Employee Benefits Guide

Plan Year January 1, 2022 thru December 31, 2022

Enroll online at www.eElect.com

Enrollment ID = 109274

Then Follow On-Screen Instructions

This handbook includes information on the following:

Medical Benefits | Dental Benefits | Vision Benefits | Life Insurance | Disability Insurance

COBRA Continuation | Important Contacts

TABLE OF CONTENTS

This booklet is a summary only. Please refer to each plan's certificate of coverage / plan document for a complete description of all benefits and exclusions. If there is any difference between the information provided in this booklet and any certificate of coverage / plan document, the certificate of coverage / plan document will govern. Copies of all certificates of coverage / plan documents are available in 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

Newly hired full-time employees are eligible for benefits on the first day of the month following 60 days of full-time employment. Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian. Federal law requires all health plans to report social security numbers for employees and covered dependents. Please make sure to have all necessary names, birthdates and social security numbers available for your enrollment.

CHANGES

Pre-Tax Deduction of Premiums (Section 125 Plan) - Health, dental, and vision insurance premiums are all deducted (if you have elected deductions) from your pay on a pre-tax basis (exempt from FICA, Federal and State tax) which in turn provides significant cost savings. This will continue and does not require any action on your part unless you desire to make changes. You will be able to make changes on any of your elections during the open enrollment period. Your selections cannot be changed until next year unless the revocation and new election are due to and consistent with a valid status change (e.g., marriage, divorce, death of a spouse or child, birth or adoption of a child or change of employment of your spouse as detailed in the Section 125 Regulations). ***If you have a status change during the year you must notify Human Resources within 30 days. Any request to make changes after 30 days will not be allowed until the next annual open enrollment.*** Please contact the County at 706-253-8820 if you have any questions regarding the open enrollment period or changes.

MESSAGE FROM CHAIRMAN KRIS STANCIL

To: **All Full Time Employees**
From: **Chairman Kris Stancil**
Subject: **Employee Benefits**

Pickens 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.

The following pages contain detailed information about your available benefits.

Kris Stancil
Chairman
Pickens County

Jerry Barnes
West

Kris Stancil
Chairman

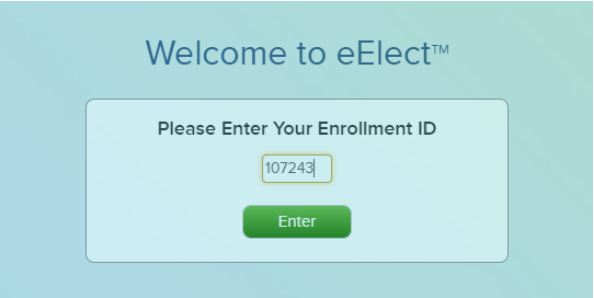
Online Enrollment - *Login Process*

The safety of your personal data is important to us and protecting it is something we take very seriously. You will now be required to log in with a username and password to access the enrollment and confirm your coverage. The first time you login to the enrollment site you will be required to go through a Multi-Factor Authentication (MAF) process and verify that you are who you say you are. The instructions below will help you with this process:

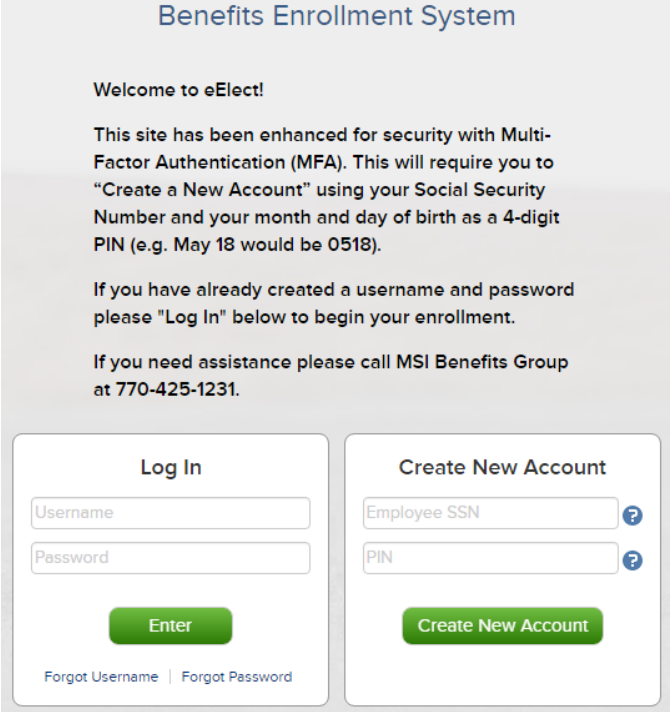
To Enroll:

First, go to www.eElect.com

Then enter Enrollment ID: 109274



Next, if this is your first time accessing the system with the new login process see the below steps. Otherwise login with your username and password.



- **Below "Create New Account" you will need to enter your Social Security Number without dashes and your Personal Identification Number (PIN), which is your month and day of birth as a 4-digit number (example, if you were born on March 7 your PIN number would be 0307)**
- **You will then be asked to enter a username and password and to provide answers to 3 security questions that you will select from a drop down menu. Finally, you will enter your email address (preferably one you have access to remotely)**
- **You will then be asked to retrieve and verify a security code from your email or mobile phone to complete the login process (this is required each time you login on a different device).**

MEDICAL PLAN AT-A-GLANCE

Pickens County will now be offering health insurance through Anthem. The plan will continue to have a $1,500 deductible and is Open Access. The plan does not require a PCP and referrals are not necessary to visit specialist physicians. This Open Access POS Plan also offers out-of-state and out-of-network coverage; however, you receive the best value by staying in-network.

