



Georgia[®]

State Personnel Administration



2012 FLEXIBLE BENEFITS PROGRAM



Your benefits are a reflection of you.

www.GaBreeze.ga.gov

TABLE OF CONTENTS

Welcome	3
General Eligibility and Enrollment Information	4
Eligibility and Enrollment	4
Dependents Eligible For Coverage.....	4
Benefit Salary.....	4
Pre-Tax Premiums	5-6
Important Information If You Are A New Employee.....	6
After You Enroll For Coverage	6
When Coverage Begins.....	6
Confirming Your Choices.....	6
To Change Your Decisions At Annual Enrollment.....	7
To Change Your Decisions Outside Annual Enrollment.....	7
Continuation of Benefits During Leave or End of Employment.....	8-9
Your Benefit Options	
Dental.....	10-12
Vision	13-15
Employee, Spouse, and Child Life Insurance and AD&D.....	16-18
Short and Long Term Disability	19-20
Long Term Care.....	21
Specified Illness.....	22-23
Legal Insurance	24-25
Spending Accounts	26-28
Employees' Retirement System	29
The Path2College 529 Savings Plan	30
Employee Checklist	31
HIPAA Privacy Notice	32-33
Benefit Phone Directory	34
Terms and Conditions	Back Cover

Welcome

The State of Georgia Flexible Benefits Program

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.

This 2012 You Decide! booklet gives you an opportunity to review and understand your benefits package. It summarizes benefits available to employees and their dependents eligible to participate in the Flexible Benefits Program, along with certain procedures to be followed to obtain these benefits.

It is up to you to understand all the options available and make the choices that best suit your needs. Making the right decisions about your options can make a real difference toward building a rewarding future for you and your family.



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 are 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.
- You are a public schoolteacher, working at least 17.5 hours, and employed in a professionally certified capacity, working half time or more and not considered a “temporary” or “emergency” employee.
- You are 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).
- You are 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), as defined by Paragraph 20 of Section 47-4-2 of the Georgia Code.
- You are an employee of a county or regional library and work at least 17.5 hours per week.
- Others deemed eligible by Federal or Georgia law.

If you aren’t sure whether you’re eligible, contact your personnel/payroll office.

Dependents Eligible For Coverage

Eligible dependents include:

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

Benefit Salary

Your Benefit Salary including your base salary and salary supplements that are regular, non-temporary, and not more than the amount on which retirement contributions are calculated, is reflected on GaBreeze and remains constant for the entire Plan year. It is calculated on your date of hire or the Benefit Calculation Date. Any adjustments to the Benefit Salary, 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. Benefit Salary is the pay used to calculate your pay-based coverage - employee life, AD&D, and disability.

General Eligibility and Enrollment Information

Continued

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 pay...and your taxes. That's because premiums for most of your insurance options, health benefit options, and spending account contributions are taken out of your paycheck before federal and state income taxes and Social Security (FICA) taxes are withheld.

This means your taxable pay 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 paid the same premiums with after-tax dollars.

Important Information If You Are A New Employee

• **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 web site (GaBreeze.ga.gov) located on the Team Georgia Connection/Flex web site (www.team.georgia.gov/flex) or calling the GaBreeze Benefits Center at 1-877-342-7339.

• **Dental**

There is a much shorter waiting period in the Regular and PPO options if you sign up immediately. Late enrollment penalties will apply to the Regular and PPO options if you do not enroll now, but elect to do so in the future. The DHMO Option

does not have waiting periods or late enrollment penalties, but you must use a DHMO network provider and live/work in the metro Atlanta area.

• **Spending Accounts**

Your paycheck reductions for the spending accounts will start the 15th of 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 medical underwriting.

• **Employee Life, Spouse Life and Child Life**

You have a one-time opportunity to choose some levels of employee and spouse life insurance coverage without providing medical underwriting. Please see Employee, Spouse, and Child Life section for specific limits.

• **Employee Specified Illness and Spouse Specified Illness**

You have a one-time opportunity to sign up for the Specified Illness guaranteed levels up to \$30,000 without providing medical underwriting. Coverage for children is included with the Employee benefit.

General Eligibility and Enrollment Information

Continued

Important Information If You Are A New Employee *(cont'd)*

You have a one-time opportunity to sign up for the Spouse Specified Illness guaranteed level up to \$10,000 without providing medical underwriting

- **Disability**

There is a one-time opportunity to sign up for long-term disability coverage without providing medical underwriting during your new hire eligibility period. If you do not sign up now, you will need to complete an Evidence of Insurability Form.

There is a one-time opportunity to sign up for short-term disability without being subject to a late entrant waiting period during the new hire eligibility period. If you did not sign up then, 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, or vision benefits.

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 another year, you may have to prove insurability through medical underwriting to be covered again, or have longer waiting periods to receive full benefits.

After You Enroll For Coverage

When Coverage Begins

Coverage for new options selected during the Plan Year 2012 Annual Enrollment will begin on January 1, 2012 as long as you have met all contractual and administrative requirements.

Your new premiums for your health benefit plan and spending account reductions begin December 15; other premiums begin December 31 (for semi-monthly pay periods). These dates may not apply if your department has a different pay schedule. Please check with your personnel/payroll office for more information. See specific plan descriptions for information about when your 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.

Confirming Your Choices

You are responsible for the benefit selections entered on the GaBreeze web site or enrolled by calling the GaBreeze Benefits Center. It is very important that you confirm your selections prior to the end of the enrollment period and ensure that you print your Confirmation page. The choices confirmed at the end of the enrollment period are the valid choice for the entire Plan Year. The Confirmation Statement does not guarantee your coverage in some benefit coverages that require additional information. If you have not completed and submitted the

General Eligibility and Enrollment Information

Continued

additional forms/information required by your selected plan, the choices shown on your Confirmation Statement may not be valid.

Compare your paycheck statements with your Confirmation Statement. It is your responsibility to notify your personnel/payroll office immediately if there is an error. Deductions should match the confirmed choices. Any changes to your benefit selections must be in accordance with IRS §125 and Employee Benefit Plan Council rules and regulations and approved by plan administrators.

To Change Your Decisions at Annual Enrollment

Every Annual Enrollment you can change your benefit decisions, based on which benefits are available and right for you. Remember, this is an annual agreement to allow the State to purchase some benefits for you through pre-tax premiums. You will not be able to change these benefit decisions until the next Annual Enrollment unless you have a qualifying change in status as described in the Terms and Conditions.

