plan	$47,000	$45,000	$44,000
Out of Employee's Pocket	$3,000	$4,000	$5,000
***Additional* Annual Payroll Deduction for Plan Compared to Lower Cost HRA**	$1,300	$260	$0
Total Out of Pocket	$4,300	$4,260	$5,000

	$1,000	Beginning HRA Balance
-	$1,000	Subtract Cost of Stay up to HRA Balance
=	$0	Remaining HRA Balance

Example 3: MRI

Based on Employee Only Coverage	Open Access POS	HRA Option 1	HRA Option 2
Cost of MRI	$2,000	$2,000	$2,000
HRA	N/A	$1,000	$1,000
Remaining Claim	$2,000	$1,000	$1,000
Deductible Paid by Employee	$1,500	$1,000	$1,000
Remaining Claim	$500	$0	$0
Coinsurance Paid by Employee	$100	$0	$0
Total Paid by Plan	$400	$0	$0
Out of Employee's Pocket	$1,600	$1,000	$1,000
***Additional* Annual Payroll Deduction for Plan Compared to Lower Cost HRA**	$1,300	$260	$0
Total Out of Pocket	$2,900	$1,260	$1,000

	$1,000	Beginning HRA Balance
-	$1,000	Subtract Cost of MRI up to HRA Balance
=	$0	Remaining HRA Balance

Medical/Prescription Drugs *[continued]*

Coverage Examples: Based on Employee Only Coverage Election *[continued]*

Example 4: Delivery of a Baby

Based on Employee Only Coverage	Open Access POS	HRA Option 1	HRA Option 2
Cost of Delivery	$7,500	$7,500	$7,500
HRA	N/A	$1,000	$1,000
Remaining Claim	$7,500	$6,500	$6,500
Deductible Paid by Employee	$1,500	$1,000	$2,000
Remaining Claim	$6,000	$5,500	$4,500
Coinsurance Paid by Employee	$1,200	$550	$450
Total Paid by Plan	$4,800	$4,950	$4,050
Out of Employee's Pocket	$2,700	$1,550	$2,450
***Additional* Annual Payroll Deduction for Plan Compared to Lower Cost HRA**	$1,300	$260	$0
Total Out of Pocket	$4,000	$1,810	$2,450

	$1,000	Beginning HRA Balance
-	$1,000	Subtract Cost of Delivery up to HRA Balance
=	$0	Remaining HRA Balance

Example 5: Emergency Room Visit

Based on Employee Only Coverage	Open Access POS	HRA Option 1	HRA Option 2
Cost of Visit	$2,500	$2,500	$2,500
Copay	$300	N/A	N/A
HRA	N/A	$1,000	$1,000
Remaining Claim	$2,200	$1,500	$1,500
Deductible Paid by Employee	$0	$1,000	$1,500
Remaining Claim	$2,200	$500	$0
Coinsurance Paid by Employee	N/A	$50	$0
Total Paid by Plan	$2,200	$450	$0
Out of Employee's Pocket	$300	$1,050	$1,500
***Additional* Annual Payroll Deduction for Plan Compared to Lower Cost HRA**	$1,300	$260	$0
Total Out of Pocket	$1,600	$1,310	$1,500

	$1,000	Beginning HRA Balance
-	$1,000	Subtract Cost of ER Visit up to HRA Balance
=	$0	Remaining HRA Balance

Medical/Prescription Drugs *[continued]*

Mechanics of the HRA

1. **First, BCBS will process the medical claim according to the medical benefit plan - to determine whether or not the claim is covered.**
2. **Then, if you have funds in your Health Reimbursement Account (HRA) to cover your portion of the expense:**
   - **For In Network providers:** BCBS will pay your portion directly to your In Network provider,
   - **For Out of Network providers:** BCBS will send your portion to you, and you will make payment to the Out of Network provider.

   Once the claim is processed by BCBS, you will receive an explanation of benefits (EOB) for the HRA with your balance. You may also check your balance by logging in at anthem.com or by calling BCBS customer service at 855-889-5682 (the number on your ID card).

   Note: If the claim is In Network and due to preventive/wellness BCBS pays the provider directly for the covered service portion of the claim and does not reduce the HRA balance.
3. **If there are not sufficient funds in the HRA, you may be billed by your provider.**
4. **If a provider asks you to pay for services before the claim is submitted, ask them to please file the claim as normal with BCBS.** It is important that BCBS follows the 3 steps above.

If you do make a payment to your provider at the time of service and your HRA has funds, you will need to contact your provider to be reimbursed once the claim is processed.