IN-NETWORK	**Open Access POS**
Individual Calendar Year Deductible	$1,500
Family Calendar Year Deductible	$4,500
Coinsurance	Member Pays 20% Plan pays 80%
Individual Out-of-Pocket Calendar Year Maximum	$5,000
Family Out-of-Pocket Calendar Year Maximum	$10,000
Primary Care Physician Copayment	$30
Specialist Physician Copayment	$60
Preventive Care *(not subject to deductible)*	$0
Live Health Online *(Online Physician Visit)*	$5
Urgent Care Center Copayment	$60
Emergency Room Copayment *(waived if admitted)*	$150 then 20%
OUT-OF-NETWORK	**Open Access POS**
Individual Calendar Year Deductible	$4,500
Family Calendar Year Deductible	$13,500
Coinsurance	Member Pays 50% Plan Pays 50%
Individual Out-of-Pocket Calendar Year Maximum (Includes Deductible)	$21,450
Family Out-of-Pocket Calendar Year Maximum (Includes Deductible)	$42,900
	VERACITY RX
PRESCRIPTION DRUG COPAYMENTS (Retail - 30 Day Supply)	**RX Deductible: $200** (Tier 1 does not apply)
Tier 1 - Generic (Preferred Pharmacy)**	$5
Tier 1 - Generic (Non-Preferred Pharmacy)**	$20
Tier 2 - Name Brand	$45
Tier 3 - Non-Formulary	$85
Prescription Drug Copayments (Retail - 90 Day Supply) *- Not Available at Non-Preferred Pharmacy*	
Tier 1 - Generic	$10
Tier 2 - Name Brand	$90
Tier 3 - Non-Formulary	$170

** "Non-Preferred" Pharmacies include CVS, Target, Walgreen's, Walmart, Sam's Club and Rite-Aid = all other pharmacies are "Preferred"

EMPLOYEE MEDICAL DEDUCTIONS

Per Pay Period (Bi-Weekly—26 deductions / year)

COVERAGE LEVEL	**Open Access POS**
Employee Only	**$ 24.25**
Employee + Spouse	**$128.97**
Employee + Child(ren)	**$104.69**
Employee + Family	**$217.00**

OPEN ACCESS POS BENEFITS SUMMARY

	OPEN ACCESS POS	
COVERED MEDICAL BENEFITS	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Overall Deductible	$1,500 member $4,500 family	$4,500 member $13,500 family
Out-of-Pocket Limit	$5,000 member $10,000 family	$21,450 member $42,900 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive care / screening / immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services **Primary Care Office Visit to treat an injury or Illness**	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit (LiveHealth Online) *Includes Mental Health and Substance Abuse*	$5 copay per visit deductible does not apply	$5 copay per visit deductible does not apply
Manipulation Therapy *Coverage is limited to 20 visits per year*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

OPEN ACCESS POS BENEFITS SUMMARY

COVERED MEDICAL BENEFITS	OPEN ACCESS POS Cost if you use an In-Network Provider	OPEN ACCESS POS Cost if you use a Non-Network Provider
X-Ray:		
Office	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *(Cost share waived if admitted)*	$150 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse Disorder		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit:		50% coinsurance after deductible is met
Facility Fees	20% coinsurance after deductible is met	
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$200 coinsurance deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance deductible does not apply	50% coinsurance after deductible is met

OPEN ACCESS POS BENEFITS SUMMARY

	OPEN ACCESS POS	
COVERED MEDICAL BENEFITS	**Cost if you use an In-Network Provider**	**Cost if you use a Non-Network Provider**
Hospital (including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care Visits - *Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per year.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Limits are combined with Rehabilitation office visits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac Rehabilitation		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance deductible does not apply	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Introducing Your New Pharmacy Plan

Our new pharmacy coverage copays are as follows:

PRESCRIPTION DRUG COPAYMENTS (Retail - 30 Day Supply)	RX Deductible: $200 (Tier 1 does not apply)
Tier 1 - Generic (Preferred Pharmacy)**	$5
Tier 1 - Generic (Non-Preferred Pharmacy)**	$20
Tier 2 - Name Brand	$45
Tier 3 - Non-Formulary	$85
Prescription Drug Copayments (Retail - 90 Day Supply) *- Not Available at Non-Preferred Pharmacy*	
Tier 1 - Generic	$10
Tier 2 - Name Brand	$90
Tier 3 - Non-Formulary	$170

** "Non-Preferred" Pharmacies include CVS, Target, Walgreen's, Walmart, Sam's Club and Rite-Aid = all other pharmacies are "Preferred"

Heads up! We're making some changes to our pharmacy benefits. **Starting January 1, 2022, our new Pharmacy Benefit Provider will be VeracityRx.** As your new benefits partner, VeracityRx will handle all claims and customer service functions including Specialty and International pharmacy fulfillment.

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

To make this transition as hassle-free as possible, we've put together this guide, to help you better understand your benefits, find care, manage costs and get the most out of your pharmacy plan.

How to Connect

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

Member Portal Access and Benefits Management

- Register for your member portal access ***on or after January 1, 2022 and after you receive your ID card.***
    - Register at: https://veracity.procarerx.com/account/login
- Use your online account to:
    - Access and/or restrict profile viewing by other family members
    - Review your prescription claims history or individual prescriptions
    - Look up a drug to identify formulary status and preferred alternatives
    - Locate pharmacies within a zip code, state, city, or county

VERACITYRx
Powered by ProCare Rx

Prescription Coverage Overview

VeracityRx

Here's what's changing as well as just a few ways our Pharmacy program strives to save members money.