To Change Your Decisions Outside Annual Enrollment

Qualifying Change in Status Event

In general, the Internal Revenue Service prohibits you from changing any coverage elections, or enrolling in or canceling any coverage under the Flexible Benefits Program outside of Annual Enrollment. However, the rules of the Internal Revenue

Service and the Employee Benefit Plan Council do permit you to change coverage or enroll or cancel coverage in certain limited circumstances, if the change corresponds to a qualifying change in status event.

The Employee Benefit 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 Annual Enrollment period.

Your request for enrollment or a change in any coverage under the Flexible Benefits Program must be entered on the GaBreeze web site 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.

Note: *For a list of possible change in status events that might permit you to change one or more coverages under the Flexible Benefits Program, please refer to the Terms and Conditions in this booklet.*

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

General Eligibility and Enrollment Information

Continued

Other Important Eligibility Information During Unpaid Leave, Retirement or Rehires

Unpaid Leave

When you go on leave without pay, you will receive a bill for coverage from GaBreeze. If you do not continue paying premiums for coverage, your benefits will be cancelled and you may be subject to penalties and wait periods, if allowed to re-enroll. You may be required to wait until the next Annual Enrollment period to re-enroll. Be sure to review each Plan Description for each option. Exceptions: FLMA and Military Leave.

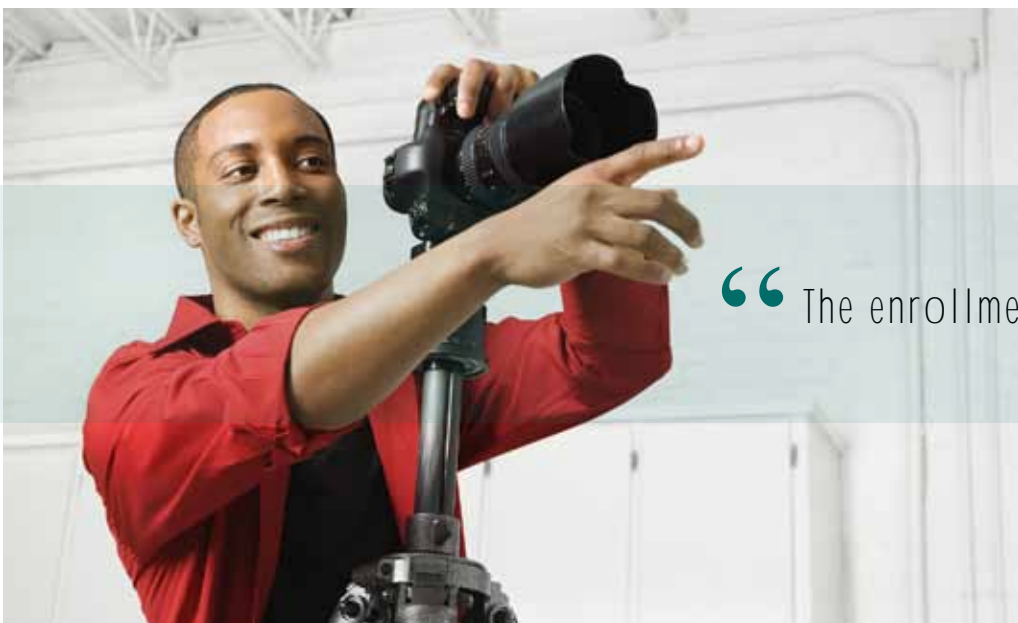
Retirement

It is the responsibility of each employee to contact the vendor directly within the required timeframe, to continue coverage unless you are retiring. If you retire and are currently enrolled in dental, your coverage will continue automatically. If you wish to cancel your dental coverage, you will need to contact the GaBreeze Benefits Center. For vision and HCSA, you may continue through COBRA.

Rehires

If you leave active State employment and then return during the same plan year and within a 30-day period, your previous 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 outside a 30-day period, you will be treated as a new hire.



“ The enrollment process is easy. ”

Can I take Insurance Coverage with me when I leave?

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 Regular & PPO DHMO Option	Yes Yes	Yes Yes	No Yes	COBRA - 60 days Convert 30 days - Prepaid Option
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	----
Employee/Spouse/Child Life Insurance	No	No	Yes	30 days
AD&D Insurance	No	No	Yes	30 days
Specified Illness	No	No	Yes	30 days
Disability/Coverage Short-Term Long-Term	No No	No No	No Yes	---- 30 days
Legal Insurance	No	No	Yes (Through end of the plan year)	30 days
Long-Term Care Insurance	No	No	Yes	30 days

Dental

Dental Plans

We offer a wide variety of dental plan choices. Each plan 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 option may depend on where you live or work, and you should check the availability of dentists carefully. The three dental plans are listed below according to the dentist network availability in geographic areas:

- Regular - For all employees throughout Georgia;
- Preferred Provider Organization (PPO)- For all employees throughout Georgia with network availability;
- Dental Health Maintenance Organization (DHMO) - Specifically for employees who live or work in metropolitan areas.

Your Choices

Regular Option with United Concordia

- Benefits are determined using the 90th percentile reimbursement levels for dental procedures.
- You may use any dentist you choose.
- You may choose a dentist in the available PPO network with benefits based on the maximum allowable charge (MAC). This may result in lower out of pocket costs.

- A non-network dentist is entitled to collect from you the difference between the amount of benefits payable by United Concordia and the dentist charge for that service.

PPO Option with United Concordia

- Benefits are based on the MAC determined by United Concordia and accepted by the PPO dentist.
- Enrollment in the PPO is with the PPO Program, not with a particular dentist. PPO dentists can discontinue their arrangement with the Program at any time.
- If you require the services of a specialist, ask your dentist to refer you to a PPO specialist.
- If you use the services of a non-PPO dentist:

The dentist is entitled to charge you the difference between the amount of benefits payable by United Concordia and the dentist's charge. This means you could pay more out-of-pocket expense for using a non-PPO dentist, because the payment is based on a percentage of the lower PPO scheduled fee.

Important Information for Regular and PPO Options

- **Six (6) Month Wait Period**
All New Hires and newly eligible dependents are subject to the Six (6)

“ With such a large network of dental providers, I found my dentist online and am pleased with their services. ”



Dental

Continued

Month Wait Period for Type III and Orthodontia (dependents under age 19 only) services.

➤ **Late Entrant Limitations**

Late entrant limitations result in delayed benefits in the Regular and PPO plans for up to twenty four (24) months. This means you won't receive some benefits until you have participated in the dental plan for a specified period of time. If you are under the Late Entrant Penalty, you will not be able to receive Type II services for twelve (12) months and Type III services for twenty four (24) months.