For medical claims (prescription drug claims are handled outside of the HRA), the HRA will pay your portion of the expense from your Health Reimbursement Account:

- directly to In Network providers, and
- to you for Out of Network providers.

If you visit a provider and do not authorize the provider to submit claims on your behalf, you will need to submit the claim to the claim address on the back of your ID card.

Finding an In Network Provider

There are two ways to verify provider status online with BCBS:

1. Log in to the BCBS member portal at bcbsga.com for the POS plan or anthem.com for the HRA plans. The websites automatically use Paulding's BCBS network, the Blue Open Access POS network, when you log in.
2. Visit bcbsga.com. If you use this option, it is the general provider directory and you will need to select the Blue Open Access POS network.

You may also call BCBS customer service or Health Advocate:

- POS: 855-397-9269
- HRA: 855-889-5682
- Health Advocate: 866-695-8622

The most up to date information is obtained through the BCBS toll free number. The toll free number and the website are updated every 2 weeks.

Important Note: *Before setting every doctor's appointment, it is a good practice to check with BCBS AND the physician's office to verify that the physician is a BCBS network physician.* *Some physicians in a practice group may be network physicians and others may not. You need to ask about the specific physician you want to see. If the physician is not a network physician, BCBS can give you the names of others who are.*

Please be aware that network doctors that you receive care from are encouraged but not required to refer you to other doctors within the network. It is **YOUR RESPONSIBILITY** to make sure any physician or lab (even those in the same building as a participating physician) are In Network if you want to receive Network benefits.

Medical/Prescription Drugs *[continued]*

Pre Certification (once you have your ID card)

BCBS's Pre Certification Department must be contacted before certain hospitalizations and procedures, per the carrier's certificate booklet. **Failure to comply will result in a reduction of benefits payable or a denial altogether.**

The Pre Certification number is 855-343-4851 and is on your participant ID card as well as in your booklet. Select Option 2 from the first menu and Option 2 (Medical Utilization Management) from the second menu.

Do not rely on the physician or hospital to make the call. They will not be paying the penalty if the call is not made. Often, a call made by a physician or hospital is to the claims department to verify benefits, not Pre Certification.

Out of Network Services

When a member visits an In Network facility (such as a hospital, Emergency Room or outpatient center) BCBS will not pay amounts above Usual, Customary & Reasonable (UCR) charges for Out of Network providers seen such as radiologists, pathologists, anesthesiologists and ER doctors. This means members can be "balance billed" even if the facility is In Network (see below for an overview and example of balance billing). In the event you are balance billed for $400 or more, Health Advocate's Medical Bill Saver service can help - see page 18 for information.

Important Note On Balance Billing (only applies to Out of Network providers)

Please be aware of "balance billing" that can occur when you use Out of Network providers.

In Network providers have agreed to discounted fees for all services they provide. They can't charge you more than these negotiated fees.

These negotiated fee agreements are not in place when you use **Out of Network** providers. The plan reimburses **Out of Network** covered expenses on a Usual, Customary and Reasonable (UCR) basis which is based on a Blue Cross Blue Shield fee schedule.

Out of Network providers may balance bill you for amounts that are not covered by the carrier above a UCR basis.

BALANCE BILLING EXAMPLE: OUTPATIENT SURGERY, Deductibles have already been met.		
In Network	**Open Access POS**	**HRA Plans**
Physician's Normal Charge:	$1,000	$1,000
Network Negotiated Charge:	$700	$700
In Network Coinsurance:	80%	90%
Plan Pays:	$560 ($700 X 80%)	$630 ($700 X 90%)
You Owe:	$140 ($700 X 20%)	$70 ($700 X 10%)
Out of Network	**Open Access POS**	**HRA Plans**
Physician Charge:	$1,250	$1,250
UCR:	$1,100 is 110% of the Medicare reimbursement rate.	$1,100 is 110% of the Medicare reimbursement rate.
Out of Network Coinsurance:	60%	70%
Plan Coinsurance Pays:	$660 (UCR limit of $1,100 X coinsurance of 60%)	$770 (UCR limit of $1,100 X coinsurance of 70%)
Your Coinsurance Owed:	$440 (UCR limit of $1,100 X coinsurance of 40%)	$330 (UCR limit of $1,100 X coinsurance of 30%)
Plus You Owe:	$150 The amount above the $1,100 UCR ($1,250 - $1,100)	$150 The amount above the $1,100 UCR ($1,250 - $1,100)
Your Total Cost:	$590 ($440 + $150)	$480 ($330 + $150)*

*Depending upon your HRA balance, there may be funds left to pay part or all of the amount you owe.

