



2017 YOU DECIDE

**Annual Enrollment
October 17 – November 4, 2016**

2017 You Decide

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Welcome to THE STATE OF GEORGIA FLEXIBLE BENEFITS PROGRAM

The State of Georgia is pleased to offer you a competitive flexible benefits program as an integral part of your Total Rewards package. Your 2017 *YOU DECIDE* booklet gives you an opportunity to review and understand these plans. It summarizes the options available to you and your eligible dependents, along with what you need do to obtain these benefits.

Are you planning or expecting the birth or adoption of a child? Getting married soon? Are you caring for an aging parent? Is it time to start thinking about supplementing your retirement? These are just some of life's changes that could affect the health care and financial needs of you and your family.

The 2017 plan year includes some enhancements, so review all your materials carefully. Please read the *YOU DECIDE* booklet to understand the options available to you and guide you in making the choices that best meet your needs. Making the right decisions today can make a real difference toward building a secure future for you and your family tomorrow.



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GENERAL ELIGIBILITY AND ENROLLMENT INFORMATION

Enrollment and Eligibility

You are eligible to participate in the Flexible Benefits Program if you are:

- A full-time, regular employee who works at least 30 hours a week and is expected to work for at least nine months. Employees who work in a sheltered workshop or work transition program, contingent employees, temporary employees, and student employees are not eligible.
- A public schoolteacher, working at least 17.5 hours per week, and employed in a professionally certified capacity, working half time or more and not considered a “temporary” or “emergency” employee.
- An employee of a local school system holding a non-certificated position. You must be eligible to participate in the Teacher’s Retirement System (TRS) or its local equivalent, and you must work a minimum of 20 hours a week (or 60% of the time necessary to carry out the duties of the position, if that’s more than 20 hours).
- An employee of a local school system working at least 15 hours (or 60% of the time necessary to carry out the duties of your position, if that’s more than 15 hours) and you are eligible to participate in the Public School Employees’ Retirement System (PSERS).
- An employee of a county or regional library and work at least 17.5 hours per week.
- Deemed eligible by Federal or Georgia law.

If you aren’t sure whether you’re eligible, contact your Human Resources/Payroll Office.

Dependents Eligible For Coverage

Eligible dependents include your:

- Legal spouse.
- Dependent child/ren who are under age 26.
- Dependent child/ren who are age 26 or over and incapable of self-sustaining employment by reason of mental incapacity or physical disability.
- Dependent child/ren are defined as you or your spouse’s natural or legally adopted child/ren. To verify eligibility of newly added dependents, you must provide supporting documentation (e.g., birth certificate, marriage certificate), if requested.

Salary for Benefit Purposes (Annual Benefit Base Rate)

Your Annual Benefit Base Rate includes your base salary and salary supplements that are regular, non-temporary, and not more than the amount on which retirement contributions are calculated. This amount is reflected on GaBreeze and remains constant for the entire plan year. It is calculated on your date of hire and updated each October 1 thereafter (the Benefit Calculation Date). Any adjustments to your Annual Benefit Base Rate, with the exception of errors (as determined by the Plan Administrator), shall be reflected on the following Benefit Calculation Date and effective for the following plan year. Promotions, demotions, and adjustments due to certifications are not deemed to be errors. Your Annual Benefit Base Rate is the pay used to calculate your coverage for employee life, AD&D, and disability insurance.

Benefits are a key part of your Total Rewards. Please note that your Annual Benefits Base Rate as of October 1 may be different from your regular salary.

The “Total Rewards” website, accessed through GaBreeze, has been enhanced and is now updated on a monthly basis. To check out the new site, go to www.team.ga.gov and click on **My Benefits** followed by **Flexible Benefits** to access GaBreeze. Then look in the upper right hand corner for the link to **Your Total Rewards**.

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Pre-Tax Premiums Help You Stretch Your Dollars

The Flexible Benefits Program allows you to save on taxes while you pay for your benefits. Pre-tax premiums reduce your taxable income – which, in turn, reduces your taxes. That’s because certain premiums (dental, vision, and, at your direction, life insurance), and Spending Account contributions are taken out of your pay *before* federal and state income taxes and Social Security (FICA) taxes are withheld.

The result? Your taxable income is lower and so are your taxes. It also means you have more in your paycheck – or more to spend on benefits than you would if you’d paid the same premiums with post-tax dollars.

Important Information for New Hires

If you are a new employee, look carefully at those Flexible Benefits that offer one-time opportunities.

- **New Hire Electronic Enrollment**
You will receive an enrollment worksheet, mailed to your home address, to prepare you to enroll. You can select your benefits using the employee website, www.GaBreeze.ga.gov or by accessing the Team Georgia Connection (www.team.ga.gov) by clicking **Flexible Benefits** under the **My Benefits** tab, or calling the GaBreeze Benefits Center at 1-877-342-7339.
- **Dental**
There is a six-month waiting period for Major services under the Select Plan and a six-month waiting period for Major and Ortho services under the Select Plus plan. The DHMO option does not have waiting periods or late enrollment penalties, but requires that you use a DHMO network provider. Go to www.cigna.com for a list of DHMO network providers.

- **Spending Accounts**
Your contributions to Spending Accounts will start on the 15th day of your first full calendar month of employment. For monthly payrolls, the full reduction will be taken once a month after your first full calendar month of employment. Your total contributions to each account are prorated by the number of months you participate in these options, up to the maximum monthly amount allowed for each account. Once you enroll, you may submit claims for services incurred on or after the first of the month after you have completed one full calendar month of employment.
- **Long-Term Care**
You have a one-time opportunity to sign up for Long-Term Care insurance without providing evidence of insurability.
- **Employee Life, Spouse Life, and Child Life**
You have a one-time opportunity to choose designated levels of employee and spouse life insurance coverage without providing evidence of insurability. Please see the Employee, Spouse, and Child Life section for specific limits.
- **Employee Critical Illness and Spousal Critical Illness**
You have a one-time opportunity to sign up for guaranteed levels of Critical Illness insurance, up to \$30,000, without providing evidence of insurability. Coverage for children is included with the Employee Benefit.

You also have a one-time opportunity to sign up for Spousal Critical Illness coverage, guaranteed up to \$30,000, without providing evidence of insurability.

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- **Disability**

During your new-hire eligibility period, you have a one-time opportunity to sign up for long-term disability coverage without providing evidence of insurability. If you do not enroll within this 30-day period, you will need to complete an evidence of insurability form. Your requested long-term disability coverage will not become effective until your evidence of insurability is approved by Standard Insurance Company (The Standard).

During your new-hire eligibility period, you have a one-time opportunity to sign up for short-term disability coverage without being subject to a late entrant waiting period (Late Enrollment Penalty). If you do not enroll within this 30-day period, you will be subject to the Late Enrollment Penalty.

- **Other Coverage**

There are no medical underwriting requirements at any time for legal insurance, AD&D, spending accounts, and dental and vision benefits.

After You Enroll For Coverage

Be sure to consider your options carefully when you first enroll. If you decline or drop some of your State coverages and want to pick them up again in a future Annual Enrollment, you may have to prove insurability through medical underwriting to be covered again, or have to complete longer waiting periods to receive full benefits.

When Coverage Begins

If you are a new employee, your benefit selection(s) and any necessary forms must be completed no later than 30 days after your hire date. Your coverage will begin on the first day of the month after you have completed a full calendar month of continuous employment.

Coverage for new options selected during Annual Enrollment will begin on January 1st of the following year, as long as you have met all contractual and administrative requirements.

Your new spending account reductions begin on the 15th of the month; other premiums are taken at the end of the month (for semi-monthly pay periods). These dates may not apply if your department has a different pay schedule. Please check with your Human Resources/Payroll Office for more information. See specific plan descriptions for information about when your coverage begins.

Confirming Your Choices

You are responsible for selecting the benefits you want by either:

- Entering selections on the GaBreeze website, or
- Calling the GaBreeze Benefits Center and verbalizing your selections.

It is crucial that you print your confirmation and verify your selections before the end of the enrollment period. The benefit elections reflected on the Statement will be in effect for the entire plan year. The Confirmation Statement does not guarantee your coverage for plans that require submission of additional information. If you have not completed and submitted the forms or other information required for your selected plan(s), the choices shown on your Confirmation Statement may not be valid.