Go Generic and Save

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

Avoid High-Cost Pharmacies

- **As of January 1, 2022**, the following pharmacies will be considered **Non-Preferred** and will require a $20 copay for generic drugs: CVS, Target, Walgreen's, Walmart, Sam's Club and Rite-Aid. *After 1/1, you will pay a higher copay if you go to one of them.*
    - **Preferred Pharmacies:** All independent pharmacies and grocery stores are considered preferred and will require a $5 copay.

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

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

Access to our Pharmacist Advocate Concierge

- **[REQUIRED] Specialty Medications**
    - When you are prescribed a **Specialty Drug**, VeracityRx will contact you to find out how we can help obtain your prescription at **$0 or Minimal Cost**. If you are currently on a specialty drug, you can get started in the meantime by going to www.veracity-rx.com and complete the **"Enrollment Form"** located at the top of the page with your information. Once completed, a VeracityRx pharmacist concierge will be in touch.

- **[REQUIRED] International Medications**
    - Medications that can be obtained internationally (from Canada) must also be acquired through the VeracityRx Pharmacist Concierge program. When the medications are obtained this way, the cost to you is **$0 Copay**. *You may still continue to fill these medications at your local retail pharmacy until you're enrolled into the program.* A VeracityRx Pharmacist Concierge will be in touch to confirm enrollment. For more information on the process and to see which drugs are considered an international type of medication, see additional information within the packet.

Note: *Some drugs require a pre-authorization. Even if you have obtained a pre-authorization with the current plan, you may have to obtain an update one for the new plan.*

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Specialty Medications

IMPORTANT: Specialty Medications

Effective January 1, 2022, Specialty Medications will only be covered by VeracityRx Pharmacist Concierge Services. A Pharmacist Concierge, who is a registered pharmacist, will work with you as their advocate. Their team works closely with you (and/or covered family members who are taking a specialty or international medication) and with the specialty medication manufacturer, the prescriber, and other entities to maintain the prescriptions while alleviating the financial burden.

- The program allows you to continue to fill Specialty medications **at low or no cost, but never more than you are currently paying.**
- To participate in this program, you will be required to submit certain documentation. If you choose not to participate in this program, you will be responsible for the **full cost of the medication.** This cost will **not** apply to your deductible or out of pocket accumulators.

Please allow a member of our Pharmacist Concierge team to take the lead in discussions with the drug manufacturer or their various foundations that offer assistance. As your concierge and patient advocate, we are here to work on your behalf. If you or your covered dependent are currently taking a medication affected by these changes, someone will be in touch with you by email or phone regarding the steps needed to alleviate your financial burden.

To begin the process, log onto the website below to complete the "Enrollment Form".

These documents typically include:

- Limited Power of Attorney (gives the Pharmacist Concierge only the authority to help and that authority permits seeking assistance for Specialty medications).
- Signed copy of most recent federal tax return;
- Front and back copy of medical insurance card.

To offset your costs, enrollment and requested documents must be provided. If you comply with the document request, you will never pay more than you are currently paying for a Specialty medication. In most cases, ***you pay nothing****.*

Examples of Commonly Prescribed Specialty and International Drugs:

Aubagio, Avonex, Bydureon, Cosentyx, Dovato, Dupixent, Enbrel, Erivedge, Genvoya, Humira, Ibrance, Imbruvica, Levemir, Orencia, Otezla, Ozempic, Praluent, Prezcobix, Repatha, Rinvoq, Skyrizi, Stelara, Tagrisso, Taltz, Tecfidera, Toujeo, Tremfya, Tresiba, Triumeq, Trulicity, Truvada, Ubrelvy, Victoza, Xeljanz, Xifaxan, Xtandi

VeracityRx Pharmacist Concierge Contact Information:

Sign-up at: www.veracity-rx.com

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International Medications

IMPORTANT: International Medications

Note: The international medications process differs slightly from the specialty.

Enrollment Process:

- If you or a covered member of your household are on any of the commonly prescribed international drugs listed below, **please continue to fill locally at your pharmacy.**

- VeracityRx will contact you once we move you into the international program. **The benefit of enrolling is that you will no longer have a copay** and your employer will save at least 50% on the cost of the medication.

- Medications fulfilled through the international program will be the same medications, made by the same manufacturers but filled through our partner pharmacy in Canada. Once we enroll you in the international program, you will be contacted to verify your shipping address and/or additional information. Processing and shipping can take up to 30 days, however, please note that your medications will continue to be filled without interruption.

COMMONLY PRESCRIBED INTERNATIONAL DRUG LIST*		
Ajovy	Isentress	Trelegy Ellipta
Apidra	Janumet	Tresiba
Atripla	Janumet XR	Trintellix
Basaglar KwikPen	Januvia	Trulicity
Biktarvy	Jardiance	Truvada
Breo Ellipta	Levemir	Victoza
Bydureon	Ozempic	Xarelto
Dexcovy	Prexcobix	
Eliquis	Rexulti	
Farxiga	Saxenda	
FIASP	Tivicay	
Invokana	Toujeo	
Invokamet	Tradjenta	