Medical/Prescription Drugs *[continued]*

BCBS Anywhere Mobile App

Take advantage of this helpful tool to:

- **Find a doctor:** Search for a doctor, specialist, urgent care center, or hospital close by.
- **Get your ID card:** Share your ID card or email it to your provider right from your smartphone.
- **Manage prescription benefits:** Check the cost of drugs, get refills, or switch to home delivery.
- **Access your mobile Health Record:** View your Health Record and share it with your doctors at office visits.

Download the mobile app at the App Store or Google Play.

24/7 NurseLine

Some of the benefits include:

- 24 hours a day, 7 days a week you can call and speak to a registered nurse about whether a medical condition warrants a trip to a physician or emergency room, management of chronic health conditions like diabetes or asthma, wellness and nutritional information and questions you have about medications.
- If you like, a nurse will call back later to check on you.
- You also have access to an AudioHealth Library with helpful prerecorded messages that cover more than 300 health topics in English and Spanish.

What is the number for 24/7 NurseLine?

Call 888-724-BLUE (888-724-2583). This number is on your BCBS ID card. Have your ID card with you when you call. It is also a good idea to save the 24/7 NurseLine number in your phone.

When should I call 24/7 NurseLine?

- If you are concerned about a fever, stomach ache, headache, etc.
- If you have a question about whether or not you should go to the doctor or the hospital.
- If you have a question about your treatment or medical condition and would like more information.

LiveHealth Online

This program includes:

- 24/7 access to in-network doctors. They can assess your condition, provide treatment options, and send a non-narcotic prescription to the pharmacy of your choice, if needed.
- Medical care for things like the flu, a cold, sinus infection, pink eye, rashes, fever, and more.
- Convenience - no appointments or long waits. Most people connect to a doctor in about 10 minutes or less.
- LiveHealth Online Psychology: see a therapist or psychologist in just a few days. Feeling stressed, worried, or having a tough time? You can talk to a licensed psychologist or therapist through video.

How do I access LiveHealth Online?

Use your smartphone, tablet or computer with a webcam. All you need to do is sign up at livehealthonline.com or download the app.

Healthy Support

All employees and spouses age 18 and older and covered on Paulding's BCBS Medical/Rx Plan have the opportunity to earn up to $700 in rewards and gym reimbursements through this program. In addition, children age 18 and older and covered on Paulding's BCBS Medical/Rx Plan have the opportunity to earn up to $400 in gym reimbursements.

Rewards are available for *gift cards* for many things like electronics, restaurants, clothing, books, and more.

The gym reimbursement program provides up to $400 in reimbursement per plan year for your gym dues.

For reward and gym reimbursement questions or for a full list of participating gift card vendors call the number on the back of your ID card:

- **POS: 855-397-9269**
- **HRA: 855-889-5682**

We know that employees active in this program will:

- Improve their health,
- Improve their quality of life,
- Lower their medical costs, and
- Help the County in controlling costs so the program we offer to employees will be as strong as it can be.

Medical/Prescription Drugs *[continued]*

Healthy Support *[continued]*

Rewards and gym reimbursements can be earned according to the following:

Activity	Reward/Reimbursement Amount
Tobacco-free Certification	$50
Preventive Wellness Exam and Flu Shot	$100
Healthy Lifestyles Online Wellness Tools	up to $150
Online Wellness Tools include: • *Complete your Well-Being Assessment,* • *Set up your Well-Being Plan,* • *Track your weight - 10 times every 90 days,* • *Track activities - any two of the following at least 10 times: smoking cessation, food, exercise, servings and steps,* • *and more.* *You earn points for each activity and can earn a $50 gift card when you reach these point levels: 100, 200 and 300.*	
Future Moms maternity program	$200
HRA only: Enroll in ConditionCare	$100
HRA only: Graduate from ConditionCare	$200
Gym Reimbursement	up to $400/year
Maximum Annual Reward and Gym Reimbursement Amount per Eligible Participant	**$700**

Important Notes

Please take the time to evaluate all options for you and your family. If an HRA Option is right for you, you will have lower payroll deductions than the Open Access POS option, and the HRA plans could lower your health plan out of pocket costs. However, depending on the type and level of claims you incur, your out of pocket costs could be higher under the HRA plans.

- **The majority of participants in the HRA plan rollover unused Health Reimbursement Account (HRA) balances each January 1st.**
- **On January 1st**, your HRA account is credited with new amounts for the new calendar year as follows:
  - $1,000 for employee only coverage.
  - $2,000 for employee + family coverage.