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Compare your paycheck statements with your Confirmation Statement. Deductions should match the confirmed choices. Should you find any discrepancies, it is your responsibility to notify your Human Resources/Payroll Office immediately. Any changes in benefits must be in accordance with IRS §125, Employee Benefits Plan Council rules and regulations and be approved by plan administrators.

To Change Your Decisions at Annual Enrollment

Each Annual Enrollment, you can change your benefit decisions based on which of the available options are best for you and your family. Remember, this is an annual agreement allowing the State to purchase selected benefits for you, as described in this booklet, through pre-tax premiums. (Note: not all benefits are available on a pre-tax basis.) You will not be able to change benefit elections until the next Annual Enrollment – unless you have a qualifying change in status, as described in the Terms and Conditions.

For new hires, if you have made your benefit decisions on the GaBreeze website and wish to make a change within your 30-day enrollment window, you will need to contact the GaBreeze Benefits Center at 1-877-342-7339.

To Change Your Decisions Outside of Annual Enrollment

Qualifying Change in Status Event

In general, the Internal Revenue Service prohibits you from changing coverage elections, or enrolling in or canceling coverage under the Flexible Benefits Program, outside of Annual Enrollment. However, the rules of the Internal Revenue Service and the Employee Benefits Plan Council *do* permit you to change coverage, enroll, or cancel coverage in certain limited circumstances, if the change corresponds to a qualifying change in status event.

Examples of Qualifying Changes in Status

- Marriage or divorce
- Birth, adoption, or legal guardianship
- Death of a dependent
- Loss of spousal coverage

For more information, see Terms and Conditions, pp. 36-37.

30-Day Window

If you have a qualifying change in status, the IRS allows you a limited period – 30 days – to make applicable benefit changes. In most cases (e.g., birth or adoption), if you make your benefit changes within the 30-day window, they will be backdated to the date of the qualifying event. If you do not do so within 30 days, you will have to wait until the following Annual Enrollment to update your benefits.

Your request for enrollment or a change in coverage under the Flexible Benefits Program must be entered on the GaBreeze website, or by calling the GaBreeze Benefits Center, within 30 days after the qualifying event. There will be no refund of premiums paid into the plan when a timely change is not made.

Generally, benefit changes will go into effect on the first day of the month following the request when the payroll deduction is changed to reflect your new choices. For some benefits, however, when you change coverage based on the acquisition of dependents, the effective date for the coverage may be retroactive to the date of the qualifying event, or may be the first of the month following the request to change coverage.

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Separation From Service

- **Unpaid Leave**

When you go on leave without pay, you will receive a bill from GaBreeze for your benefits coverage. If you do not continue paying these premiums, your benefits will be cancelled and you may be subject to penalties and waiting periods when you seek to reinstate them. You may also be required to wait until the next Annual Enrollment period to re-enroll. Be sure to review Plan Descriptions for each option. Unpaid Family Medical Leave (FML) and Military Leave will be handled in accordance with applicable laws.

- **Retirement**

It is the employee's responsibility to contact the provider directly, within the required timeframe, to continue coverage for Employee/Spouse/Child Life, AD&D, Long-Term Care, Long-Term Disability, Employee/Spouse Critical Illness, or Legal Insurance, as applicable. If you retire and are currently enrolled in dental, your coverage will continue automatically. If you wish to cancel your dental coverage, contact the GaBreeze Benefits

Center. (Please note that, once cancelled, dental coverage cannot be reinstated.) If you wish, you may continue your Health Care Spending Account (HCSA) through COBRA.

- **Breaks in Employment**

If you leave active State employment but return within a 30-day period during the same plan year, your previous benefit choices will remain in effect unless you report a qualifying change in status event. If you leave active State employment and return in the same plan year *beyond* a 30-day period, you will be treated as a new hire and must make new benefit elections. If you retired and are a rehire returning to a benefits-eligible position, you must re-elect dental in order to continue coverage.

- **Termination of Employment**

If you stop working for the State, your benefits typically end 30 days after your most recent premium or contribution has been paid. See p. 9 for a list of benefits eligible to be continued, on a post-tax basis, either through COBRA or by arrangement with a carrier.



Can I take Insurance Coverage with me when I terminate employment?

Benefits	Retiree Coverage Available Through Retirement Plan Benefit Deductions	Coverage Can Be Continued Through COBRA	Coverage Can Be Direct Billed by Carrier or Converted to an Individual Policy	You Must Decide and Complete Carrier Forms Within
Dental Coverage				<i>COBRA</i> 60 days
Select & Select Plus	Yes	Yes	No	<i>Convert</i> within 31 days
DHMO Option	Yes	Yes	Yes	(DHMO only)
Vision Coverage	No	Yes	No	60 days
Health Care Spending Accounts	No	Yes (through end of the plan year)	No	60 days
Dependent (Child) Care Spending Account	No	No	No	N/A
Employee/Spouse/Child Life Insurance	No	No	Yes	31 days
AD&D Insurance	No	No	Yes	31 days
Critical Illness	No	No	Yes	31 days
Disability Coverage				
Short-Term	No	No	No	N/A
Long-Term	No	No	Yes	31 days
Legal Insurance	No	No	Yes (for 30 months)	30 days
Long-Term Care Insurance	No	No	Yes	60 days

YOUR FLEXIBLE BENEFIT OPTIONS

Dental

You can choose among three dental plans:

- Cigna Dental Care[®] (DHMO)
- Delta Dental Select
- Delta Dental Select Plus

Each has different payment schedules and providers. Closely review these plans to determine which one best fits the needs of you and your family. Use the comparison chart in this guide to learn about the plans. Due to availability, your best benefit option may depend on where you live or work, so be sure to check the availability of dentists carefully. For example:

- **Cigna Dental Care[®] (DHMO)** – designed specifically for employees who live or work in metropolitan Atlanta and other designated areas.
- **Delta Dental Select and Delta Dental Select Plus** – for other employees throughout Georgia

Cigna Dental Care[®] (DHMO) Plan

Cigna Dental Care[®] (DHMO) plan features:

- No deductibles to pay before you can use your plan
 - No annual dollar maximums that limit benefits
 - No claim forms to file
 - No ID cards required to receive care
 - No age limit on sealants to prevent cavities
 - No referrals required to visit a network orthodontist or for children under seven to visit a network pediatric dentist
- **Cigna Dental Oral Health Integration Program[®]**
This program reimburses out-of-pocket costs for specific dental services used to treat or help prevent gum disease and tooth decay. The program is for people with certain medical conditions that may be impacted by dental care. The only requirement is that you're currently being treated by a doctor for heart disease, stroke, diabetes, head and neck cancer radiation, maternity, chronic kidney disease, or organ transplant.

The Cigna DHMO is available to employees who live or work in metropolitan Atlanta and other designated areas. With the Cigna DHMO, you'll know exactly what you'll pay ("copays") for covered services – even for specialty care with a referral approved for payment. Just choose a general dentist from the Cigna DHMO network at enrollment and visit that dentist for all your dental care needs. Network dentists aren't allowed to charge you more than the co-pay for covered services. Most preventive services, such as exams, x-rays and cleanings, are covered 100% (frequency limits may apply). Dental treatments, such as fillings, crowns and root canals are covered at reduced, fixed co-pays.

Keep in mind that there is no out-of-network coverage with a DHMO plan. But finding a network dentist near you is easy when you use the **Provider Directory** at www.cigna.com and click on **Find a Doctor** at the top of the screen. Then select **If your insurance plan is offered through work**. Next, click **Find a . . . Dentist**. Enter the geographic location you want to search – by city, state, or zip code. Click on **Select a Plan**, and select **Cigna Dental Care HMO** under the **Dental Plans** section. Then, press **Choose**. Your covered family members can each select their own general dentists. After you enroll, you can change your general dentist at any time – online or by phone.

For additional information regarding Cigna's Oral Health Integration Program, please visit www.cigna.com.