Late Entrant Limitations will apply to:

- current employees who are enrolling in either the Regular or PPO Options for the first time and are not able to present a certificate of continuous coverage with a group dental plan; or
- employees who fail to pay premiums when they are on an unpaid leave, except for FMLA and Military Leave; or
- current employees who choose not to continue coverage and re-enroll at a later date.

❖ Important Note: New employees are not subject to the late entrant limitations as long as they enroll when first eligible.

Dental HMO (DHMO) Plan:

CIGNA Dental Care® (DHMO) plan makes it **easy and affordable** for you to take care of your dental health.

- No deductibles
- No annual dollar maximums
- No claim forms to file
- No ID cards required to receive care

- No age limit on sealants
- No referrals required to visit a network orthodontist or for children under 7 to visit a network pediatric dentist

With the CIGNA DHMO, you'll know exactly what you 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. Most Preventive services such as exams, x-rays and cleanings, are covered by a \$0 or low copay (frequency limits may apply). Dental treatments such as fillings, crowns and root canals are covered reduced, fixed copays for covered services.

The CIGNA DHMO is only available to employees who **LIVE** or **WORK** in the metropolitan Atlanta and select cities.

Keep in mind, 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. Your covered family members can each choose their own general dentists participating in the CIGNA network. After you enroll, you can change your general dentist anytime - online or by phone.

Did you know research supports a relationship between gum (periodontal) disease and complications for diabetes, heart disease and stroke, pre-term birth, and other health issues? That's why CIGNA created the **CIGNA Dental Oral Health Integration Program.®** Under this program, eligible State of Georgia Flexible Benefits Program participants enrolled in a CIGNA plan can enjoy enhanced preventive dental coverage.

Dental Options Comparison Chart

	REGULAR - United Concordia	PPO - United Concordia	DHMO - Cigna
TYPE I – PREVENTIVE	100% of the 90th percentile***	100% MAC**	100% Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
TYPE II – BASIC	80% of the 90th percentile***	90% MAC**	100% Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges (amalgam (silver) fillings only)
TYPE III – MAJOR	50% of the 90th percentile***	50% MAC**	60%* Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
ORTHODONTIA	50% of the 90th percentile***	50% MAC** for dependents	50% for employee for dependents under 19 (and eligible dependents*) Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
ANNUAL DEDUCTIBLE	\$50 per person; \$150 for family (applies to Type II and Type III Major services only) each plan year		NONE
MAXIMUM BENEFITS	\$1,000 per person each plan year; \$1,500 lifetime benefit for Orthodontia		NO MAXIMUM
WAITING PERIOD FOR BENEFITS	New employees or newly enrolled dependents – after six months of continuous coverage for Type III Major services and Orthodontia		NO WAITING PERIOD
LATE ENTRANT LIMITATIONS FOR BENEFITS	Current employees enrolling for coverage for the first time after 12 months continuous coverage for Type II Basic services; after 24 months		NO LIMITATION

*Your share of the cost for these services will actually be a flat dollar co-payment. See Schedule of Benefits for details.

TYPE I – PREVENTIVE	TYPE II – BASIC	TYPE III MAJOR	ORTHODONTIA
<ul style="list-style-type: none"> • Oral exams • Prophylaxis • Space maintainers for dependents under 14 • X-rays 	<ul style="list-style-type: none"> • Fillings • Root canals • Extractions • Scaling and root planing • Repairs to dentures, bridges, and crowns • Sealants for children under 16 	<ul style="list-style-type: none"> • Crowns • Dentures • Bridgework • Surgical periodontal 	<ul style="list-style-type: none"> • Cephalometric x-rays • Treatment study • Bands, appliances

**United Concordia reimburses all fee-for-service (regular plan) and PPO dentists according to the maximum allowable charge (MAC) schedules. The MAC is determined using charge data submitted to United Concordia from more than 100,000 participating providers.

United Concordia policies & procedures and exclusions limitations apply.

This chart is a representative listing of services covered and under the program.

***You may use a PPO provider even if you enrolled in the Regular Dental Option. This may result in lower out-of-pocket costs.

Pre-Determination of Benefits

Under the Regular and PPO Dental Options, for any service of more than \$300, the service should be reviewed by United Concordia before receiving treatment. Ask your dentist to submit a pre-determination of benefits for any services expected to exceed this amount.

Vision

Vision Plans with OptumHealth

Vision coverage is available with two plan options – Select and Select Plus. Both plans offer these features:

- covered exams and materials;
- statewide access to a network of panel providers;
- no claims to file for “in-network” benefits; and
- benefits for “out-of-network” providers.

The OptumHealth Vision Care participating provider network includes private practice optometrists, ophthalmologists and retail chains.

Your Options

Select Option

- The Select Plan covers standard single vision and standard lined multi focal lenses for glasses. Cosmetic lens options such as tinting, UV coating, progressive lenses, etc., are not covered, but are provided to OptumHealth Vision’s members at a savings below normal retail charges.
- Certain standard contact lenses, including daily wear, and up to 4 boxes of standard single vision disposable contacts are covered in full for your co-payments. Under the Select Plan, if you purchase contacts that are not among OptumHealth Vision’s “covered in full” selection, you will receive an annual \$105 allowance toward the purchase of contact lenses, and professional fees (i.e., fit and follow-up).

- To receive the full \$105 allowance under the Select Plan, you must receive your exam, fitting and evaluation at a single visit to the same network provider. The allowance will only apply 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.

Select Plus Option

- In addition to the coverage in the Select Plan, the Select Plus Plan does offer cosmetic lens options for Tints, UV, Polycarbonate and Basic Progressive lenses.
- To receive the full \$125 allowance under the Select plus Plan, you must receive your exam, fitting and evaluation at a single visit to the same network provider. The allowance will only apply 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 Select and Select Plus Plans

- Benefits are provided every 12 months for exams, lenses and/or contacts and every 24 months for frames measured from the last date of service. Note: Benefit service limitations are calculated on a rolling calendar year. Example: if you receive exam services in March, you will be eligible to receive another exam in March of the following year.