Remember these important decision making points concerning the HRA plans:

- Preventive care is paid at 100% and **none of the cost comes out of your HRA account**. It is paid by the insurance company.
- You pay only copays for prescription drugs. **The balance of the cost of drugs does not come out of your HRA account**. It is paid by the insurance company.
- Any costs that **are paid from you HRA account, are paid first from Paulding County's contributions to your HRA account. You pay nothing unless the costs that are paid out of your account exceed what the PCBOC has contributed.** Then you pay the difference between expenses that exceed the amount in your HRA account, up to your maximum out of pocket for the calendar year. **The plan pays 100% after that point, for the balance of the calendar year.**
- **You pay no office visit copays** under either HRA plan.
- **You are only worse off for being in one of the HRA plans**, if you exhaust the PCBOC HRA contributions and the amount you pay out of pocket is more than the annual pay period savings you enjoy for the plan year.
- **With Health Advocate's Medical Bill Saver there is opportunity** to control out of pocket costs.

Health Advocate

For those who enroll in the Medical/Rx plan package.

Health Advocate provides personalized and professional assistance with any healthcare related question. Your Personal Health Advocate is equipped to handle your Protected Health Information (PHI) appropriately.

Remember: Your Personal Health Advocate is the appropriate resource for the assistance you need with your PCBOC Medical, Dental, and Vision benefits.

You, your spouse, dependent children, parents, and parents-in-law can all use the service - even if you only cover yourself on the PCBOC plans.

- **Health Advocate is** a resource to assist you in addressing the complexities associated with using the healthcare system successfully.
- Health Advocate is designed to help you best utilize your employee benefits so that you can receive the right medical care at the lowest cost to you. Health Advocate is not designed to give you medical advice or a diagnosis.
- **A goal of Health Advocate** is to put you in a position to make best decisions regarding your healthcare by answering your questions, and helping you understand your conditions and diagnoses.
- The **phone number** for Health Advocate is: 866-695-8622. **The first time you call Health Advocate** you will speak with a Personal Health Advocate, who will then become the individual that will personally assist you for the duration of the issue.
- Health Advocate's **phone lines are open from 8 a.m. to 12 a.m. (midnight)** Eastern Time, Monday through Friday. If you call after hours and during weekends, leave a message and a Personal Health Advocate will return your call the next business day.
- When you receive an Explanation of Benefits (EOB) from BCBS, Guardian, or a bill from a provider and need claims assistance, you may want to first call the carrier's customer service number. If you still have questions, are confused, or do not understand what you were told, that is when Health Advocate works to help you understand the EOB, explains your benefits, and if needed, helps to correct issues with the carrier or provider.

In case of a true emergency, ALWAYS call 911.

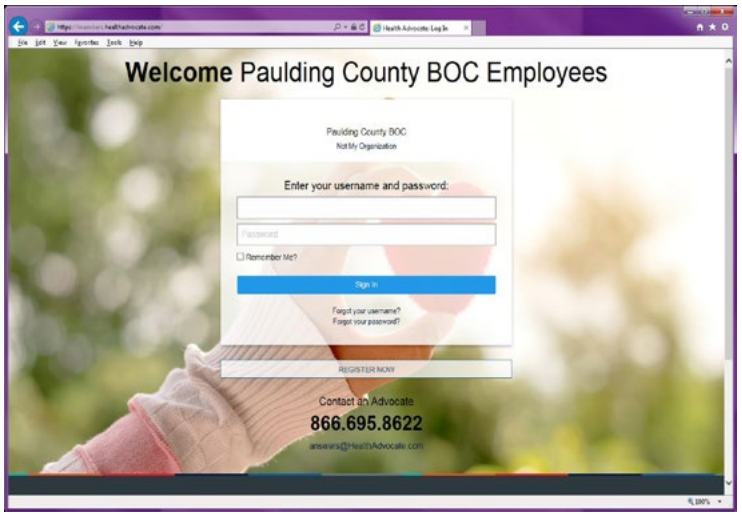
Call Health Advocate at 866-695-8622 if you have any of these needs:

- Help understanding your BCBS plan options
- Help finding an In Network doctor, specialist, dentist, or eye doctor
- Questions about a health condition
- Help with eldercare issues for a parent or parent-in-law such as Medicare or healthcare-related issues
- Help transferring medical records
- Would like to have an estimate of how much a medical procedure or test may cost
- Help with a billing or claims payment issue
- Questions about a medical test or recommended treatments

Visit the Health Advocate Website* www.HealthAdvocate.com/Paulding to:

- Learn about services Health Advocate can provide
- Watch a video about your Health Advocate benefit
- Print the HIPAA Authorization form that allows Health Advocate to work on your behalf with providers and insurance companies

*Register for the site by clicking "Register" and then entering your first name, last name, date of birth, and home zip code.