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Cigna Dental Care DHMO Plan

Benefits & Covered Services	In Network
Type I Diagnostic & Preventive Services Oral Exams, Cleanings, X-rays,	Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges (amalgam [silver] fillings only)
Type II Basic Services Fillings, Root Canals, Extractions, Scaling and Root Planning, Repairs to Dentures, Bridges and Crowns Sealants	Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges (amalgam [silver] fillings only)
Type III Major Crowns, Dentures, Bridgework, Surgical Periodontal	Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
Orthodontic Benefits Cephalometric X-rays, Treatment Xstudy, Bands, Appliances	Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
Annual Deductible	NONE
Maximum Benefits	No Maximum
Waiting Period for Benefits	No Waiting Period

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Delta Dental Select and Delta Dental Select Plus

If you choose a Select or Select Plus plan with Delta Dental:

- You may go to any dentist.
- If you visit a Delta Dental PPO network dentist, they accept reduced fees for covered services, so you'll usually pay the least when you visit a PPO network dentist. This provision also ensures that Delta Dental PPO dentists won't balance-bill you the difference between the contracted amount and their usual fee.
- If you visit *non*-Delta Dental network dentists, they *can* balance bill you the difference between the amount of benefits payable by Delta Dental and the dentist charge for that service.

- **Note:** Orthodontia services for adults and dependent children are available only through the Select Plus Plan.

Important Information for Select and Select Plus Options

Six (6) Month Wait Period

All New Hires are subject to the Six (6) Month Wait Period for Major (Type III) and Orthodontia services (for adults and children under the Select Plus Plan).

If a current employee selects dental for the first time, they and any eligible dependents will be required to meet the Six (6) Month Wait Period for Type III and Orthodontia services (for adults and children under the Select Plus Plan).

If an employee switches from the Select to the Select Plus option, they and any eligible dependents will be required to meet the Six (6) Month Wait Period for Type III and Orthodontia services (for adults and children under the Select Plus Plan).



Delta Dental PPO

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26		
Deductibles*	\$50 per person / \$150 per family each calendar year *Deductible is waived for Diagnostic & Preventative		
Maximums*	\$500 per person each calendar year Dental Select Plan \$2,000 per person each calendar year Dental SelectPlus Plan *Diagnostic & Preventative does not count towards the maximum		
Waiting Period(s)	Basic Benefits 0 Months	Major Benefits 6 Months	Orthodontics 6 Months – Plus Plan Only

Benefits and Covered Services**	Dental Select Plan			Dental Select Plus Plan		
	PPO Dentists	Premier Dentists	Non-Delta Dental	PPO Dentists	Premier Dentists	Non Delta Dentists
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays	100%	100%	100%	100%	100%	100%
Basic Services Fillings, simple tooth extractions sealants	80%	80%	80%	90%	90%	90%
Endodontics (root canals) Covered Under Basic Services	80%	80%	80%	90%	90%	90%
Periodontics (gum treatment) Covered Under Basic Services	80%	80%	80%	90%	90%	90%
Oral Surgery Covered Under Basic Services	80%	80%	80%	90%	90%	90%
Major Services Crowns, inlays, onlays and cast restorations, bridges, dentures & TMJ, surgical periodontics	50%	50%	50%	60%	60%	60%
Orthodontic Benefits adults and dependent Children	Not Covered	Not Covered	Not Covered	50%	50%	50%
Orthodontic Maximums Lifetime	Not Covered	Not Covered	Not Covered	\$2,000	\$2,000	\$2,000

* If you switch plans during the calendar year your Deductible and Annual Maximum may be adjusted accordingly.

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees

† Reimbursement is based on PPO contracted fees for PPO dentists. Premier contracted fees for Premier dentists and 80th percentile for non-Delta Dental dentists.

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Customer Service
866-496-2384
www.deltadentalins.com

Claims Address
P.O. Box 1809
Alpharetta, GA 30023-1809

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

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Vision

Vision coverage is available through Blue Cross Blue Shield of Georgia. You have a choice between two plan options – Vision Select Plan and Vision Select Plus Plan. Both plans offer these features:

- Covered exams and materials
- Statewide access to a network of providers
- No claims to file for “in-network” benefits
- Benefits for “out-of-network” providers.

The Blue Cross Blue Shield or Georgia Vision Care participating provider network includes both private practice ophthalmologists and retail chains. Many providers – including retail chains – are open evenings and weekends. Participating retail chain providers include LensCrafters, Target Optical, JCPenney Optical, Sears Optical, Walmart, Pearle Vision, and 1-800-Contacts, among others.

To locate participating private providers, just go to www.bcbsga.com:

- Click **Find a Doctor**
- Choose your State (GA)
- Scroll down to **Vision** and select **Blue View Vision**.

Your Plan Options

- **Vision Select Plan**
The Vision Select Plan covers standard single vision and standard lined multi-focal lenses for glasses. Cosmetic lens options, such as tinting, UV coating, and transitional lenses are not covered, but are available at discounted rates.

Certain standard contact lenses, including daily wear, and up to four boxes of standard single vision disposable contacts, are covered in full by copays. Under the Vision Select Plan, if you purchase contacts that are not among Blue Cross Blue Shield of Georgia Vision’s “covered in full” selection, you will receive an annual \$105 allowance toward the purchase of contact lenses, and professional services (e.g., fit and follow-up).

To receive the full \$105 allowance under the Vision Select Plan, you must receive your exam, fitting, and evaluation during a single visit to the same network provider. The allowance will apply only to one purchase per plan year.

If you use a non-network provider, you must submit all receipts at the same time. Any balance remaining, and not used during the plan year when the purchase occurred, will be forfeited.

- **Important Information for the Vision Select Plan**
Benefits are provided every 12 months for exams, lenses and/or contacts, and for frames, based on the last date of service. The out-of-network allowance for contact lenses is \$105.

Note: Benefit service limitations are calculated on a calendar year. Example: if you receive exam services in March, you will be eligible to receive another exam in January of the following year.

If you choose contact lenses, no benefits will be available for covered eyeglass lenses during that period.

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Vision Select Plan

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	Non-Network Providers
Eye Exam Limited to one exam per Member every Calendar Year	\$10 Copayment	Reimbursed up to \$40
Prescription Lenses Limited to one set of lenses per Member every Calendar Year	\$20 Copayment	
Basic Lenses (Pair) <ul style="list-style-type: none"> • Single Vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses Includes: <ul style="list-style-type: none"> • Factory scratch coating • Tint (solid and gradient) • Polycarbonate and Photochromic lenses (for children under age 19) • UV coatings 		Reimbursed up to \$40 Reimbursed up to \$60 Reimbursed up to \$80 Reimbursed up to \$80
Frames Limited to one set of frames per Member every two years	No Copayment Allowable Amount up to \$130 retail allowance	Reimbursed up to \$45
Prescription Contact Lenses* (traditional or disposable)	No Copayment	
<ul style="list-style-type: none"> • Non-Elective Contact Lenses (Once every Calendar Year) 	Covered in full	Non-Network providers are reimbursed up to \$210
<ul style="list-style-type: none"> • Elective Contact Lenses (Once every Calendar Year) 	No Copayment \$105 retail allowance	Non-Network providers are reimbursed up to \$105

* If you choose contact lenses, no benefits will be available for covered eyeglass lenses during that period.

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- **Vision Select Plus Plan**

In addition to the coverage in the Vision Select Plan, the Vision Select Plus Plan offers cosmetic lens options for Tints, UV, Polycarbonate, and Basic Progressive lenses.

To receive the full \$200 allowance under the Vision Select Plus Plan, you must receive your exam, fitting, and evaluation during a single visit to the same network provider. The allowance will apply only to one purchase per plan year. You must submit all receipts at the same time. Any balance remaining, and not used during the plan year when the purchase occurred, will be forfeited.

- **Important Information for the Vision Select Plus Plan**

Benefits are provided every Calendar Year for exams, lenses and/or contacts, and for frames measured from the last date of service. The out-of-network allowance for contact lenses is \$200.

Note: Benefit service limitations are calculated on a calendar year. Example: If you receive exam services in March, you will be eligible to receive another exam in January of the following year.

If you choose covered Non-Elective Contact Lenses or Elective Contact Lenses, no benefits will be available for covered eyeglass lenses in that period.