“ My daughter and I both needed glasses, but we opted for contacts instead with the Vision Plus Option. ”



Select Plan Option

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam <i>Every 12 months</i>	100% after \$10 copay	Reimburses up to \$40
Lenses Standard <i>Every 12 months</i>		
Single vision, or	100% after \$20 copay	Reimburses up to \$60
Lined Bifocal, or	100% after \$20 copay	Reimburses up to \$80
Lined Trifocal, or	100% after \$20 copay	Reimburses up to \$80
Lenticular	100% after \$20 copay	Reimburses up to \$45 of retail
Frames <i>Every 24 months after a \$20 materials copay*</i>	Retail Providers (Examples: Eye Glass World, For Eyes and Wal-Mart) <ul style="list-style-type: none"> • Up to \$130 retail allowance toward any frame package • Frames below \$130 provided at no additional cost Private Doctors Office <ul style="list-style-type: none"> • \$130 retail allowance towards any frame. You pay the difference. • Group of select frames or frames below \$130 provided at no additional cost 	
Contact Lenses <i>Every 12 months in place of eyeglasses</i>	After \$20 copay. Covered in full contact lenses in lieu of eyeglasses. At in-network providers includes fitting/evaluation fee, contacts and two follow up visits. If you chose disposable contacts, you receive up to four boxes. Non-covered contacts receive \$105 allowance.	Reimburses up to \$105
Medically Necessary	Covered after \$20 materials copay	Reimburses up to \$210
Not Medically Necessary	Covered after \$20 material copay for covered lenses selected from OptumHealth's list. Up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a \$105 allowance that includes fitting, follow-up & materials. Please note to receive the full \$105 credit, you must receive your exam, fitting evaluation and all contact materials at the same provider at the same time. (At Wal-Mart \$70 of the \$105 allowance is allocated to materials and \$35 to professional fees).	Up to \$105 max that includes fit, follow-up & materials
Refractive Eye Surgery Access to discounted provider locations throughout the United States. To find a participating laser eye surgeon, visit our web site at www.myoptumhealthvision.com	Discount only: The in-network benefit is a discount off the full retail price.	No benefits

Remember if you use in-network providers, you are responsible only for your portion of the cost. If you decide to use a non-network provider, you pay everything and file a claim to receive payment according to the out of network payment schedule.

*Must qualify as medically necessary as described in the enrollment booklet.

Select Plus Plan Option

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam <i>Every 12 months</i>	100% after \$10 copay	Reimburses up to \$40
Lenses Standard <i>Every 12 months</i>	Lens Options covered are: Tints, UV, Polycarbonate and Basic Progressives lenses.	OON Lens options are not covered.
Single vision, or	100% after \$25 copay	Reimburses up to \$40
Lined Bifocal, or	100% after \$25 copay	Reimburses up to \$60
Lined Trifocal, or	100% after \$25 copay	Reimburses up to \$80
Lenticular	100% after \$25 copay	Reimburses up to \$80
Frames <i>Every 24 months after a \$20 materials copay*</i>	Retail Providers (Examples: Eye Glass World, For Eyes and Wal-Mart) <ul style="list-style-type: none"> • Up to \$130 retail allowance toward any frame package • Frames below \$130 provided at no additional cost Private Doctors Office <ul style="list-style-type: none"> • \$130 retail allowance towards any frame. You pay the difference. • Group of select frames or frames below \$130 provided at no additional cost 	Reimburses up to \$45 of retail
Contact Lenses <i>Every 12 months in place of eyeglasses</i>	After \$25 copay. Covered in full contact lenses in lieu of eyeglasses. At in-network providers includes fitting/evaluation fee, contacts and two follow up visits. If you chose disposable contacts, you receive up to four boxes. Non-covered contacts receive \$125 allowance.	
	Covered after \$25 materials copay	Reimburses up to \$210
Medically Necessary Not Medically Necessary	Covered after \$25 material copay for covered lenses selected from OptumHealth's list. Up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a \$125 allowance that includes fitting, follow-up & materials. Please note to receive the full \$125 credit, you must receive your exam, fitting evaluation and all contact materials at the same provider at the same time. (At Wal-Mart \$70 of the \$125 allowance is allocated to materials and \$55 to professional fees).	Up to \$125 max that includes fit, follow-up & materials
Refractive Eye Surgery Access to discounted provider locations throughout the United States. To find a participating laser eye surgeon, visit our web site at www.myoptumhealthvision.com	Discount only: The in-network benefit is a discount off the full retail price.	No benefits

Remember if you use in-network providers, you are responsible only for your portion of the cost. If you decide to use a non-network provider, you pay everything and file a claim to receive payment according to the out of network payment schedule.

** Must qualify as medically necessary as described in the enrollment booklet.

Employee, Spouse, and Child Life Insurance and AD&D

Do you need Life Insurance?

Yes, if any of the situations below apply to you:

- > Children under 19;
- > Unemployed spouse;
- > Mortgage and/or other debts are greater than your salary.

Employee Life Insurance With Minnesota Life

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

Available Coverage Amounts

- one times your pay (maximum coverage is \$300,000)
- two times your pay
- three times your pay
- four times your pay
- five times your pay
- six times your pay
- seven times your pay
- eight times your pay
- nine times your pay

If you are a newly eligible employee, you may elect Employee Life Insurance at one (1) times your Benefit Salary up to \$300,000 or Two (2) through Nine (9) times your Benefit Salary up to and

including \$200,000. If you apply for an amount of insurance in excess of \$200,000, you will be subject to medical underwriting. The coverage maximum is \$500,000. If you are age 65 or older, the value of your life coverage is reduced.

Spouse Life Insurance *With Minnesota Life*

If you choose employee life insurance for yourself, you may also choose spouse life insurance coverage for your spouse. Spouse life insurance premiums are based on the coverage level and employee age. Premiums for spouse coverage are after-tax. However, if you are age 65 or older, the value of your spouse life coverage is reduced.

Available Coverage Amounts

Spouse Life - \$ 6,000 - \$ 12,000 - \$ 30,000
- \$ 60,000 - \$100,000 - \$150,000
- \$200,000 - \$250,000

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.

If you are a newly eligible employee, you may elect \$30,000 or less of spouse life coverage without medical underwriting.

Child Life Insurance *With Minnesota Life*

If you choose life insurance for yourself, you may also choose child life insurance

NEW! Legacy Planning Services provides end of life planning and resources at no cost.

Employee, Spouse, and Child Life Insurance and AD&D

Continued

coverage for your child(ren). Child life insurance premiums are after-tax.

Available Coverage Amounts

Child Life	- \$ 3,000	- \$ 6,000	- \$ 10,000
		- \$ 15,000	- \$ 20,000

Your children are eligible for coverage if they are under age 26.