Health Advocate – Additional Resources

For those who enroll in the Medical/Rx plan package.

Medical Bill Saver™

Medical Bill Saver is a money-saving benefit from Health Advocate. The Medical Bill Saver service can attempt to negotiate substantial discounts off health bills you are responsible for and/or negotiate a payment plan with your provider. This service is best engaged before a procedure is performed when they have the most leverage to negotiate. If you wait until after the procedure there is a lower chance of successful negotiation, and if you have already paid the bill, there is almost no chance.

These are bills for services and costs such as:

Medical/Rx:

1. Not covered by the Medical plan
2. Any cost applied to your deductible or coinsurance (not copay) for both In Network and Out of Network (Allowed in Georgia, but not all other states.)
3. Out of Network provider
4. Above plan coverage limits
5. Not covered by the Prescription plan

Dental:

1. Not covered by the dental plan
2. Out of Network provider
3. Above plan coverage limits

Medical Bill Saver will work with your providers to lower the balance on any uncovered medical or dental bill of $400 or more – just send Health Advocate your bill and ***you keep 100% of any savings***!

Medical Bill Saver can help reduce your balance due for noncovered medical bills. This service:

- Works with doctors/other providers on your behalf
- Has high success rates with significant savings
- Can lower out-of-pocket costs
- Helps you become a more savvy healthcare consumer
- Negotiate a payment plan with your provider
- And much more!

Here's how Medical Bill Saver can help:

- Negotiation can result in significant savings
- Easy-to-read, personal Savings Result Statement, summaries outcome and payment terms

You, your spouse, dependent children, parents, and parents-in-law can all use the service. To access Medical Bill Saver, simply call Health Advocate at 866-695-8622.

MedChoice Support™

MedChoice Support is an online, self-directed, resource that provides you access to independently developed and widely accepted medical information to help you share in the decision-making process with your healthcare provider. Over 150 topics are currently available, examples include:

- Heart Disease - should I have an angiogram?
- When should I start having mammograms?
- Should I have knee replacement surgery?
- Should my child be treated for fluid buildup in the middle ear?
- Should my child take medicine for ADHD?
- Breast Cancer - should I have chemotherapy for early-stage breast cancer?
- Diabetes - should I get an insulin pump?

Access MedChoice Support:

- www.HealthAdvocate.com/Paulding
- Log in with your User Name and Password, or click "Register" if it is your first visit to the website. To register, you will enter your first name, last name, date of birth, and home zip code.

Life Insurance and Accidental Death & Dismemberment

Basic Life Insurance

Guardian is your carrier.

For you:

- The amount of your benefit to be paid to your designated beneficiary is based upon the following classification of your employment:
  - Group I -- Elected Officials -- $50,000
  - Group II -- All other full-time employees -- 1 times salary to a maximum of $100,000
- The Amount of Basic Life Insurance will be reduced by 50% at age 70 and coverage terminates at retirement.
- Your Basic Life Insurance includes:
  - LifeAssist - Provides supplemental monthly income that equals 1% of your Basic Life benefit to a maximum of $2,000 if you are ADL disabled.
  - Accelerated Life Benefit - A lump sum benefit paid to you if you are diagnosed with a terminal condition, as defined by the plan.

For your enrolled dependents:

- Your spouse will have life insurance of $5,000.
- Each child older than 14 days will have life insurance of $2,500.

Accidental Death & Dismemberment

Guardian is your carrier.

- This coverage provides an additional amount to your beneficiary, equal to the Basic Life amount, if your death is due to accidental causes and the cause is not specifically excluded under the Accidental Death or Dismemberment (AD&D) coverage.
- Dismemberment is based on a schedule. Example: you receive ½ of the amount above for the loss of a hand, foot or sight in an eye.
- The Amount of AD&D Insurance will be reduced by 50% at age 70 and coverage terminates at retirement.
- TravelAid Services: When you are traveling more than 100 miles from your home, you have emergency medical assistance, travel and communication assistance, informational assistance, repatriation of remains, and many other services.

Voluntary Term Life Insurance

Guardian is your carrier.