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Vision Select Plus Plan

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	Non-Network Providers
Eye Exam Limited to one exam per Member every Calendar Year	\$10 Copayment	Reimbursed up to \$40
Prescription Lenses Limited to one set of lenses per Member every Calendar Year		
Basic Lenses (Pair) <ul style="list-style-type: none"> • Single Vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses 	\$25 Copayment	Reimbursed up to \$40 Reimbursed up to \$60 Reimbursed up to \$80 Reimbursed up to \$80
Includes the following Lens Options: <ul style="list-style-type: none"> • Factory scratch coating • UV coating • Tint (solid & gradient) • Polycarbonate lenses • Transitions Photochromic lenses • Standard & Premium Progressive lenses • Standard Anti-Reflective coating (Not Covered For Non-Network Providers) 		
Frames Limited to one set of frames per Member every Calendar Year	No Copayment Allowable Amount up to \$150 retail allowance	Reimbursed up to \$45
Prescription Contact Lenses* (traditional or disposable)	No Copayment	
<ul style="list-style-type: none"> • Non-Elective Contact Lenses (Once every Calendar Year) 	Covered in full	Non-Network providers are reimbursed up to \$210
<ul style="list-style-type: none"> • Elective Contact Lenses (Once every Calendar Year) 	No Copayment \$200 retail allowance	Non-Network providers are reimbursed up to \$200

* If you choose contact lenses, no benefits will be available for covered eyeglass lenses during that period.

Still have questions?

Please contact Georgia Breeze or Blue Cross Blue Shield of Georgia Vision Customer Service at 1-855-556-4844.

Employee, Spouse, Child Life, and Accidental Death & Dismemberment Insurance

If you want life insurance protection, or want to supplement the coverage you already have, you may choose MetLife group term coverage under the Flexible Benefits Program. The amount you select is paid to the beneficiaries you name to receive these benefits should you die while this coverage is in effect.

Your 2017 Annual Enrollment

- **Employee Life Coverage** – ability to elect benefits of one to 10 times your pay, up a maximum benefit of \$2,000,000. You have the option to pay premiums for Employee Life on a pre-tax or post-tax basis. (Note: Coverage is reduced starting at age 65.)

Note: During 2017 Annual Enrollment, you may increase your coverage by one-times pay, guaranteed, without having to provide evidence of insurability.
- **Premium Waiver** – provides continuation of Employee Life insurance without premium payment should you become disabled.
- **Will Preparation Service** – allows you to consult, in person or via phone, with a participating Hyatt Legal plan attorney, who will complete a will, living will, or power of attorney for you and your legal spouse, at no charge to you.
- **Estate Resolution Services** – gives your beneficiaries the support of a Hyatt Legal plan attorney, in-person or via telephone, to discuss matters related to probating your estate.

If You are a New Employee

As a new hire, you have a one-time opportunity to elect certain levels of employee and spouse life insurance, guaranteed, without having to provide evidence of insurability.

Coverage for you is available in increments of your pay – from one to 10 times pay, up to \$2,000,000. Amounts of one-times pay, up to \$200,000, are issued, guaranteed. Higher levels of coverage will be subject to evidence of insurability.

Child life insurance and up to \$30,000 of spouse life coverage is also available, guaranteed, without need to provide evidence of insurability.

- **Spouse Life Insurance**
If you choose employee life insurance for yourself, you may also select coverage for your spouse. Spouse life insurance premiums are based on the coverage level and your age. Your premiums for Spouse Life are paid on a post-tax basis. (If you are 65 or older, the amount of your spouse life coverage is reduced.)

Spouse Life coverage cannot exceed 100% of your amount of Employee Life coverage.

You are the beneficiary of spouse life insurance coverage and will receive the insurance benefit in the event of your spouse's death.
- **Child Life Insurance**
If you choose life insurance for yourself, you may also elect child life insurance for your child(ren) under age 26. This coverage, which is issued guaranteed (without need for medical underwriting), is paid for on a post-tax basis.

2017 You Decide

Important Notes about Child Life:

Child coverage begins at live birth. Coverage from live birth to six months is the lesser of the elected amount or \$6,000. From six months of age to age 26, the full elected amount applies.

- Child Life coverage cannot exceed your amount of Employee Life benefits.
- You are the beneficiary of child life insurance coverage and will receive the benefit in the event of the child's death.
- **Accidental Death and Dismemberment Insurance**
The Flexible Benefits Program offers accidental death and dismemberment (AD&D) insurance to be paid to you or your beneficiary if your injury or death is the result of a covered accident. In case of permanent and total disability, you are eligible for AD&D benefits if your injury prevents you from working at any job for which you are qualified by education, training, or experience.

You may elect coverage in increments of your pay – from one to 10 times pay, up to \$2,000,000. Your premiums for AD&D are paid on a pre-tax basis. (If you are age 75 or older, this coverage is reduced.)

• **Important Notes about Employee, Spouse, Child Life and AD&D Insurance**

The life and AD&D insurance amounts you choose will be based on your Annual Benefit Base Rate as of October 1. This amount is rounded up to the next higher \$1,000, after you multiply your coverage and adjust for age reductions.

If your coverage selection requires medical underwriting, you will need to complete the online MetLife Statement of Health Form along with any other required information. MetLife must approve your application before coverage can take effect.

Be sure to designate your beneficiaries by accessing the GaBreeze web site or calling the GaBreeze Benefits Center. Also, you can change and update your beneficiaries at any time.

Please be advised.

No paper Statement of Health Form will be mailed for the employee and/or the spouse to complete. An online pre-registration process will need to be completed for a spouse requiring medical underwriting before the Statement of Health Form will be available online.

- For information regarding conversion and portability of your Employee Life, Spouse Life, Child Life insurance, and AD&D insurances, contact MetLife, toll-free, at 1-877-255-5862.

Short and Long-Term Disability

To help provide income protection against the unexpected, the Flexible Benefits Program allows you to choose:

- Short-Term Disability insurance and/or
- Long-Term Disability insurance.

Short-Term Disability with Standard Insurance Company

If you choose short-term disability (STD) coverage, the plan will work in coordination with other income benefits to replace 60% of your Annual Benefit Base Rate during the plan year the disability began, up to \$1,000 per week. If you receive other benefits (including but not limited to workers' compensation, other disability plans and/or programs including the State retirement systems, earnings from work you perform while disabled) which replace a total of 60% or more of your Annual Benefit Base Rate, the short-term disability plan will not pay a benefit for this disability.

Your Options

- Seven (7) Day Benefit Waiting Period
- Thirty (30) Day Benefit Waiting Period

- **How STD Works**

A late enrollment penalty will apply for late entrants to the STD plan (employees who do not elect STD within 30 days of employment). Your STD benefits are calculated on the Annual Benefit Base Rate that is in effect during the plan year your disability began, less other income benefits. For example, if your first day of disability is December 3, 2016, your disability benefit will be calculated from the 2016 Annual Benefit Base Rate, not your 2017 Annual Benefit Base Rate. The 2016 Annual Benefit Base Rate is based on your

weekly rate of earnings in effect on October 1, 2016, or your hire date, if after this date.

Your STD benefits can continue until you recover, cease to be disabled, or are disabled for a maximum of 150 calendar days or a maximum of 173 calendar days (depending on the coverage level you have chosen).

- **What Is A Late Enrollment Penalty For Late Entrants?**

An employee choosing coverage for the first time more than 30 days after beginning employment is considered a late entrant. For STD late entrants who become disabled due to physical disease, pregnancy, or mental disorder during the 12-month period after the date your STD insurance becomes effective, benefits will not begin until after you have been continuously disabled for 60 days, unless you have been insured for at least 12 consecutive months. For STD late entrants whose disabilities begin after this 12 month period, benefits will start after the benefit waiting period (seven or 30 continuous calendar days, as applicable) is satisfied.

When changing from the 30-day Benefit Waiting Period to the seven-day Benefit Waiting Period, your Benefit Waiting Period for a disability resulting from physical disease, pregnancy, or mental disorder will be extended to 30 days, until you have been insured under the seven-day Benefit Waiting Period for at least 12 consecutive months. This does not apply to accidental injuries.

- **Enrolling For Short-Term Disability Coverage**
Your premiums will be based on your age, coverage level, and Annual Benefit Base Rate. This premium is a post-tax deduction – so you won't pay taxes on the benefits you receive.

NOTE: You should check with your Human Resources Office and/or manager concerning leave policies when disabled. Agency policy may impact your eligibility to receive Short-Term Disability benefits.