Child life coverage can be elected without medical underwriting.

Important Notes about Child Life:

- Child coverage can begin at live birth.
 - There shall be automatic coverage of \$3,000 for a newborn child if the child dies within 30 days of birth, but prior to you enrolling for child life coverage.
- Child Life coverage cannot exceed 100% of your amount of Employee Life coverage. Physically and/or mentally handicapped children covered under Child Life may continue to be covered beyond the age of 26.
- You are the beneficiary of child life insurance coverage and will receive the insurance benefit in the event of the child's death.

Accidental Death and Dismemberment Insurance *With Minnesota Life*

The Flexible Benefits Program offers accidental death and dismemberment (AD&D) insurance to be paid to you or your beneficiary if your death or injury 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.

Available Coverage Amounts

- one times your pay
- two times your pay
- three times your pay
- four times your pay
- five times your pay
- six times your pay
- seven times your pay
- eight times your pay
- nine times your pay

The coverage maximum is \$500,000. If you are age 75 or older, the value of your coverage is reduced.

Note: Waive of Premium - If you become disabled and are approved for benefits by Minnesota Life, your monthly premium for all your life insurance will be waived.

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 Benefit Salary as of October 1, 2011. This amount is rounded up to the next higher \$1,000, after you multiply your coverage and the premium has been adjusted for your October 1, 2011 pay and age.
- If your coverage selection requires medical underwriting, you will need to complete the Minnesota Life Evidence of Insurability Form along with any other required information. An approval by Minnesota Life, the insurance carrier, must be made before coverage can be in effect.
- Be sure to designate your beneficiaries by accessing the GaBreeze web site

or calling GaBreeze Benefits Center. Also, you can change and update your beneficiaries at any time.

- Minnesota Life now offers Legacy Planning Services for end-of-life planning and resources for the Employee and Spouse Life options

- For information regarding conversion and portability of your Employee Life, Spouse Life, and Child Life insurance, contact Minnesota Life Insurance toll-free at 1-800-660-2519.



“ I wanted to make sure my family would be financially secure and that's why I decided to increase my life insurance. ”

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 The Standard*

If you choose short-term disability (STD) coverage, this plan will work with other income benefits to replace 60% of your Benefit Salary (in effect during the Plan Year the disability began) up to \$800 per week. If you receive other benefits, (such as Social Security, workers' compensation, other disability plans and/or programs including the State retirement systems) that total 60% of your Benefit Salary, the short-term disability plan will not pay for this disability.

Your Options

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

How STD Works

In general:

- A late enrollment penalty may apply for late entrants to the STD plan (employees who do not elect STD when first eligible).
- Your STD benefits are calculated on the Benefit Salary 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, 2010, your disability benefit will be calculated from the 2010 Benefit Salary, not your 2011 Benefit Salary.
- Your STD benefits can continue until you recover, return to work, or receive

benefits for a maximum of 150 calendar days or a maximum of 173 calendar days, depending on the coverage level you have chosen. The calendar-day maximums are reduced by any days of paid sick leave, donated leave or Special Injury Leave that you use which exceeds the applicable wait period.

- When changing from the 30-day Benefit Waiting Period to the 7-day Benefit Waiting Period, a Pre-Existing clause is applicable. If you have a condition for which you should have sought medical care or which originated prior to the 7-day Benefit Waiting Period effective date, you will be subject to the rules of the 30-day Benefit Waiting Period until you are on the plan for 12 consecutive months. The Pre-Existing clause does not apply to accidental injuries.

What Is A Late Enrollment Penalty For Late Entrants?

A late enrollment may apply for late entrants to the STD plan (employees who do not elect STD when first eligible). A current employee choosing coverage for the first time or re-enrolling after discontinuing coverage 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 disabled for 60 days until you are on the plan for 12 consecutive months. For STD late entrants whose disabilities begin after this 12 month period, benefits will start after the benefit waiting period (7 or 30 continuous calendar days) is satisfied for STD.

Short and Long Term Disability

Continued

Enrolling For Short-Term Disability Coverage

Your premiums will be based on your coverage level and Benefit Salary. Since you pay for this coverage with after-tax premiums, you won't pay taxes on the benefits you receive.

NOTE: Employees should check with your agency concerning leave usage policies when disabled. Agency policy may affect your eligibility to receive Short-Term Disability benefits.

Long-Term Disability *With The Standard*

Long-Term Disability Protection

The Flexible Benefits Program's Long-Term Disability (LTD) coverage works with other benefits you are eligible to receive, including Social Security, workers' compensation, other disability plans and programs, including the State retirement systems. The plan assures that your combined disability benefits from all these sources will equal 60% of your Benefit Salary up to \$4,000 a month.

How Long LTD Benefits May Be Payable

These benefits will begin after you have been disabled for 180 calendar days and are reduced by any sick leave you

use. LTD benefits end when you are no longer disabled or reach age 65, except benefits for disabilities caused by mental disorders, or other limited conditions, which are limited to two years. If you become disabled after reaching age 60, however, your benefits could continue for a limited period after age 65. Your plan contains incentives and extra benefits to help keep you at work. Accommodations may be available under the plan to adjust your workplace so you can stay at work, or to help you return to work. Vocational rehabilitation and return to work services may be available to help you return to work after a disability.

Enrolling For Long-Term Disability Coverage

Your cost for long-term disability coverage is based on your age, whether you pay into Social Security, Benefit Salary, and whether or not you are eligible for disability coverage through any State of Georgia retirement plan.

LTD premiums are paid with pre-tax dollars. These benefits are considered taxable income and you are responsible for paying taxes to the Internal Revenue Service (IRS).

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

“ When I had to take a leave of absence, because of disability, I didn't have to worry about my finances. ”



Long Term Care

Long-Term Care *With Unum*

Long-Term Care 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 very high. Home care can be as much as \$25,000 per year, and nursing home care can range in cost from \$40,000 to \$80,000 annually. Generally, you 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 the long-term care is provided - either in a nursing facility, or home/day/assisted living facility - and the daily dollar level of the coverage you have selected. With any of these daily benefit 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 on 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 to be accepted for LTC coverage. Your family members' premiums will be billed directly by the insurance company. Your payroll deduction will be for your individual coverage only.

When Benefits Are Paid

Benefits begin after a 90-day waiting 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. Benefits from long-term care insurance are not taxed when you receive them.