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

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Prescription Coverage FAQs

Frequently Asked Questions

Pharmacy FAQs	Pharmacy Benefits
Who is my Pharmacy Benefit Provider?	VeracityRx is your Pharmacy Benefit Provider.
Are there preferred or non-preferred pharmacies?	There are a few pharmacies that are considered *non-preferred.* They are CVS, Walgreen's, Walmart, Target, Rite Aid, and Sam's Club. All other independent pharmacies are considered preferred. We encourage grocery store chains, locally-owned neighborhood pharmacies and Costco as your lowest cost options.
Where can I fill my prescriptions?	Virtually any pharmacy can fill your prescription(s). However, you will pay a higher copay if you go to a *non-preferred* pharmacy. If you request a brand drug when a generic is available, you will pay the difference in cost.
Can I get a 90-day supply?	A 90-day supply is available at any pharmacy ***other than*** the non-preferred pharmacies.
What is considered a specialty or international drug?	**Examples of Commonly Prescribed Specialty and International Drugs:** *Aubagio, Avonex, Bydureon, Cosentyx, Dovato, Dupixent, Enbrel, Erivedge, Genvoya, Humira, Ibrance, Imbruvica, Levemir, Orencia, Otezla, Ozempic, Praluent, Prezcobix, Repatha, Rinvoq, Skyrizi, Stelara, Tagrisso, Taltz, Tecfidera, Toujeo, Tremfya, Tresiba, Trikafta, Triumeq, Trulicity, Truvada, Ubrelvy, Victoza, Xeljanz, Xifaxan, Xtandi*
Where can I fill my specialty or international prescriptions?	Our Pharmacist Concierge can help you obtain your specialty or international drugs at the lowest possible cost for you and the company. Go to: www.veracity-rx.com to get started!

Common drug exclusions

The plan does not cover certain items. Some exclusions may include:

- Over the counter (OTC) medications or their equivalents, including certain Proton Pump Inhibitors (PPI) or allergy medications, such as Prevacid, Prilosec, Nexium, Zyrtec, Allegra, and Claritin
- Drug products used for cosmetic purposes
- Vitamins and minerals (except prenatal vitamins)
- Experimental drug products, or any drug used in an experimental manner

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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.

Anthem BlueCross BlueShield LiveHealth ONLINE

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.

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How much does it cost to use LiveHealth Online?

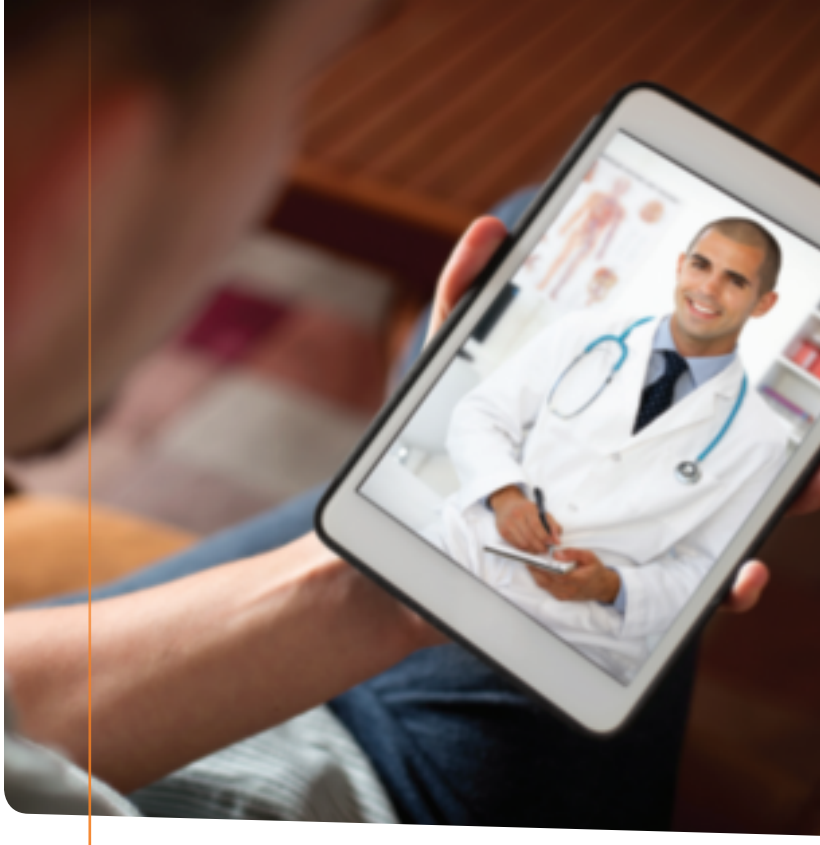
Your Anthem plan includes benefits for video visits using LiveHealth Online. **$5 copay per visit, deductible does not apply.**

Will I be charged more if I use LiveHealth Online on weekends, holidays or at night?

No, the cost is the same.

How do I pay for a LiveHealth Online visit?

You can use PayPal, American Express, Visa, MasterCard and Discover cards to pay for an online doctor visit. Keep in mind that charges for prescriptions aren't included in the cost of your visit.



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.**

Anthem BlueCross BlueShield LiveHealth ONLINE

* 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.

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]

If you're feeling anxious or having trouble coping on your own and need some support, you can have a video visit with a therapist using LiveHealth Online. Make an appointment in four days or less at **livehealthonline.com** or on the phone at **1-888-548-3432** from 7 a.m. to 7 p.m., seven days a week.[2] Evening and weekend appointments are available. You can get help for anxiety, depression, grief, panic attacks and more.

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.

Anthem BlueCross BlueShield

LiveHealth ONLINE

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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.

Sydney Health makes healthcare easier

Access personalized health and wellness information wherever you are

The Sydney Health mobile app is the one place to keep track of your health and your benefits. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you such as gender, languages spoken, or location.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker, then consult with a doctor through a video visit or text session.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals.

Community Resources

This resource center helps you connect with organizations offering free and reduced-cost programs to help with challenges such as food, transportation, and child care.

Live Chat

Find answers quickly with the Live Chat tool in Sydney Health. You can use the interactive chat feature or talk to an Anthem representative when you have questions about your benefits or need information.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

Download Sydney Health today

Use the app anytime to:

- Find care and compare costs
- See what's covered and check claims
- View and use digital ID cards

GET IT ON Google Play

Download on the App Store

Use your smartphone camera to scan this QR code

Anthem

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Dental Insurance

Pickens County offers a dental insurance plan through Cigna to benefit eligible employees. The costs per pay period for coverage are listed in the table below and a brief summary of benefits is provided on the following pages. For more detailed information about the dental plans, please refer to the certificate of coverage.