2017 You Decide

Long-Term Disability with Standard Insurance Company

The Flexible Benefits Program's Long-Term Disability (LTD) coverage works with other benefits you are eligible to receive, including but not limited to Social Security, Workers' Compensation, other disability plans benefit and programs, including the State retirement systems. The plan assures that your combined disability benefits and income from other sources will equal 60% of your Annual Benefit Base Rate up to \$5,000 per month. There is a minimum monthly benefit of \$100.00.

- **How Long LTD Benefits May Be Payable**

If you qualify for benefits, they will begin after you have been disabled for 180 calendar days. LTD benefits end when you are no longer disabled or you reach your Social Security Normal Retirement Age. Benefits for disabilities caused by mental disorders, substance abuse and other limited conditions will not be paid for more than two years. If you become disabled after reaching age 61, an age-graded maximum benefit period will apply.

- **Enrolling For Long-Term Disability Coverage**

Your cost for long-term disability coverage is based on your age, your FICA Status, Annual Benefit Base Rate, and whether or not you are eligible for disability coverage through any State of Georgia retirement plan, and/or through Social Security.

LTD premiums are paid with post-tax dollars. Any benefits you receive are not considered taxable income.

Note that other exclusions and limitations apply to these coverages. Refer to the Certificates of Insurance for more information.

If you have any questions about eligibility or how the short-term and long-term disability insurance plans work, call The Standard at 1-888-641-7186.



Long-Term Care

Long-Term Care Insurance with Unum

Long-Term Care (LTC) refers to a wide range of personal care, health, and social services for people of all ages who suffer a chronic disease or long-lasting disability. These services can be provided in a nursing facility, an adult day care center, or at home, and can involve some nursing care. The cost for this kind of care is typically very high – as much as \$20,000 per year for home care, and from \$20,000 to \$60,000 annually for a nursing home. Generally, you have to pay these expenses out of your own pocket, because medical insurance and Medicare do not cover long-term care.

- **Your Long-Term Care Options**

You can choose from one of three daily benefit levels and the corresponding monthly premium that is right for your needs and budget. The amount of the benefit depends on two factors: where care is provided – either in a nursing facility, or home/day/assisted living facility – and the daily dollar level of coverage you select. With any of these options, benefits are paid on a monthly basis. The monthly benefit is equal to 100% of your elected daily benefit amount for care provided in a state-licensed nursing home facility, and 60% of your elected daily benefit amount for care provided in an assisted living facility or at home. If you wish, you can add a reduced paid-up option and/or an inflation protection option.

- **Who Can Be Covered**

This plan is offered to you, your spouse, your parents, or your parents-in-law. “Parents” are biological (natural), adoptive, or step-parents of eligible employees or spouses. Your spouse, parents, and parents-in-law will have to complete a medical underwriting process and be approved for LTC coverage. Your family members’ premiums will be billed directly by Unum. Your payroll deduction will be for your individual coverage only. You can elect spouse or family coverage even if you do not enroll.

- **When Benefits Are Paid**

Benefits begin after a 90-day elimination period in which you or a covered family member has an eligible physical or cognitive disability. You qualify for benefits if the disability creates a need for you to receive continual help from another person to carry out any three of the six activities of daily living: bathing, dressing, toileting, transferring, continence, and eating. Because long-term care premiums are taken from your post-tax income, benefits are provided tax-free.

- **Please note:** A pre-existing condition limitation will apply to coverage purchased on a guaranteed-issue basis. It will *not* apply to coverage that is medically underwritten. If a pre-existing condition limitation applies, and loss is caused by, contributed to, or results from a pre-existing condition present six months before the effective date of coverage, and occurs during the first six months after coverage begins, no benefit will be payable until both the six-month period and the waiting period have been fulfilled.

2017 You Decide

- **About Your Premiums and Enrolling**

You pay for your LTC coverage, through the convenience of payroll deduction, with post-tax dollars. Using post-tax premium dollars permits the benefits you receive to be paid tax-free. Premium costs are based on your age as of the Benefit Calculation Date (October 1) or your hire date, whichever is later. The younger you are when you purchase this coverage, the lower your premiums. Your family members' premiums are based on their age as of the date they apply for coverage. They will pay premiums directly to Unum.

If you are a new employee and enroll in LTC insurance during your initial enrollment period, you may select LTC with no medical underwriting requirements. If you are a current employee enrolling in LTC for the first time, or an employee currently enrolled who wants to increase benefit levels, add options, or are re-enrolling after discontinuing coverage, medical underwriting will be required. Coverage for your spouse and other eligible family members will be medically underwritten.

For more information about long-term care coverage, visit www.unuminfo.com/sog or call Unum at 1-888-SOG-FLEX (1- 888-764-3539).



Critical Illness

Critical Illness Plan with Aflac/CAIC

The group critical illness plan helps you and your family cope with, and recover from, the financial stress of a critical illness or health condition.

Employee Coverage Levels

\$ 5,000	\$10,000	\$20,000
\$30,000	\$40,000	\$50,000

- Lump-sum benefits are paid directly to the insured following the diagnosis of each covered critical illness after you are hospital-confined for said condition.
- Rates cannot be individually increased due to change in age, health, or individual claim.
- No medical underwriting is required for up to \$30,000 in coverage, and simplified medical underwriting, with only a few health questions, for higher amounts.
- The plan is portable, subject to certain stipulations, so you may be able to take your coverage with you if you leave your job.
- Benefits will not reduce due to age.

Spouse Coverage Levels

\$ 5,000	\$10,000	\$20,000
\$30,000	\$40,000	\$50,000

- No medical underwriting is required for up to \$30,000 in coverage, with simplified medical underwriting (only a few health questions) for higher amounts.
- Employee must elect Critical Illness benefits for the spouse to be eligible for coverage.
- Rates are based on the employee's age.

Child Coverage

- All your children, ages 0-26, are covered at 50% of your benefit amount, at no additional cost.
- Child benefits are automatically included in existing employee coverage.

Dependent Child Illnesses Covered at 100% of Maximum Benefit

- Cystic Fibrosis
- Cerebral Palsy
- Cleft Lip or Cleft Palate
- Down Syndrome
- Spina Bifida

Covered Critical Illnesses* Illnesses Covered

	<i>Percentage of Face Amount</i>
• Heart attack	100%
• Stroke	100%
• Major organ transplant	100%
• Renal failure (end stage)	100%
• Internal cancer	100%
• Coma	100%
• Severe burns	100%
• Paralysis	100%
• Loss of sight, hearing, or speech	100%
• Carcinoma in situ	25%
• Coronary artery	25%
• Advanced Alzheimer's disease	25%

* A partial benefit (25%) is payable for carcinoma in situ and coronary artery bypass surgery. Payment of the partial benefit for carcinoma in situ will reduce the benefit for internal cancer. Payment of the partial benefit for coronary artery bypass surgery will reduce the benefit for a heart attack.

2017 You Decide

First Occurrence Benefit

After receipt of written proof of loss, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Additional Occurrence Benefit

If an insured individual collects full benefits for a critical illness under the plan, and later has one of the remaining covered illnesses, the full benefit amount for any additional illness will be paid. The two dates of diagnosis must be separated by at least 90 days (or, for cancer, after at least 12 months treatment-free). Additional critical illnesses cannot be caused, or contributed to, by a critical illness for which benefits have already been paid.

Re-Occurrence Benefit

Once benefits are paid for a critical illness, additional benefits are payable for a new event of the same critical illness, provided the reoccurrence is diagnosed at least 90 days from the date of initial diagnosis.

- Cancer reoccurrence: The insured must be treatment-free for 12 months to receive the Reoccurrence Benefit for a cancer diagnosis.
- Cancer that has spread (metastasized), even if there is a new tumor, will not be considered an additional occurrence unless the insured has been treatment-free for 12 months.

Health Screening Benefits

A covered employee can receive a maximum of \$100 for any single covered screening test per calendar year. This benefit is paid regardless of the results of the test and will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the covered employee can receive the health screening benefit; it will be paid as long as the policy remains in force.

The covered health screening tests include:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography

2017 You Decide

Critical Illness Select Plus Plan

Includes Accident Benefits for you and your family in the event of an on or off the job accidental injury.