About Your Premiums and Enrolling

You pay for your LTC coverage through the convenience of payroll deduction with after-tax dollars. Premium costs are based on your age as of the Benefit Calculation Date (October 1). Your family members' premiums are based on their age as of the date they apply for coverage. Their premiums will be sent directly to Unum, not deducted from payroll.

If you are a newly eligible employee or a current employee and are selecting LTC insurance for the first time, you may select LTC with no medical underwriting requirements. If you are currently enrolled and want to increase your benefit level, add options, or are re-enrolling after discontinuing coverage, medical underwriting will be required. For more information about long-term care coverage, call Unum at 1-888-SOG-FLEX (1- 888-764-3539).

Specified Illness

Specified Illness Plan *With Continental American Insurance Company*

With the group specified illness plan, our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness or condition.

Employee coverage levels:

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

- Lump-sum benefits paid directly to the insured following the diagnosis of each covered specified illness after you are hospital confined for the specified illness and charged for room and board. (See the chart for information on covered specified illnesses.)
- Rates cannot be individually increased due to change in age, health or individual claim.
- No medical underwriting required for up to \$30,000 in coverage, and simplified medical underwriting process with only a few health questions.
- The plan is portable* - take your coverage with you if you leave your job.
- Available to employees age 18-69.
- Benefits for participants reduced 50% at age 70.

Spouse coverage levels:

- \$5,000 benefit • \$10,000 benefit
- No medical underwriting required
- Employee must have coverage for the spouse to have coverage
- Rates are based on employee age

Child coverage:

- Children covered at no additional cost
- All children are covered at 25% of employee benefit amount
- Children ages 0 - 26, if a dependent

- Child coverage automatically included in existing employee coverage

Covered Cricital Illnesses*	
Illnesses Covered under the Plan	Percentage of Face Amount
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
Renal Failure (End Stage)	100%
Internal Cancer	100%
Coma	100%
Severe Burns	100%
Paralysis Loss of Sight, Hearing , or	100%
Speech	100%
Alzheimer's (NEW)	25%
Carcinoma in situ	25%
Coronary artery	25%

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 collects full benefits for a Critical Illness under the plan and later has one of the remaining covered illnesses, then we will pay the full benefit amount for any additional illness. Occurrences must be separated by at least 6 months.

Re-Occurrence Benefit

If an insured receives full benefit for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis

Specified Illness

Continued

must be separated by at least 12 months or 12 months treatment free for Internal Cancer.

Health Screening Benefits

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

*Certain stipulations apply to portability.
**A partial benefit (25%) is payable for Alzheimer's, 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.

“ You can't predict if you're going to need coverage for Specified Illness, but you can plan ahead in case you do. ”



Legal Insurance

Legal Insurance Plan with Hyatt Legal Plan

Whether you're buying a new home, drawing up a will or just need some legal advice, the Hyatt Legal Plan can give you easy access to experienced, local network attorneys.

Now you have a resource at your fingertips for important everyday legal services. You can use the plan as often as you need legal representation. What's more, you'll also have someone to turn to for unexpected legal matters. You can now enroll in a great new voluntary benefit legal plan offered through Hyatt Legal Plans.

- Civil Litigation Defense - **NEW!**
- Consumer Protection Matters
- Debt Collection Defense
- Identity Theft Defense
- Enforcement or Modification of Support Orders
- Eviction and Tenant Defense
- Guardianship/Conservatorship
- Adoption
- Immigration Assistance
- Tax Audits
- Divorce (As defined by the SPD)
- Real Estate Matters for Second Residence or Vacation Home
- Incompetency - **NEW!**

Don't miss your chance to enroll in this important and worthwhile benefit – it can pay for itself the first time you use it.

Your Legal Benefit Options

Select Plan

The Select option provides benefits for the following services:

- Powers of Attorney
- Office Advice and Consultation
- Wills and Codicils
- Living Wills
- Traffic Matters (no DUI)
- Document Preparation
- Real Estate Matters for Primary Residence
- Elder Law Matters - **NEW!**
- Home Equity Loan Assistance - **NEW!**

Select Plus Plan

The Select Plus option offers the same services as the Select Plan with some additional services. A few of the differences are:

Access to Over 11,000 Attorneys

The Hyatt Legal Plan provides members with access to a national network of more than 11,000 Plan Attorneys. Also, if you wish to use an attorney that does not participate in the Hyatt Legal Plan, Hyatt will reimburse you according to a set fee schedule. If you find yourself in need of legal assistance while traveling within the U.S., call our Client Service Center. You will be referred to an attorney in the area.

What Are the Exclusions?

The legal plan excludes appeals; class actions; matters which Hyatt Legal Plans deems frivolous, non-meritorious or unethical; and any employment-related matters. For a complete list of exclusions, view the Summary Plan Description on the web site www.GaBreeze.ga.gov.

Legal Insurance

Continued

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, visit the web site www.legalplans.com. Click on “Thinking About Enrolling?” and enter a password:

Select Plan

7600001 - Employee Only

7610001 - Employee w/Dependents

Select Plus Plan

7620001 - Employee Only

7630001 - Employee w/Dependents



“With the legal insurance, I now can afford a lawyer.”

Spending Accounts with SHPS

Spending accounts let you pay for certain eligible health and/or dependent care expenses using pre-tax dollars. They offer tax savings by letting you pay for out-of-pocket expenses with pre-tax money. This can mean savings of approximately 20%-40%, depending on your individual tax situation!

For the 2012 Plan Year, the spending accounts being offered are:

	Health Care Spending Account	Dependent (Child) Care Spending Account
Annual Maximum	\$5,040	\$4,992
Annual Minimum	\$ 120	\$ 120

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

Health Care Spending Account (HCSA)

The Health Care Spending Account (HCSA) helps you save tax dollars on the health-related treatment you and your family receive.

Some of the eligible expenses include:

- 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;
- Prescriptions;

- Mental health services;
- Physical therapy; and
- Certain other IRS approved expenses.

A few examples of expenses that are not eligible include:

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

➤ The Debit Card

When you enroll in a Health Care Spending Account, you'll receive a VISA® Spending Account Card for purchases of eligible healthcare expenses. You will automatically receive the Card, along with information about the card and how it can be used. You may request up to 4 additional cards with your spouse or dependent's name on it, for a fee of \$5.00 per card. If your card is lost or stolen, you may request another card for a fee of \$15.00. For additional cards, call SHPS at 1-800-893-0763.