EMPLOYEE DENTAL DEDUCTIONS Bi-Weekly (26 deductions / year)	
Tier of Coverage	**Dental**
Employee Only	$11.68
Employee + Spouse	$23.63
Employee + Child(ren)	$29.15
Employee + Family	$41.11

Group Certificate of Coverage

A copy of the **Group Certificate of Coverage** may be requested from Human Resources or is available as follows:

Go to: www.msibg.com
Username: pickensEE
Password: Benefits123

Can I go to any dentist?

You will typically spend less when you visit a Cigna network dentist because Cigna has negotiated discounted rates with these dentists. When you stay in the network you'll save as long as the procedure is listed on the dentist's discount schedule. These savings apply even if you reach your plan maximum. If you go out-of-network, you will not receive Cigna network discounts and the dentist may bill you for the difference between the payment they receive from Cigna and their usual fees.

Do I pay up front and submit a claim or will the dentist submit claims for me?

In most instances, if you are using an in-network dentist, they will submit claims on your behalf and will bill you for any deductible or coinsurance payment that you owe. If you use an out-of-network dentist, you may need to file your own claims after payment.

What information is available to help me choose a dentist?

As you choose your network dentist or specialist, you have several important factors to consider such as cost, experience and location. The **myCigna** directory helps you find a dentist by providing helpful digital tools, such as:

- **Brighter Score™.** Use this scoring method to compare dentists. The score is based on things like affordability, patient experience and professional history.
- **Dental office reviews and comparisons.** Find detailed information to compare dental offices. View dentist profiles with photos and videos. Read verified patient reviews. Write your own review after your appointment.
- **Online appointment scheduling.** With dental offices that offer this service, you can make an appointment right from your laptop or mobile device, and even receive appointment reminders.
- **Enhanced search and transparent pricing.** Search for a dentist by service. Information is personalized for your specific plan. Shows price with coinsurance and deductibles.

Can you explain the deductible, maximum and percentages listed?

The deductible is the amount you need to pay for covered services before your benefits begin. You will pay for your dental treatment until you reach that amount. Then, you and your plan begin to share a percentage of your covered dental costs, known as coinsurance. **The percentage** shown on your plan materials is the percentage the plan pays for the listed procedures, and then you pay the difference.

The maximum is the most your plan will pay for your dental claims during the plan year. Once you reach that maximum, your plan will no longer pay a percentage of your costs for the rest of that plan year. Even after you reach the maximum, however, dentists in the network may continue to offer you discounted fees for the services

Cigna DPPO Dental Plan At-A-Glance

Network	Cigna DPPO
Calendar Year Maximum Benefit Per Member	
Class I, II, III Expenses	$1,000
Plan Year Deductible	
Per Member	$50
Per Family	$150
Class I Expenses: Preventive & Diagnostic Care	
Oral Exams *(2 per year)*	Plan pays 100% Deductible Waived
Cleanings *(2 per year)*	
Routine X-rays *(2 per year)*	
Fluoride Application *(2 per year under age 19)*	
Non-Routine X-rays *(1 per 36 months)*	
Emergency Care to Relieve Pain	
Class II Expenses: Basic Restorative Care	
Fillings *(amalgam or composite)*	Plan pays 80%, After Deductible
Oral Surgery	
Surgical Extraction of Impacted Teeth	
Anesthetics	
Periodontics	
Root Canal Therapy / Endodontics	
Brush Biopsy	
Class III Expenses: Major Restorative Care*	
Relines, Rebases and Adjustments	Plan pays 50%, After Deductible
Repairs (Bridges, Crowns, Inlays and Dentures)	
Crowns / Inlays / Onlays	
Stainless Steel / Resin Crowns	
Dentures	
Bridges	
Class IV Expenses: Orthodontia*	
Lifetime Maximum	$1,000
Benefit *(Dependent child less than 19 years of age)*	Plan pays 50%

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit ww.mycigna.com. When completing search criteria, select Cigna Total DPPO network.

Late Entrant Provisions

You are considered a late entrant if you elect the insurance more than 30 days after you become eligible for it; or you again elect it after you cancel your payroll deduction.

Class I and II are paid at the amounts set forth in the schedule. All other classes of service are paid at 50% of the amounts set forth in the schedule. After a person has been continuously insured for 12 months, this limit no longer applies.

Vision Insurance

Pickens County offers vision insurance through Cigna to benefit eligible employees. The costs per pay period for coverage are listed in the table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the certificate of coverage.

EMPLOYEE VISION DEDUCTIONS Bi-Weekly (26 deductions / year)	
Tier of Coverage	**Employee Cost**
Employee Only	**$ 3.06**
Employee + Spouse	**$ 6.13**
Employee + Child(ren)	**$ 6.19**
Employee + Family	**$ 9.88**

Group Certificate of Coverage

A copy of the **Group Certificate of Coverage** may be requested from Human Resources or is available as follows:

Go to: www.msibg.com
Username: pickensEE
Password: Benefits123

Make the Most of Your Vision Coverage

With your vision plan through Cigna, you and your covered family members have access to quality vision care. Your plan provides coverage for routine eye exams and may include glasses and/or contact lenses. Check your plan materials for details. Also, make sure you know the difference between in-network and out-of-network coverage.

In-Network

You'll save the most money if you pick an eye doctor from Cigna Vision's large network. And you'll have lots of choices. We offer one of the largest specialty networks of optometrists, ophthalmologists and nationally recognized eye care retailers.