- Indemnity benefits paid as the result of an accidental injury
- 24-hour coverage
- Over 50 accident indemnity benefits included
- No medical underwriting required up to Guaranteed Issue amount
- Rates cannot be individually increased due to change in age, health or individual claim
- The plan is portable, subject to certain stipulations, so you may be able to take your coverage with you if you leave your job
- Wellness Benefit of \$60

Plan Benefits Summary

Please refer to your certificate of coverage for definitions, limitations and exclusions

Benefits Include:

- Medical Fees (Physician Charges, X-Rays, Emergency Room Services and Supplies)
- Hospital Fees (Hospital Admission, Daily Hospital Confinement and Intensive Care)
- Accidental Injuries (Fractures/Dislocations, Lacerations, Tendons/Ligaments, Ruptured Disk, Torn Knee Cartilage, Burns, Eye Injuries)
- Accident Follow-up Benefits (Physical Therapy, In-patient Rehab, Follow-up treatments)
- Additional Benefits (Family Lodging, Transportation, Gunshot Wound, Paralysis, Prosthesis)

For a complete list of benefits and descriptions, please refer to the Critical Illness Select Plus PDF Brochure or your certificate of coverage



Premiums for the Critical Illness coverages in this section are paid on a post-tax basis – which allows you to receive benefits *tax-free*

Legal Insurance

Legal Insurance with Hyatt Legal Plans

Whether you're buying a new home, drawing up a will, or just need some legal advice, the Hyatt Legal Plan can give you access to experienced, local network attorneys at an affordable rate, through premiums taken on a post-tax basis.

Legal Benefits

The legal services covered by the plan, as defined by your Summary Plan Description (SPD), are fully covered when you see a Participating Plan Attorney. You can use the plan as often as you need legal representation, without waiting periods, copayments, or deductibles.

Access to Over 14,000 Attorneys

The Hyatt Legal Plan provides members with access to a national network of more than 14,000 Plan Attorneys. If you prefer, you may use your own attorney and be reimbursed according to a set fee schedule. If you find yourself in need of legal assistance while traveling within the U.S., call the Hyatt Client Service Center at 800-821-6400, visit www.info.legalplans.com, or download Hyatt Legal Plan's mobile app to locate participating attorneys in the area.

Your Legal Benefit Options

Review the coverages below and on the following page and select the plan that fits the needs of you and your family. You can enroll in either plan with single coverage or coverage for you and your dependents (up to age 26).

Select Plan

The Select option provides benefits for the following services:

- Wills and codicils
- Living wills
- Powers of attorney
- Unlimited phone and office advice and consultations
- Traffic ticket defense (no DUI)
- Document review
- Deeds
- Mortgages
- Promissory notes
- Elder law matters
- Sale, purchase and refinancing of your primary and second home
- Home equity loans for your primary and second home
- Debt collection defense
- Identity theft defense

2017 You Decide

Select Plus Plan

The Select Plus option provides benefits for the following services:

- Wills and codicils
- Living wills
- Powers of attorney
- Unlimited phone and office advice and consultations
- Probate proceedings
- Consumer protection matters
- Debt collection defense
- Identity theft defense
- Personal bankruptcy
- Tax audits
- Civil litigation defense
- Administrative hearings
- Incompetency defense
- Change or establishment of custody order or visitation rights
- Adoption and legitimization
- Divorce* (\$1,000 maximum for contested)
- Enforcement or modification of support order
- Guardianship/conservatorship
- Immigration assistance
- Traffic ticket defense (no DUI)
- Sale, purchase, refinancing of your primary and second home
- Eviction and tenant problems (tenant only)
- Home equity loans for primary and second home
- Name changes

- Juvenile court defense
- Deeds, promissory notes & mortgages
- Document review
- Elder law matters
- Security deposit assistance (tenant)
- Protection from domestic violence

The Select Plus option offers the same services as the Select Plan, plus additional services in family law, debt matters, consumer protection, tenant matters, immigration, and civil litigation defense.

What Are the Exclusions?

The legal plan excludes appeals; class actions and appeals; matters that Hyatt Legal Plans deem frivolous, non-meritorious, or unethical; farm and business matters; patent, trademark, and copyright matters; costs and fines; matters for which an attorney-client relationship exist prior to your becoming eligible for plan benefits, and any employment-related matters. For a complete list of exclusions, visit www.GaBreeze.ga.gov.

What if I have More Questions?

Call 1-800-821-6400 Monday through Friday from 8 a.m. to 7 p.m. (Eastern Time). A Client Service Representative will help you understand coverage, find a plan attorney in the location most convenient to you, offer information about using an out-of-network attorney, and answer any other questions.

For more information, download Hyatt's mobile app or visit the website www.info.legalplans.com. Enter the appropriate access code, as follows:

Select Plan

7600001 - Employee Only

7610001 - Employee w/Dependents

Select Plus Plan

7620001 - Employee Only

7630001 - Employee w/Dependents

2017 You Decide

Spending Accounts

The Spending Account plans are administered by ADP.

For the 2017 plan year, the annual amounts you may contribute are:

	<u>Minimum</u>	<u>Maximum</u>
Dependent Care	\$ 120	\$4,960
Health Care	\$ 120	\$2,510

The IRS rules and the rules of the Employee Benefits Plan Council designate eligible expenses. The Employee Benefits Plan Council has the responsibility to interpret these rules and make all decisions as to an expense's eligibility.

Important Information About Spending Accounts

- Deductions for spending accounts are made on a pre-tax basis every pay period.
- Your spending account elections are binding for the plan year. You may be able to make limited changes if you have a qualified status change.
- You cannot carry over expenses that you have incurred in one plan year into the next plan year for reimbursement.
- You cannot transfer money from one account to another.
- Claims should be submitted only after services have been provided.
- You may submit claims at any time for any amount, but payment will not be made until your claims total \$25 or more. Reimbursement may be by check or by direct deposit to your bank account.

- During the year, you receive statements showing how much you have in each account.
- Reimbursements are issued on a daily basis.
- Under IRS rules, any money left in your accounts, and not claimed for the previous plan year's expenses by the claim filing deadline, is forfeited. It is retained by the plan and used for administrative expenses.

The Health Care Spending Account has a grace period that can help you avoid losing money for unclaimed expenses. See page 31.

- A monthly administration fee of \$3.20 is included in the total contribution amount for the Health Care Spending Account.

Important Note: Please be aware that if you are currently contributing to a spending account, your annual allocation will not automatically continue into the new plan year. You must make a new election if you want to contribute to the plans in 2017.

Contact GaBreeze Benefits Center at 1-877-342-7339 for more information.

Dependent Care Spending Account (DCSA)

The Dependent Care Spending Account provides you with the opportunity to use tax-free dollars to pay for the care of your children under age 13 or other IRS-eligible dependents (such as a disabled child of any age or an elderly parent) while you and your spouse work or attend school full time.

2017 You Decide

Eligible child care services may include your cost to send a child to preschool, after school, or nursery school. Also, expenses for dependents of any age who are unable to care for themselves because of a physical or mental handicap are eligible. A person qualifying for this type of care must spend at least eight hours a day in your home. Elderly dependent care may include your cost to send a dependent parent to an elder care facility or have someone care for them in your home.

If you are married, both you and your spouse must be working, or be a full-time student, during the time the care is received. Your income tax return (long and short forms) will require you to include your dependent care provider's name and tax number or Social Security number.

Dependent Care Spending Account Exclusions List

These are a few examples of dependent care expenses that are *not* eligible for reimbursement.

- Activity and book fees
- Cleaning and cooking services not provided by the care provider
- Field trips
- Food, clothing, and entertainment
- Kindergarten
- Overnight camps
- Sports lessons

- Transportation to and from the child care provider
- Tuition for private school

NOTE: You should carefully review your options and consult a qualified tax advisor for assistance in determining using the Dependent Care Tax Credit or using the Dependent Care Spending Account.

Dependent Care Spending Account Limits

You may not be able to deposit the full \$4,992 if any of the following situations apply to you.

- If your spouse works for the State, or another employer who offers a similar plan, the total of your family's contributions to a dependent care spending account cannot exceed \$4,992.
- If either you or your spouse earns less than \$5,000 a year, you can deposit as much as the smaller of your two incomes.
- If your spouse is either a full-time student or incapable of self-care, you may deposit up to \$3,000 for one dependent, or \$4,992 for two or more dependents.
- If you are married but file a separate federal income tax return, you may deposit a maximum of \$2,500 to your dependent care spending account.
- If you are hired after January 1, or have a qualified change in status during the plan year (see Terms and Conditions), you may contribute up to \$416 per month for the remainder of the plan year.