➤ Keeping Receipts

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

➤ 2½ Month Grace Period

Employees have an additional 2½ months to spend the money in their Health Care Spending Account. This means qualified expenses may be reimbursed for services provided

Spending Accounts

Continued

through March 15. Employees will have until April 30 to send their claims to SHPS for reimbursement. Remember, if a claim is mailed, the envelope must be postmarked by April 30th. The fastest way to get claims to SHPS is to fax them at 1-866-643-2219.

To best take advantage of this grace period, plan only for expenses you expect to have for the 12 month period. If you do not use all of the money you contributed, you can then use it in the grace period.

Important note: The IRS does not allow participation in Health Care Spending Accounts and Health Savings Accounts at the same time.

Dependent (Child) Care Spending Account (DCSA)

The Dependent (Child) 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 while you and your spouse work or go to school full time.

Childcare 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 elderly daycare facility or to have someone to care for them in your home.

If you are married, both you and your spouse must be working or 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 (Child) 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 to 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 (Child) 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 (child) care spending account cannot exceed \$4,992.

Spending Accounts

Continued

- 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 (child) 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.

Important Information About Spending Accounts

- ❖ Reductions for spending accounts are made every pay period.
- ❖ Your spending account enrollment is 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.
- ❖ Claims should only be submitted 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.
- ❖ You receive a bi-monthly statement showing how much you have in each account.
- ❖ You cannot transfer money from one account to another.
- ❖ Reimbursements are issued on a daily basis.
- ❖ Spending account claims for the 2011 Plan Year (January 1 - December 31, 2011) must be faxed or mailed with correct documentation and postmarked on or before **April 30, 2012**.
- ❖ Spending account claims for the 2012 Plan Year (January 1 - December 31, 2012) must be faxed or mailed with correct documentation and postmarked by **April 30, 2013**.
- ❖ 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.

Contact GaBreeze Benefits Center at 1-877-3GBREEZ (1-877-342-7339) for more information or log onto the web site at www.GaBreeze.ga.gov



“ I use my Health Care Spending Account to pay health care deductibles. ”

Employees' Retirement System



Are You Maximizing Your Retirement Savings?

If you are a full-time state employee hired on or after January 1, 2009, you're a member of the Georgia State Employees' Pension and Savings Plan (GSEPS). GSEPS members receive a match on contributions to the Peach State Reserves 401(k) Plan. When you contribute 1% of your pay, the state matches your contribution dollar for dollar. For a \$30,000 annual salary, that's your \$300 contribution plus an additional \$300 matching contribution in your 401(k) every year.

But did you also know you get a 50¢ match when you contribute 2% to 5% of your pay? For example, contributing 5% of a \$30,000 salary gives you a match of \$900 a year. That's free money. If you're saving less than 5%, you're missing out on that extra cash. Access your account at www.gabreeze.ga.gov or 1-877-342-7339 to increase your contribution.



You May Have Life Insurance through the Retirement System

As you're reviewing your benefit coverage during Annual Enrollment, keep in mind that state employees covered under the Employees' Retirement System (ERS) "New" or "Old" Plans (generally, full-time employees hired prior to January

1, 2009*) and Legislative Retirement System and certain Judicial Retirement System members hired prior to 7/1/2009 have Group Term Life Insurance coverage through the retirement system equal to 18 times your monthly salary while in active status and prior to age 60; at age 60 coverage begins to reduce.

For more information about any life insurance coverage you may have through the retirement system, access your account at www.ers.ga.gov or call 1-800-805-4609.

*Full-time employees hired on or after January 1, 2009 and covered under the GSEPS retirement plan do not have this coverage. No new members can be added to the Group Term Life Insurance plan per legislation passed in 2008 and 2009.

Update Your Beneficiaries with the Retirement System

In addition to any beneficiary designations you make through GaBreeze, it's also critical to designate or update your beneficiaries through the Retirement System, including any beneficiaries for the Group Term Life Insurance coverage you may have through ERS (see above). Beneficiary designations and changes can be made by accessing your retirement account at www.ers.ga.gov. Now would be a great time to review and update ALL your beneficiary designations, as you go through your annual benefits review.



Offered by
the Georgia Higher Education Savings Plan

Start your child on the path to a brighter future.

There are a number of paths to choose from to pay for a child's education. Choose the right one, and virtually any college dream can be within reach. And college can lead to a brighter future. Even if your child receives a HOPE Scholarship or other forms of financial aid, saving for college now is a key step to avoiding loans and providing flexibility down the road.

Thanks to a program offered by the State of Georgia - the Path2College 529 Plan, formerly referred to as the Georgia Higher Education Savings Plan (GHESP) - you have a smart and flexible way to help save for future higher education expenses.

With a Path2College 529 Plan account, you don't pay Georgia or federal taxes on earnings as your account grows. Then, when it's time to pay for college, the money you withdraw for qualified higher education expenses is also Georgia and federal tax-free. In addition, Georgia offers a state income tax deduction for up to \$2,000 in contributions for each beneficiary.

With the Path2College 529 Plan, you can choose from seven investment options designed to meet your savings goals. There are no start-up or application fees, no maintenance fees, and no sales charges or broker commissions. You pay only a low annual management fee of less than one-half of a percent.



Start your child on the path to a brighter future.

It's easy to enroll.

Don't worry about a big up-front financial commitment. You can open an account for as little as \$25 per contribution. And the Path2College 529 Plan offers an Automatic Contribution Plan that drafts your checking or savings account, or you can sign-up for the payroll deduction program and contribute as little as \$15 per pay period. Once you start, it's easy to stay on track!

You can obtain enrollment, ACP, and payroll deduction information by contacting the state office of the Path2College 529 Plan at (404) 463-0000 or outside metro-Atlanta at (866) 529-9529 or by email at path2college@treasury.ga.gov. You can also obtain the necessary payroll forms by visiting www.otfs.georgia.gov. Click on College Savings Plan Forms and review the Employee Payroll Checklist for New Accounts (if you do not currently have an account), or the Employee Payroll Checklist for Existing Accounts (if you already have an account). Visit www.path2college529.com for more information.

Please note: Payroll contributions are made using after-tax dollars; therefore, you are not subject to the limits and restrictions for flexible benefits during the Annual Enrollment period. Your payroll deduction can be started, stopped, increased or decreased at anytime during the year by contacting us at the numbers above.