Out-of-Network

If you choose a doctor who's not in the network, you'll have to pay the total amount due at your appointment. To get reimbursed, you'll need to submit a Cigna Vision claim form with an itemized receipt. You can find the claim form on **myCigna.com** on the "Forms" page. The whole amount may not be covered. You're responsible for paying any charges not covered under your plan.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

Eye-Opening Information

A routine eye and vision exam can help your doctor test your vision and spot the early stages of eye disease. It's important to get your eyes dilated during the exam. This can help spot certain eye diseases, including the early stages of diabetes.

Keep an Eye on Your Kids

Eye exams aren't just for adults. They're also important for children. According to the American Optometric Association, one in four children has a vision problem that can affect their learning. Your kids may get a vision test at school or at their pediatrician's office. But these exams might not catch a serious eye disorder. That's why it's important to have your child visit an eye doctor, such as an optometrist or ophthalmologist. These specialist can help check your child's vision and eye health.

Vision Plan At-A-Glance

Cigna Vision Network		
Services	**In-Network**	**Out-of-Network**
Eye Exam Copay	$10 Copay	Up to $45 Reimbursement
Materials Copay	$20 Copay	N/A
Frequency of Services (Calendar year basis)		
Examination	Once per 12 months	
Lenses	Once per 12 months	
Frames	Once per 24 months	
Contact Lenses	Once per 12 months	
Lenses		
Single	Covered 100%	Up to $32 Reimbursement
Bifocal		Up to $55 Reimbursement
Trifocal		Up to $65 Reimbursement
Frames		
Eye Glass Frames	$130 Retail Allowance	Up to $71 Retail Allowance
Contact Lenses		
Elective *(Includes Fitting, Evaluation & Follow-up)*	Up to $130 Allowance	Up to $105 Allowance
Non-Elective; Medically Necessary *(Prior Authorization Required)*	Covered 100%	Up to $210 Allowance

Healthy Rewards® - Vision Network Savings Program

When you see a Cigna Vision Network Eye Care Professional, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

Locate a Provider

Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans. Choosing an eye doctor is easy with Cigna. There are three ways to find a quality in-network eye doctor in your area:

1. Log into **myCigna.com**, click "Coverage", and select "Vision page". Click on "Visit Cigna Vision". Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.

2. Don't have access to **myCigna.com**? Go to **Cigna.com**, At the top of the page select "Find A Doctor, Dentist or Facility", then click "Cigna Vision Directory", under Additional Directories.

3. Call the toll-free number found on your Cigna Vision ID card and talk with a Cigna customer service representative.

What's Not Covered

Plan deductibles, coinsurance, copays, frequency limitations, allowances, and options may apply. In general, Cigna Vision plans do not cover the following: (a) Orthoptic or vision training and any associated supplemental testing; (b) Medical or surgical treatment of the eyes; (c) Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; (d) Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related; (e) Charges in excess of the usual and customary charge for the Service or Materials; (e) Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy; (f) Experimental or non-conventional treatment or device (g) Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage; (h) VDT (video display terminal)/computer eyeglass benefit; and (i) Claims submitted and received in excess of twelve (12) months from the original Date of Service. Depending on the terms of your specific plan, the following also may not be covered: (a) Any non-prescription eyeglasses, lenses, or contact lenses; (b) Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage; (c) Prescription sunglasses; (d) Two pair of glasses, in lieu of bifocals or trifocals; and (e) Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage. Your vision plan's actual terms may vary. Refer to your plan documents for the coverage details of your specific vision plan.

Basic Life and AD&D Insurance

Basic Term Life

Pickens County provides Basic Term Life and AD&D Insurance to eligible employees through Anthem Life. The cost of Basic Term Life and AD&D Insurance is paid entirely by Pickens County. Below is a brief description of group life insurance coverage underwritten by Anthem. The summary highlights some of the features of the Group Policy, but it is not intended to be a detailed description of coverage. Your Certificate and Summary Plan Description 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.

Basic Term Life Benefit

$20,000

Accidental Death & Dismemberment

Also, at no cost to the employee, the County provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit.

Reductions in Insurance

Life and AD&D insurance reduces to 65% at age 65 and then to 50% of the original amount at age 70.

Basic Dependent Life Insurance

Basic Dependent Life Insurance is provided as follows:
Spouse: $5,000
Child(ren): $2,500

Voluntary Term Life Insurance

Voluntary Term Life Insurance

Eligible employees may elect to purchase additional Life and insurance on a voluntary basis through Anthem. This coverage may be purchased in addition to the Basic Term Life coverage. Voluntary Life insurance offers coverage for employees in **$10,000 increments up to a maximum of $250,000.**

Newly hired employees may purchase Voluntary Employee Life Insurance without having to go through Medical Underwriting (also known as Evidence of Insurability - EOI) up to the **Guaranteed Issue (GI) amount of $100,000.**

Voluntary Spouse and/or Dependent Child(ren) Life Insurance

Dependents are eligible for coverage as long as the employee is enrolled in coverage. Spousal Life Insurance is offered in $5,000 increments up to a maximum of $100,000. A spouse of a newly hired employee has a **Guaranteed Issue amount of $20,000** while dependent **Child(ren) are offered $5,000 or a $10,000** benefit.

Note: Spouse and Child Life amounts cannot exceed 50% of the employee's elected amount.

Reductions in Insurance

Voluntary life insurance reduces to 65% at age 65 and then to 50% of the original amount at age 70.

Accelerated Life Benefit

If you become terminally ill and meet other eligibility requirements you may receive an Accelerated Death Benefit of up to 75% of your Life Insurance.

Conversion and Portability Options Included

Important Notes

Always remember to keep beneficiary information updated.
Beneficiary information may be updated anytime through the Human Resources department.