2017 You Decide

Health Care Spending Account (HCSA)

The Health Care Spending Account (HCSA) helps you save tax dollars on health-related products and services received by you and your family.

Debit Card

When you enroll in a Health Care Spending Account, you'll receive a VISA® Spending Account Card for purchases of eligible health care services. This card will arrive funded with your *full annual allocation*. You may request up to four additional cards with your spouse or dependent's name on it, for a fee of \$5 per card. If your card is lost or stolen, you may request another card for a fee of \$15. For additional cards, call ADP at 1-800-893-0763.

Keeping Receipts

Remember, you must keep your receipts since some transactions may require validation by ADP.

Important Note: The IRS does not allow participation in both Health Care Spending Accounts *and* Health Savings Accounts.

HCSA Grace Period of 2½ Months

Under the HCSA, the IRS allows you a grace period to avoid the "Use It or Lose It" provision. If you have any HCSA funds remaining on December 31, you have an additional 2½ months – through March 15 of the following year – to deplete your account. You can continue to use your debit card, or submit qualified expenses for reimbursement, for products and services purchased through March 15th. You'll have until April 30th to submit such claims to ADP. Remember, if a claim is mailed, the envelope must be postmarked by April 30th. The fastest way to get claims to ADP is to fax them at 1-866-643-2219.

To best take advantage of this grace period, fund only those expenses you expect to have during the 12-month period. If you do not spend all of the money you contributed, during the plan year, be sure to use it up during the grace period.

Examples of Eligible Expenses

- Deductibles and co-payments not paid by any health or dental insurance in which you or your family members participate
- Costs for procedures not covered or not covered fully by a health, dental, or vision plan
- Specialized equipment for disabled persons
- Preventative care screenings
- Contact lens and glasses
- Laser eye surgery
- Prescription
- Mental health services
- Physical therapy
- Certain other IRS approved expenses

Examples of *Ineligible* Expenses

- Cosmetic procedures/drugs
- Electrolysis
- Hair transplants
- Herbal supplements
- Insurance premiums
- Nicotine patches and gum
- Nutritional supplements
- Teeth whitening/bonding
- Vitamins
- Over-the-counter medications

2017 You Decide

EMPLOYEE CHECKLIST

- Review** *YOU DECIDE* for valuable information for each option, descriptions of required medical underwriting requirements, and Terms and Conditions.
- Ensure** you have your ID and password for the GaBreeze website.
- Check** with your entity's Human Resources/Payroll Office for applicable deadlines.
- Confirm** on the GaBreeze website to see if additional documentation required, such as medical underwriting forms.
- Review** your Confirmation Page and report discrepancies immediately to GaBreeze Benefits Center 1-877-342-1339. Follow up to ensure that corrections are made.
- Compare** your pay stub(s) against the options you selected. Contact your personnel/payroll office if you find any discrepancies.
- Report** any incorrect information to your personnel/payroll office.

Additional Information

The Flexible Benefits Program attempts to be as consistent as possible with State Health Benefit Plan rules and regulations. This is not always possible due to the variations in benefit offerings.

This booklet summarizes the benefits you can choose through the State of Georgia Flexible Benefits Program. A more detailed explanation of benefit provisions is provided in each Benefit Summary Plan Description. Every attempt has been made to ensure that the information in this booklet is accurate.

The State of Georgia Flexible Benefits Program is governed by legal documentation and insurance contracts. However, in the event there are any conflicts between this booklet and the official plan descriptions and contracts, the terms of the official plan descriptions and contracts will prevail.

The Flexible Benefits Program is governed by current tax law and is subject to, and operated in accordance with, regulations of the Internal Revenue Service (IRS). If changes in the Flexible Benefits Program are necessary, we will make updates to comply with applicable IRS regulations.

HIPAA PRIVACY AND SECURITY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities, including state agencies that deal with Protected Health Information (PHI), provide you with this notice regarding programs administered by the Department of Administrative Services (DOAS) in which DOAS may maintain various types of PHI about you. DOAS understands that information about you and your family is personal. As such, DOAS is committed to securing and protecting your confidentiality.

This notice tells you (a) how DOAS uses and discloses information about you and, (b) discusses your rights in keeping this information private and secure. Please review this notice carefully.

Overview

What is HIPAA?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, is a federal law regarding the confidentiality and security of Protected Health Information (PHI). It imposes restrictions on how your health information can be used and shared, and confirms rights for individuals concerning their health information.

What is PHI?

PHI, Protected Health Information, is individually identifiable health information that is maintained or transmitted by a covered entity. It is information related to a person's health, provision of care, or payment. Examples of items containing PHI include a bill for health services, an explanation of benefits statement, receipts for reimbursement from a health

care spending account, or any list showing the amount of benefits paid with a breakdown by social security number. This also includes your employer (e.g., state agency, school system, authority) transmitting information about you to DOAS. This information may include your name, address, birth date, social security number, employee identification number, and certain health information

How DOAS Uses and Discloses Protected Health Information

When services are contracted, DOAS may disclose some or all of your information to the company to perform the job DOAS has contracted with them to do. DOAS requires the company to safeguard your information in accordance with federal and state law.

Privacy and Security Law Requirements

DOAS is required by law to:

- Maintain the privacy of your information.
- Protect electronic PHI by implementing reasonable and appropriate physical administrative and technical safeguards.
- Provide this notice of DOAS' legal duties and privacy and security practices regarding the information that DOAS has about you.
- Abide by the terms of this notice.
- Refrain from using or disclosing any information about you without your written permission, except for the reasons given in this notice. You may revoke your permission at any time, in writing. That revocation will not apply to information that DOAS disclosed prior to receiving your written request. If you are unable to give your permission due to an emergency, DOAS may release information, if it is in your best interest. DOAS must notify you as soon as possible after releasing the information.

2017 You Decide

Your Health Information Rights

You have the following rights regarding the health information maintained by DOAS about you:

- See and obtain a copy of your health information. This right would not extend to information needed for a legal action relating to DOAS.
- Ask DOAS to change health information that is incorrect or incomplete. DOAS may deny your request under certain circumstances or request additional documentation.
- Request a list of the disclosures that DOAS has made of your health information beginning in April 2003.
- Request a restriction on certain uses or disclosures of your health information. DOAS is not required to agree with your request.
- Request that DOAS communicate with you about your health in a way or at a location that will help you keep your information confidential.
- Request another copy of this notice from DOAS, or you may obtain a copy from the DOAS web site, www.doas.ga.gov (under “Privacy”).

For More Information and To Report a Problem

If you have questions and would like additional information about Protected Health Information (PHI) you may contact GaBreeze at 1-877-342-7339 Monday thru Friday 8:00 a.m. to 5:00 p.m. You may also visit DOAS web site, www.doas.ga.gov.

DOAS does not discriminate on the basis of disability in the admission or access to, or treatment of employment in its programs or activities. If you have a disability and need additional accommodations to participate in any DOAS programs, please contact the DOAS at the numbers listed. For TDD relay service only: 1-800-255-0056 (text-telephone) or 1-800-255-0135 (voice).

If you believe your privacy or security rights have been violated:

- You may file a complaint in writing to the DOAS Privacy Unit at:
*Department of Administrative Services
Attn: Privacy Officer
200 Piedmont Avenue SE
West Tower, Suite 502
Atlanta, GA 30334-9010*
- You can file a complaint with the Secretary of Health and Human Services by writing to: Secretary of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201. For additional information, call 1-877-696-6775.
- You may file a grievance with the United States Office for Civil Rights by calling 1-866-OCR-PRIV (1-866-627-7748) or 1-886-788-4989 TTY.

There will be no retaliation for filing a complaint or grievance.

If DOAS changes its privacy or security practices significantly, DOAS will post the new notice on its web site at www.doas.ga.gov.