- This is life insurance you may purchase through payroll deduction, in **addition** to the Basic Life insurance amounts paid for by Paulding County.
- You may purchase through payroll deduction $25,000 to $500,000 of life insurance on yourself in increments of $25,000. If you elect when first eligible, $250,000 is Guarantee Issue. Medical Evidence of Insurability forms are not required for this amount.
- If you purchase coverage on yourself, you may purchase coverage on your spouse and/or child(ren).
  - Spouse: You may elect up to $250,000 (but can not exceed 50% of your coverage amount), $62,500 is Guarantee Issue if elected when first eligible.
  - Child(ren): Coverage is available for your child(ren) age 14 days up to 26 years: $10,000 for each child.
- **If you do not enroll when first eligible, or enroll and later wish to increase the coverage amount, you must complete Medical Evidence of Insurability forms, and possibly a physical at your expense, to determine if coverage will be issued.**
- **If you have a Qualifying Event or Life Status Change, you may be able to add coverage for a new spouse or child(ren) without Medical Evidence of Insurability** if you do so within 31-days of the event. Please see Human Resources for details.
- If you elect at least $25,000 when first eligible but less than the $250,000 Guarantee Issue amount, you may be able to increase your coverage in $50,000 increments without Medical Evidence of Insurability each May 1st until you reach $250,000.
- The Amount of Supplemental Life Insurance will be reduced by 35% at age 65, reduced by 60% of pre-65 amount at age 70, reduced by 80% of pre-65 amount at age 75, and coverage terminates at retirement.
- With this coverage you have access to WillPrep Services with online planning documents, a resource library and access to professionals (for a small fee) to help with Wills and Living Wills, Advanced Health Care Directives, Financial/Healthcare Power of Attorney, Estate Taxes, Guardianship and Conservatorship, and Trusts.

Disability

Short Term Disability

Guardian is your carrier.

- You will receive 60% of your weekly pre-disability salary, to a maximum of $830, if the carrier determines you are disabled.
- Benefits begin accruing on the 15th day for non-occupational accidental injury and the 15th day for non-occupational sickness or pregnancy.
- Benefits are payable for up to 24 weeks. You may be eligible for the Long Term Disability plan thereafter.

Long Term Disability

Guardian is your carrier.

- You will receive 60% of your monthly pre-disability salary to a maximum of $6,000 less deductible sources of income and disability earnings, if the carrier determines you are disabled. The minimum monthly benefit is the greater of 10% of your gross monthly benefit or $100.
- You will begin accruing LTD benefits from the 181st day of disability, and could receive them up to your Social Security Retirement Age if you are disabled prior to age 60. If disabled at or after age 60, benefits are payable according to an age-based schedule.
- Disabilities due to mental illness and self-reported conditions are limited to 24 months of benefits during your lifetime.

Spouse Disability Rider - Provides a Long Term Care Type Benefit

Guardian is your carrier.

- A covered employee's spouse who is functionally disabled, meaning unable to perform two or more Activities of Daily Living or cognitively impaired, will receive a benefit of $1,000/month for up to 24 months.
- If you were not covered on the Disability Plan as of 4/30/17, you must be covered for 24 months for your spouse to receive this benefit.
- To qualify for this benefit, your spouse must meet these conditions:
  - ➢ is not currently working for wage or profit,
  - ➢ must have a functional disability which lasts for at least 30 days in a row, and
  - ➢ is receiving regular care from a doctor.
- Benefits are paid after the first 30 days that your spouse is functionally disabled.
- Other policy provisions apply and are outlined in your certificate of coverage.

How to File a Disability Claim

Call Guardian at 888-262-5670, Monday through Friday 9:00am - 9:00pm. A Specialist will ask you a few questions to gather information about your claim. Please tell them you are on the Paulding County BOC plan, and have the following information handy when you place your call:

- Your name, address, phone number, and Social Security Number,
- Your physician's name, address, phone and fax number (for the treatment provider/physician who is disabling you),
- Whether or not you gave your treatment provider/physician an Authorization to Obtain Information form, and
- Information regarding your disability (Diagnosis, treatment dates, etc).

Dental

Guardian is your carrier. A summary of benefits is provided in the chart below.

Summary of Benefits	PPO	
	In Network	Out of Network
Calendar Year Deductible	*Waived for preventive care*	*Waived for preventive care*
Per Individual	$50	$50
Family Maximum	$150	$150
Annual Maximum Dental Benefit	$1,000 per person	$1,000 per person
Maximum Rollover	If a member does not have $500 or more in paid expenses during a plan year and visits the dentist at least once during the year, a rollover of up to $250 applies to the next plan year, increasing the total annual maximum for the next year to $1,250. This occurs each year until a $2,000 annual limit is achieved.	