Voluntary Term Life Insurance

EMPLOYEE / SPOUSE* LIFE OPTIONS Bi-Weekly (26 deductions / year)									
AGE	< 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$10,000	$0.37	$0.46	$0.88	$1.66	$2.59	$4.34	$7.39	$13.03	$20.14
$20,000	$0.74	$0.92	$1.76	$3.32	$5.18	$8.68	$14.78	$26.06	$40.28
$30,000	$1.11	$1.38	$2.64	$4.98	$7.77	$13.02	$22.17	$39.09	$60.42
$40,000	$1.48	$1.85	$3.53	$6.65	$10.36	$17.35	$29.56	$52.12	$80.57
$50,000	$1.85	$2.31	$4.41	$8.31	$12.95	$21.69	$36.95	$65.15	$100.71
$60,000	$2.22	$2.77	$5.29	$9.97	$15.54	$26.03	$44.34	$78.18	$120.85
$70,000	$2.58	$3.23	$6.17	$11.63	$18.12	$30.37	$51.72	$91.20	$140.99
$80,000	$2.95	$3.69	$7.05	$13.29	$20.71	$34.71	$59.11	$104.23	$161.13
$90,000	$3.32	$4.15	$7.93	$14.95	$23.30	$39.05	$66.50	$117.26	$181.27
$100,000	$3.69	$4.62	$8.82	$16.62	$25.89	$43.38	$73.89	$130.29	$201.42
$110,000	$4.06	$5.08	$9.70	$18.28	$28.48	$47.72	$81.28	$143.32	$221.56
$120,000	$4.43	$5.54	$10.58	$19.94	$31.07	$52.06	$88.67	$156.35	$241.70
$130,000	$4.80	$6.00	$11.46	$21.60	$33.66	$56.40	$96.06	$169.38	$261.84
$140,000	$5.17	$6.46	$12.34	$23.26	$36.25	$60.74	$103.45	$182.41	$281.98
$150,000	$5.54	$6.92	$13.22	$24.92	$38.84	$65.08	$110.84	$195.44	$302.12
$160,000	$5.91	$7.38	$14.10	$26.58	$41.43	$69.42	$118.23	$208.47	$322.26
$170,000	$6.28	$7.85	$14.99	$28.25	$44.02	$73.75	$125.62	$221.50	$342.41
$180,000	$6.65	$8.31	$15.87	$29.91	$46.61	$78.09	$133.01	$234.53	$362.55
$190,000	$7.02	$8.77	$16.75	$31.57	$49.20	$82.43	$140.40	$247.56	$382.69
$200,000	$7.38	$9.23	$17.63	$33.23	$51.78	$86.77	$147.78	$260.58	$402.83
$210,000	$7.75	$9.69	$18.51	$34.89	$54.37	$91.11	$155.17	$273.61	$422.97
$220,000	$8.12	$10.15	$19.39	$36.55	$56.96	$95.45	$162.56	$286.64	$443.11
$230,000	$8.49	$10.62	$20.28	$38.22	$59.55	$99.78	$169.95	$299.67	$463.26
$240,000	$8.86	$11.08	$21.16	$39.88	$62.14	$104.12	$177.34	$312.70	$483.40
$250,000	$9.23	$11.54	$22.04	$41.54	$64.73	$108.46	$184.73	$325.73	$503.54

* Spouse rates are based on the employee's age

CHILD(REN) BENEFIT OPTION	
$5,000 BENEFIT	Bi-Weekly Cost - $0.47
$10,000 BENEFIT	Bi-Weekly Cost - $0.93

Evidence of Insurability (EOI)

Anthem requires EOI in order for new employees to purchase insurance above the guaranteed issued amount, for any employee who has previously declined coverage or if you are requesting to increase your current coverage amount. EOI involves completing a medical questionnaire and receiving carrier approval before your insurance takes effect.

Waiver of Premium

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

Conversion Privilege

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.

Portability

An employee may request to continue coverage by submitting a written application and the required amount of premium within 31 days of the date coverage terminated under the policy.

Voluntary Short Term Disability Plan

Pickens County offers Voluntary Short Term Disability Insurance to all eligible full-time employees through Anthem. These benefits are designed to pay you an income if you cannot work as a result of an illness or an illness or an accident that occurs off the job.

Short Term Disability	
% of Salary	Up to 60% of Weekly Salary
Maximum Weekly Benefit	Up to $750
Elimination Period	15 Days
Duration Period	26 Weeks
Pre-Existing Conditions	The plan does not cover a disability due to pre-existing condition during the 12 months after your effective date of coverage, for treatment received within 3 months prior to your effective date of coverage

HOW TO CALCULATE YOUR INDIVIDUAL PREMIUM - To calculate your per-paycheck cost for this coverage, complete the calculations below.

NOTE: *If your weekly salary exceeds $1,250 use $1,250 as your weekly salary in the calculation.*

_____ ÷ 52 = _____ X ___60%___ = _____
Annual Salary | Weekly Salary | Benefit % | **Your Weekly Benefit**

_____ ÷ 10 = _____ X ___1.30___ = _____
Your Weekly Benefit | Your Rate | **Your Monthly Cost**

_____ X 12 = _____ ÷ _____26_____ = _____
Your Monthly Cost | Annual Cost | # Paychecks per Year | **Cost per Paycheck***

*Final Cost may vary slightly due to rounding.

Sick / Holiday Policy

SICK PAY

The County expects each employee to perform his/her job as scheduled. However, the County also realizes that employees may be required to be absent for legitimate medical reasons. In recognition, the County provides eligible full-time employees payment for absences due to medical reasons in certain circumstances.

Eligible full-time employees receive sick pay credit at a rate of ten (10) days (eight hours per day) per year and sick pay accrues on a pro-rata basis.