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BENEFIT PLANS PHONE DIRECTORY

GaBreeze Benefits Center
Website: www.GaBreeze.ga.gov
Phone: 1-877-342-7339

Benefit Type	Name & Contact Information
Dental Insurance	CIGNA 1-800-642-5810 www.cigna.com Delta – Select and Select Plus 1-866-496-2384 www.deltadentalins.com
Vision Coverage	Blue Cross Blue Shield 1- 855- 556- 4844 www.bcbsga.com
Employee, Spouse, Child Life Insurance and Accidental Death and Dismemberment	MetLife 1-877-255-5862 www.mybenefits.metlife.com
Disability Insurance	The Standard 1-888-641-7186 www.standard.com
Long-Term Care Insurance	Unum 1-888-SOG-FLEX (1-888-764-3539) www.unum.com
Critical Illness Insurance	Aflac 1-800-433-3036 www.aflacgroupinsurance.com
Legal Insurance	Hyatt Legal Plans 1-800-821-6400 www.legalplans.com
Spending Accounts	ADP – GaBreeze 1-800-893-0763 www.myspendingaccount.adp.com

TERMS AND CONDITIONS

The Flexible Benefits Program is offered by the Employee Benefits Plan Council and participating departments and authorities. The Flexible Benefits Program is governed by the Internal Revenue Code, section 125, and rules issued by the Employee Benefits Plan Council. The Flexible Benefits Program provides you with a method to have your employer purchase benefits with money that would have been paid to you. You do not receive the premium amounts and contributions for the pre-tax options you select as taxable income (and therefore do not pay taxes on that amount); you do receive the benefits as an employer paid benefit. The election is a binding salary agreement. Failure to comply with all contractual and administrative requirements will result in any excess salary reductions being retained by the Plan. The following statements apply to the benefit options listed on the Annual Enrollment web site.

- 1) Your participation in the Flexible Benefits Program is voluntary. You are not required to choose any of the options. If you do not wish to participate in these benefits, select 'no coverage' in each benefit category.
 - 2) Some coverage levels available to you and the premium amount for each coverage level may be calculated using your retirement salary, your age, your eligibility for disability retirement benefits, and FICA status on your date of hire or the Benefit Calculation Date, whichever is deemed appropriate by the Plan Administrator. Any adjustments to the Annual Benefit Base Rate, with the exception of errors (as determined by the Plan Administrator shall be reflected on the following Benefit Calculation Date, to be effective for the following plan year.) Promotions, demotions, adjustments due to certifications are not deemed to be errors. Any errors in these items should be reported to your personnel or payroll office immediately.
 - 3) The calculation of tax savings does not take into consideration any other income earned by employee or family members, income reduction program such as Deferred Compensation or Tax Sheltered Annuities, or any changes you may make in coverages for the upcoming year.
 - 4) By selecting coverages and indicating contributions to Spending Accounts, you are agreeing that your agency may reduce your taxable income by the amount necessary to purchase those coverages and make those contributions. Except in certain circumstances, the amount of income reduction may not be changed until the next enrollment period.
 - 5) For dependent and/or spousal coverage, it is your responsibility to notify the GaBreeze Benefit Center if the person ceases to be eligible to participate in the Plan. There will be no refund of premiums paid into the Plan, when a timely change is not made.
 - 6) After this enrollment period you may become a participant or make changes in some coverages only under limited conditions in accordance with the rules of the IRS code, the Employee Benefits Plan Council. The Employee Benefits Plan Council has the responsibility to interpret these rules and make the final decision as to whether you may enroll or change any coverage outside of the enrollment period. Your request for enrollment or a change outside of the enrollment period will only be considered if you submit the proper documentation within the timeframe allotted.
- Your request for enrollment or a change in coverage under the Flexible Benefits Program must be done by calling the GaBreeze Benefit Center or on the website within 30 days. A list of events that might permit you to enroll or change one or more coverages under the Flexible Benefits Program:
- a) You gain or lose a spouse; or
 - b) You gain (no time limit if due to judgment, decree or order) or lose an eligible dependent; or
 - c) Your spouse or dependent becomes eligible for or loses coverage under another employer's plan, COBRA or a governmental plan; or
 - d) An event causes your dependent to gain or lose eligibility for coverage under your employer's plan; or
 - e) Your change of residence causes you or your spouse or dependents to gain or lose eligibility for coverage under your plan or another employer's plan; or
 - f) The cost of your dependent care increases or decreases significantly and your dependent provider is not related to you, your spouse, or your dependent; or
 - g) Your spouse's employer increases, decreases or ceases coverage, or conducts open enrollment.
- 7) This salary agreement will be terminated if you change the agreement during the next enrollment period. If you do not change the agreement, your benefit choices will rollover in the next Plan year or default to a specified coverage with the exception of the Flexible Spending Accounts.
 - 8) If you are eligible to participate in the Plan, you terminate and are rehired within 30 days during the same plan year, you must maintain the same options.
 - 9) Options and coverage under the Flexible Spending Accounts are set forth in the Flexible Benefit Plan Document. For all other benefits under the Flexible Benefits Program, the options and coverage levels offered conform to policies provided by the insurance company making the offer. By selecting an option and coverage level you agree to abide by the terms and conditions of that policy.
 - 10) Contributions to Spending Accounts are voluntary. You should not participate in Spending Accounts until you thoroughly read the sections of the Enrollment Booklet related to Spending Accounts. By choosing to contribute money to one or more Spending Accounts you are agreeing to abide by the Rules of the Employee Benefits Plan Council related to Spending Accounts. In particular, you are agreeing to the following provisions:
 - a) Money contributed to the Health Care Spending Account cannot be used to pay claims for the Dependent Care expenses. Money contributed to the Dependent Care Spending Account cannot be used to pay claims for the Health Care expenses.
 - b) In general, the amount contributed for a Dependent Care Account cannot be greater than the earned salary of you or your spouse, whichever is less.
 - c) If you are married filing separately, the amount contributed for a Dependent Care Account cannot be greater than \$2,500.
 - d) The validity of a claim against a Spending Account is determined in accordance with the Plan, Internal Revenue Code, and IRS regulations as interpreted by the Administrator subject to the appeal provisions of the Plan.

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- e) Any money not reimbursable to you will be forfeited to the Flexible Benefits Program. Forfeited money will not be returned or paid to the employee but will be used to reduce the costs associated with providing this benefit. NOTE: This rule is intended to ensure you allocate *only* those expenses you expect to incur. See p. 31 for information about the grace period that can help you avoid having to forfeit Health Care Spending Account funds.
 - f) For the Spending Accounts, eligible expenses will be reimbursed in accordance with the Rules of the Employee Benefits Plan Council and the IRS code.
 - g) For the Dependent Care Spending Account, you will not be reimbursed for more than the Plan has received from your department on your behalf.
 - h) If you decide to activate and use the Spending Account debit card, you agree to abide by all requirements as indicated in the cardholder's agreement received with the card.
- 11) By selecting the Critical Illness Benefit, you are agreeing to the following:
- a) I am asserting that to the best of my knowledge and belief, the answers to the questions on the application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued. It is understood and agreed that coverage will not become effective unless I am actively at work on the date of enrollment and the effective date of coverage.
 - b) I understand and agree that no benefits are payable for loss starting or occurring within 12 months of the effective date of coverage which is caused by, contributed to by, due to or resulting from a Pre-existing condition, unless I have gone 12 months without medical care, treatment or supplies for the Pre-existing condition.
 - c) I realize that any false statement or misrepresentation may result in loss of coverage under the certificate. I understand that no insurance will be in effect until approved by Continental American Insurance Company and the necessary premium is paid. Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
- d) I authorize my employer to deduct the appropriate amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each month for my insurance.
- 12) Other terms and conditions:
- a) If you choose not to participate or choose not to continue coverages, your ability to enroll at a later date will be subject to contractual provisions, which may include medical proof of insurability or limited coverages.
 - b) If you failed to enroll in options requiring medical underwriting when first eligible and you choose new or increased levels of coverage, you must complete the medical underwriting process and be approved.
 - c) If you choose coverage under the Life Insurance options and the Accidental Death and Dismemberment options, the same Beneficiary election information will be used. If a beneficiary is not named, the beneficiary will follow the order stated in the policy.
 - d) If you select more than \$50,000 under the Life Insurance option, you may choose to pay the premium with post-tax dollars to avoid having to pay imputed income; this will eliminate any tax savings on the life insurance premium.
- 13) In the event of an administrative error with respect to the Flexible Benefits Program, decisions will be made in accordance with the Internal Revenue Code, and the Rules of the Employee Benefit Plan Council for the Flexible Benefits Program.