Your Plan Pays	PPO	
	In Network	Out of Network
Preventive Care*	100%, Deductible Waived	100% up to the 90th percentile of UCR, Deductible Waived
Basic Care*	80% after Deductible	80% up to the 90th percentile of UCR, after Deductible
Major Care*	60% after Deductible	60% up to the 90th percentile of UCR, after Deductible
Orthodontia* (for dependent children under age 19, or if treatment started before turning 19)	60% after Deductible	60% up to the 90th percentile of UCR, after Deductible
Lifetime Orthodontia Maximum	$1,000 per person	$1,000 per person
***When the expected cost of a treatment is $300.00 or more, your dentist should send Guardian a treatment plan for Pre-Treatment Review, so you know what the plan will pay, and your financial responsibility, if applicable.**		

To find Participating Providers:

- Call Guardian at 800-541-7846.
- Visit www.guardiananytime.com. Select "Find a Provider" and "Find a Dentist." Then select the "PPO" plan, enter your location, and select the "DentalGuard Preferred" network.

Once enrolled, log into www.guardiananytime.com to verify benefits, print your ID card, or check claim status.

Have a smartphone or tablet? Download the Guardian Anytime Mobile App from your device's app store. Use it to access an image of your ID card and to locate participating providers.

Guardian Vision Discount Program

This benefit is included with your Dental Coverage if you do not have the Vision Coverage. Exams, frames, lenses, a doctor's charges for contact lens professional services, and laser surgery have discounted fees. See your Guardian Dental Certificate of Coverage booklet (Vision Discount Program section) for more information.

Important note: Contact lenses are not discounted.

Guardian College Tuition Benefit

This benefit is included with your Dental Coverage:

- Employees enrolled in a Guardian dental plan earn $2,000 in annual rewards, and a bonus in year 4.
- One Tuition Reward point = $1 in tuition reduction.
- You will receive rewards each year you have Guardian Dental Plan benefits.
- Rewards can be used at over 375 institutions.
- Tuition Rewards can be given to your relatives: children, nephews, nieces, and grandchildren.

Register at www.Guardian.CollegeTuitionBenefit.com.

Vision

Guardian/Davis Vision is your carrier. A summary of benefits is provided in the chart below.

Your Plan Pays	PPO	
	In Network (Your Plan Pays)	Out of Network (Your Plan Pays)
Exam *(Every Calendar Year)*		
Vision Examination	100% after $10 Copay	$50 maximum reimbursement after Copay
Materials		
Eye Glass Lenses *(Every Calendar Year)*		
Single Vision	100% after $25 Copay	$48 maximum reimbursement after Copay
Lined Bifocal	100% after $25 Copay	$67 maximum reimbursement after Copay
Lined Trifocal	100% after $25 Copay	$86 maximum reimbursement after Copay
Lenticular	100% after $25 Copay	$126 maximum reimbursement after Copay
Contact Lenses *(Every Calendar Year)**		
Elective and Conventional	$130 maximum (Copay waived), 15% discount above $130	$105 maximum reimbursement (Copay waived)
Planned Replacement/Disposable	$130 maximum (Copay waived), 15% discount above $130	$105 maximum reimbursement (Copay waived)
Medically necessary	100% after $25 Copay	$210 maximum reimbursement (Copay waived)
Frames *(Every Two Calendar Years)***	$130 maximum, 20% discount above $130	$48 maximum reimbursement after Copay
Other Discounts		
Laser Correction Surgery	Up to 25% off the usual charge or 5% off promotional price	No discounts
Cosmetic Extras	Average 40-60% off retail price	No discounts
Glasses (Additional pair of frames and lenses)	Courtesy discount from most providers	No discounts

*Contact lenses are in lieu of eyeglass lenses and/or frames.

Contact lenses from Davis Vision's Collection are available at most private practice locations. Contacts from the Collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. To find one of these providers, visit www.DavisVision.com/Open-Enrollment. Under "See the Value" enter Client Code 7070 and press 'Enter' on your keyboard. Click on "Find a Provider," enter your search information and click on "Search Now." Providers that have the Collection are listed with one of the following "Services," Contact Lenses and Eyeglasses, Exam and Contact Lenses, or Full Service, and the eyeglasses icon  .

Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.

**Due to lower prices available at Walmart and Sam's Club locations, discounts do not apply. Members will pay 100% of the amount over their allowance. Extra $50 at Visionworks stores.