As a general matter, sick pay can only be used when an eligible employee is unable to perform his/her job due to legitimate medical reasons or if an employee misses work for reasons which would entitle an employee to leave pursuant to the Family and Medical Leave Act. Additionally, sick pay shall accumulate from year-to-year for a maximum of sixty (60) days. Employees who voluntarily quit or are separated from County employment for any reason will not receive payment for any accumulated sick pay.

Absences in excess of three (3) consecutive working days will only qualify for sick pay if the eligible employee submits a written statement from his or her physician certifying that the employee's condition prevented him/her from performing their job.

HOLIDAYS

The County provides the following paid holidays for all eligible full-time employees:

New Year's Day	**Martin Luther King, Jr's Birthday**	**Good Friday**	**Memorial Day**
July 4th (Independence Day)	**Labor Day**	**Columbus Day**	**Veteran's Day**
Thanksgiving Day (2 days)	**Christmas Eve**	**Christmas (2 days)**	**New Year's Eve**

If a holiday should occur on a Saturday or Sunday, the County may elect to observe the holiday on some other day of the week.

Your holiday pay will be your hourly rate multiplied by eight (8) hours.

To be eligible for holiday pay, an employee must work the full last scheduled work day before the holiday and the full next regularly scheduled work day after the holiday or, if absent, the absence was excused.

Vacation / Bereavement Policy

VACATION

The County believes that an annual vacation is an important part of an employee's health and welfare. It is the County's policy that each eligible employee take and be paid for the vacation to which he/she is entitled. Only full-time employees are eligible for paid vacation.

All full-time eligible employees shall be entitled to accrue annual leave. Annual leave accrues from the date of employment on a pro-rata hourly basis per pay period. However, only those eligible employees who have worked for the County more than six (6) months may take vacation, and the vacation cannot be taken before it is fully earned. Vacation pay is calculated using the employee's straight-time hourly rate at the time when the vacation is taken.

There will be no payment for accrued vacation in lieu of taking vacation, except for time off under the Family and Medical Leave Act. A maximum two (2) weeks earned unused annual leave hours may be rolled over into the following year.

Accumulation Rate – the accumulation rate for annual vacation is determined by the length of continuous service of the employee. The following is the accumulation schedule that is effective at the appropriate anniversary date:

Years of Service	80 hr. full-time employee	Sheriff/E-911	Fire/EMS
0 thru 5	80 hrs. (3.08 per pay)	86 hrs. (3.31 per pay)	108 hrs. (4.16 per pay)
6 thru 10	120 hrs. (4.62 per pay)	129 hrs. (4.97 per pay)	168 hrs. (6.47 per pay)
11 thru 15	144 hrs. (5.54 per pay)	155 hrs. (5.97 per pay)	194 hrs. (7.47 per pay)
16 thru 20	160 hrs. (6.16 per pay)	172 hrs. (6.62 per pay)	216 hrs. (8.31 per pay)
21 and above (MAX)	184 hrs. (7.08 per pay)	198 hrs. (7.62 per pay)	242 hrs. (9.31 per pay)

Maximum End of Year Roll Over is two weeks

** Sick leave accrues at 3.08 per pay period for all full-time employees*

BEREAVEMENT PAY

Paid bereavement time off of up to three (3) days (eight hours per day) is allowable upon the death of a full-time employee's immediate family member.

Immediate family is defined as an employee's spouse, child, grandchild, parent, brother, sister, parent-in-law, daughter-in-law, son-in-law, brother-in-law, sister-in-law, stepparent, stepchild and grandparent.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become eligible for the Pickens 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.

You may have other options available to you when you lose group health coverage.

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice **in writing** to: **Pickens County, Paula Peace, 1266 E. Church Street, Suite 150, Jasper, GA 30143.**

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.

Are there other coverage options besides COBRA Continuation Coverage?

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

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:

Pickens County
Paula Peace
1266 E. Church Street, Suite 150
Jasper, GA 30143
Phone: 706-253-8820

Benefit Elections and Costs

Type of Benefit	Benefit Plan	Coverage Level / Coverage Amount	Deduction Amount
Medical			
Dental			
Vision			
Basic Life and AD&D Insurance			
Supplemental Term Life Insurance			
Spousal Term Life Insurance			
Dependent Life Insurance			
Voluntary Short Term Disability			
		Total Per Pay Cost:	
		Total Annual Cost:	

Notes

Human Resources	Paula Peace HR Director	Phone: (706) 253-8820 Email: **ppeace@pickenscountyga.gov**
Medical Insurance	Anthem	Phone: (844) 274-5201 **www.anthem.com**
Pharmacy Benefits Manager	VeracityRx	Phone: (888) 388-8828 **https://veracity.procarerx.com/account/login**
LiveHealth Online	Anthem	Customer Service: (888) 548-3432 **livehealthonline.com** Smartphone App: "LiveHealth Online"
Dental Insurance	Cigna	Phone: (800) 244-6224 **www.mycigna.com**
Vision Insurance	Cigna	Phone: (800) 244-6224 **www.mycigna.com**
Basic Life and AD&D Insurance **Supplemental Life Insurance**	Anthem	Phone: (800) 851-8544 **www.anthem.com**
Short Term Disability	Anthem	Phone: (800) 851-8544 **www.anthem.com**
Online Benefit Enrollment (Only available during open enrollment)	MSI Benefits Group	**www.eElect.com** Phone: (770) 425-1231 Email: **eligibility@msibg.com**
Claims Resolution **Questions About Your Benefits** **Order ID Cards**		
Certificates and Plan Documents	MSI Benefits Group	**www.msibg.com** Username: pickensEE Password: Benefits123

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
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