EMPLOYEE CHECKLIST

Employee Checklist

- ✓ Check with personnel/payroll office for deadlines.
- ✓ Review the enrollment booklet, providing you with valuable information for each option descriptions of required supplemental for medical underwriting requirements, and Terms & Conditions.
- ✓ Check on the website (GaBreeze.ga.gov) to confirm if additional forms are required, such as medical underwriting forms.
- ✓ Review your Confirmation Page thoroughly and immediately report discrepancies to GaBreeze Benefits Center. Follow-up to assure corrections were made.
- ✓ Compare your pay stub(s) against options selected. Contact your personnel/payroll office with discrepancies.
- ✓ Report any incorrect information to your personnel/ payroll office.

Other Important Information

For questions about claims or benefits for the State Health Benefit Plan, see Benefit Phone Directory for phone numbers. For general questions about the Flexible Benefits Program, call GaBreeze 1-877-342-7339.

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 the current tax law and is subject to and operated in accordance with the regulations of the Internal Revenue Service (IRS). If changes in the Program are necessary to comply with the law or IRS regulations, you will be notified.

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. This notice pertains to those programs specifically administered by the State Personnel Administration (SPA) in which SPA may maintain various types of PHI about you. SPA understands that information about you and your family is very personal. As such, SPA is committed to protecting and securing your information.

This notice tells you how SPA uses and discloses information about you and 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 own 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 flexible spending account or any list

showing the amount of benefits paid with a breakdown by social security number. This also includes your employer (state agency, school system, authority, etc.) transmitting information about you to SPA. This information may include your name, address, birth date, social security number, employee identification number and certain health information

How SPA Uses and Discloses Protected Health Information

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

Privacy and Security Law Requirements SPA 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 SPA's legal duties and privacy and security practices regarding the information that SPA 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 SPA disclosed prior to receiving your written request. If you are unable to give your permission due to an emergency, SPA may release information, if it is in your best interest. SPA must notify you as soon as possible after releasing the information.

PRIVACY AND SECURITY NOTICE

Continued

Your Health Information Rights

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

- You have the right to see and obtain a copy of your health information. This right would not extend to information needed for a legal action relating to SPA.
- You have the right to ask SPA to change health information that is incorrect or incomplete. SPA may deny your request under certain circumstances or request additional documentation.
- You have the right to request a list of the disclosures that SPA has made of your health information beginning in April 2003.
- You have the right to request a restriction on certain uses or disclosures of your health information. SPA is not required to agree with your request.
- You have the right to request that SPA communicate with you about your health in a way or at a location that will help you keep your information confidential.
- You may request another copy of this notice from SPA, or you may obtain a copy from the SPA web site, www.spa.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 the SPA Privacy Officer at 404-656-2730 (Atlanta calling area) or 1-888-968-0490 (outside of Atlanta calling area). You may also visit SPA web site, www.spa.ga.gov.

SPA 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 SPA programs, please contact the SPA 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 by calling the SPA Privacy Unit at 404-656-2730 (Atlanta calling area) or 1-888-968-0490 (outside of Atlanta calling area), or by writing to:
State Personnel Administration
Attn: Privacy Officer
2 MLK Jr. Drive, SE
Suite 502, West Tower
Atlanta, GA 30334
- 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 SPA changes its privacy or security practices significantly, SPA will post the new notice on its web site at www.spa.ga.gov (Under "Privacy"). This notice, effective April 14, 2003, was amended April 20, 2005.

Benefit Phone Directory

Flexible Benefits Program

GaBreeze Benefits Center Website: GaBreeze.ga.gov	1-877-342-7339
Employee, Spouse, Child Life Insurance Accidental Death and Dismemberment Life conversion and Portability information	1-800-660-2519
Dental Insurance CIGNA - www.cigna.com United Concordia-Regular & PPO www.unitedconcordia.com	1-800-642-5810 1-866-215-2356
Vision Coverage www.myoptumhealthvision.com	1-800-638-3120
Disability Insurance	1-888-641-7186
Long-Term Care Insurance	1-800-227-4165
Legal Insurance www.legalplans.com	1-800-821-6400
Spending Accounts Hearing Impaired www.shps.net	1-800-893-0763 1-800-952-0452
Specified Illness Insurance Portability Information	1-800-433-3036 1-800-433-3036

State Health Benefit Plans

SHBP Eligibility	1-800-610-1863	404-656-6322
United Healthcare of Georgia Health Reimbursement Arrangement (HRA) High Deductible Health Plan (HDHP) Health Maintenance Organization (HMO) Retirees	1-800-396-6515 1-877-246-4189 1-877-246-4189 1-877-755-5343	
CIGNA Healthcare Active Employees Retirees	1-800-633-8519 1-800-942-6724	

TERMS & CONDITIONS

The Flexible Benefits Program is offered by the Employee Benefit Plan Council, the Board of Community Health and participating departments and authorities. The Flexible Benefits Program is governed by the Internal Revenue Code, section 125, and rules issued by the Employee Benefit Plan Council and the Board of Community Health. 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. 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 GaBreeze 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 the benefits, click 'no coverage' in each benefit category and complete the confirmation process on the GaBreeze web site.
- 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, which ever is deemed appropriate by the Plan Administrator. Any adjustments to the Benefit Salary, 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 Flexible Benefits Program 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 Benefit Plan Council, and the Board of Community Health. The Employee Benefit Plan Council and the Board of Community Health have 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. To submit a request for enrollment or change to coverage under the State Health Benefit Plan, you must complete and submit a Membership or Discontinuation Form to your employer's Benefits Coordinator within 30 days. Your request for enrollment or a change in any other coverage under the Flexible Benefits Program must be done by calling GaBreeze Benefit Center or on the website within 30 days. For mid-year changes as a result of birth or adoption, the employee has 90 calendar days to make a QSE request following the event. For all other QSE events, the timeframe is 30 calendar days following the event. 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; or
 - h) You, your spouse or your dependent gain or lose eligibility for Medicare or Medicaid.
- 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.
- 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 levels under the State Health Benefit Plan are set forth in the State Health Benefit Plan Document. 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 Benefit Plan Council related to Spending Accounts. In particular, you are agreeing to the following provisions:
 - a) Money contributed for one type of Spending Account cannot be used to pay claims payable from another type of Spending Account.
 - 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.
 - 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.
 - f) For the Spending Accounts, eligible expenses will be reimbursed in accordance with the Rules of the Employee Benefit 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 agreement received with the card.
- 11) By selecting the Specified 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 enroll in the Employee and/or Spouse Life Insurance, you may be required to pay taxes on imputed income.
- 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, the Rules of the State Health Benefit Plan, and the Rules of the Employee Benefit Plan Council for the Flexible Benefits Program.