Frames from the Fashion or Designer collections are covered in full in excess of the plan's materials copay. Frames from the Premier collection are covered in full in excess of a $25 copay applied in addition to the plan's materials copay. Frames from a network provider that are not in the collections are covered up to the plan's retail allowance in excess of the plan's materials copay, if applicable.

To find Participating Providers:

- Call Guardian/Davis Vision at 877-393-7363.
- Visit www.guardiananytime.com. Select "Find a Provider" and "Find a Vision Provider." Then select the "Davis Vision" plan, enter your location, and click "Continue."

Once enrolled, log into www.guardiananytime.com to verify benefits, print your ID card, or check claim status.

Have a smartphone or tablet? Download the Guardian Anytime Mobile App from your device's app store. Use it to access an image of your ID card and to locate participating providers.

Spending Accounts and Employee Assistance Program

Medical Flexible Spending Account (FSA)

Administered by Medcom.

This account allows you to set aside funds on a pre-tax basis (meaning you pay no Federal, State or FICA taxes) to pay for non-covered expenses such as:

- Medical / Prescription Drug Copays and Deductibles
- Copays for prescription eye glasses
- Certain over the counter medicines - only with a doctor's prescription
- Dental services (non-cosmetic)
- Bandages
- Contact lenses and cleaning solution
- Orthodontia

If you have a spouse and/or Child(ren), your out-of-pocket expenses for their health care and treatments are eligible too.

The amount you may set aside depends on when you are eligible for benefits. If you are eligible for benefits on May 1, the maximum you may set aside is $2,650, and the maximum is then prorated each month following.

The Medical FSA has a rollover provision, allowing amounts up to $500 to carry over to the new plan year. The rollover does not affect your ability to set aside the maximum for the new plan year. **Note:** any amount over the $500 rollover that you have elected and do not file for reimbursement within 90-days of the April 30th plan year end is forfeited.

You will receive a MasterCard debit card directly linked to your FSA account to conveniently pay for your out-of-pocket health care expenses.

Easily manage your FSA with Medcom's mobile app and web portal.

Dependent Care Spending Account

Administered by Medcom.

This account enables you to pay for certain out-of-pocket, work-related dependent daycare costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work, or, in some situations, if your spouse goes to school full-time. Single employees with a child or children can also use the account.

The amount you may set aside depends on when you are eligible for benefits. If you are eligible for benefits on May 1, the maximum you may set aside is $5,000 if single or married filing jointly, or $2,500 if married filing separately, and the maximum is then prorated each month following.

You will receive a MasterCard debit card directly linked to your account to conveniently pay for your eligible dependent day care expenses.

Employee Assistance Program

Provided through Guardian.

The WorkLife Matters EAP provides:

- Unlimited free telephonic consultation with an EAP counselor available 24 hours a day, 7 day a week,
- A website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center, and
- Up to three free face-to-face visits with counselors to help with a short term problem.

Why might I want to speak with a counselor?

- **Education:** Admissions testing & procedures, Adult re-entry programs, College Planning, Financial aid resources, Finding a pre-school
- **Lifestyle & Fitness Management:** Anxiety & depression, Divorce & separation, Drugs & alcohol
- **Dependent Care & Care Giving:** Adoption Assistance, Before/after school programs, Day Care/Elder Care, In-home services
- **Working Smarter:** Career development, Effective managing, Relocation
- **Legal and financial:** Basic tax planning, Credit & collections, Debt Counseling, Home buying, Immigration

Who is eligible to call?

You and your family members that live in your household.

How do I access the EAP?

- **By Telephone:**
  800-386-7055
- **Online:** www.ibhworklife.com
  User Name: Matters
  Password: wlm70101

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your family members (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new family member as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your family members, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

The Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. Therefore deductibles and coinsurance apply.

Please call Blue Cross Blue Shield at the number on your ID Card for more information.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and y**ou must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	KANSAS – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
ALASKA – Medicaid	KENTUCKY – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARKANSAS – Medicaid	LOUISIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	MAINE – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
FLORIDA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120
GEORGIA – Medicaid	MINNESOTA – Medicaid
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
INDIANA – Medicaid	MISSOURI – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864 Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid	MONTANA – Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	TEXAS – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	UTAH – Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	VERMONT– Medicaid
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825 Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
OKLAHOMA – Medicaid and CHIP	
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	
OREGON – Medicaid	WASHINGTON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
WYOMING – Medicaid	WISCONSIN – Medicaid and CHIP
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Please note that this guide is a general summary of your benefits. For specific details, you may refer to each carrier's certificate booklet/summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.