FLEXIBLE BENEFITS PROGRAM

Department of Administrative Services

Your benefits are a reflection of you.

2015

ANNUAL ENROLLMENT • OCTOBER 27, 2014 – NOVEMBER 14, 2014

www.GaBreeze.ga.gov

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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 2015 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.

There are some plan enhancements for the 2015 Plan Year, so review all information carefully. 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).
- 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 must provide supporting documentation (i.e., birth certificate, marriage certificate), if requested.

Benefit Salary
Your Benefit Salary includes 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 for or pertaining to employee life, AD&D, and disability.

General Eligibility and Enrollment Information

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 (www.GaBreeze.ga.gov) or the GaBreeze Benefits Center at 1-877-342-7339.

- **Dental**
  There is a 6 month waiting period for Major services under the Select Plan and a 6 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 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. 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 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 Spousal 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

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

You have a one-time opportunity to sign up for the Spousal Specified Illness guaranteed level up to $30,000 without providing medical underwriting

- **Disability**
  During your new hire eligibility period there is a one-time opportunity to sign up for long-term disability coverage without providing medical underwriting. If you do not sign up within this 30-day new hire eligibility period, you will need to complete an Evidence of Insurability Form and 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 there is 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 sign up within this 30-day new hire eligibility 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, 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

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 personnel/payroll office for more information. See specific plan descriptions for information about when your coverage begins.

Confirming Your Choices

You are responsible for the benefit selections entered on the GaBreeze web site or 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 choices 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 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 Benefits 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 benefits available and are right for you. Remember, this is an annual agreement to allow the State to purchase some benefits for you through pre-tax or post-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.

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

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To Change Your Decisions Outside 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.

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 coverage outside of the Annual Enrollment period.

Your request for enrollment or a change in other 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.

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 choices. For some benefits, however, when you change

General Eligibility and Enrollment Information

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.

Continuation of Benefits During Unpaid Leave, Retirement or End of Employment

- **Unpaid Leave**

When you go on leave without pay, you will receive a bill to pay 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. 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 the employee 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 Specified Illness, or Legal. 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.

Ending Employment

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 and must make new elections. If you retired and are a rehire returning to a benefits eligible position, you must re-elect dental in order to continue coverage.

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				COBRA - 60 days Convert 30 days - Prepaid Option
Select & Select Plus	Yes	Yes	No	
DHMO Option	Yes	Yes	Yes	
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	No	No	No	----
Long-Term	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 three (3) plans: the Select and Select Plus from Delta Dental and the dental HMO option from Cigna Dental Care ® (DHMO). 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:

- Delta Dental Select and Delta Dental Select Plus – For all employees throughout Georgia;
- Cigna Dental Care ® (DHMO) – Specifically for employees who live or work in metropolitan Atlanta area.

Your Choices

Select and Select Plus Options 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 provided, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.
- If you visit a non-Delta Dental dentist, 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 through the Select Plus Plan only.

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 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).

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26		
Deductibles*	$50 per person / $150 per family each calendar year Yes		
Deductibles waived for D & P	Yes		
Maximums*	$500 per person each calendar year Dental Select Plan $2,000 per person each calendar year Dental Select Plus Plan		
D & P counts toward maximum?	No		
Waiting Period(s)	**Basic Benefits** **0 Months**	**Major Benefits** **6 Months**	**Orthodontics** **6 Months – Plus Plan Only**

	Dental Select Plan			Dental SelectPlus Plan		
Benefits and Covered Services **	PPO Dentists†	Premier Dentists†	Non-Delta Dental Dentists†	PPO Dentists†	Premier Dentists†	Non-Delta Dental 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

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

deltadentalins.com

Dental

Cigna Dental Care ® (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

The Cigna DHMO is available to employees who live or work in the metropolitan Atlanta area. 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 (frequency limits may apply). Dental treatments such as fillings, crowns and root canals are covered at reduced, fixed copays.

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. After you enroll, you can change your general dentist anytime - online or by phone.

Oral Health Integration Program®
Research shows an association between oral health and overall health.[1] By getting the right oral health care, along with regular medical treatments, high-risk individuals may be able to improve their overall health.

Eligible employees who enroll will have access to enhanced dental coverage through the Cigna Dental Oral Health Integration Program® (OHIP).
With this program, eligible members with certain medical conditions may receive 100% reimbursement of their copay for select covered dental services.
The qualifying medical conditions for OHIP: heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head & neck cancer radiation.

For additional information regarding OHIP, please visit http://www.cigna.com.

1 Appropriate Periodontal Therapy Associated with Lower Medical Utilization and Costs." Presented at the International Association for Dental Research Meeting March 2013, Seattle Program participants enrolled in a Cigna plan can enjoy enhanced preventive dental coverage.

Cigna Dental

Cigna – DHMO Comparison Chart	
Benefits & Covered Services	**In Network**
Type I Diagnostic & Preventive Services Oral Exams, Cleanings, x-rays,	100% Reduced, fixed, preset charges for all covered services. See your Patient Charge Schedule for Specific Charges
Type II Basic Services Fillings, Root canals, Extractions, Scaling and root planning Repairs to dentures, bridges and crowns Sealants	100% Reduced, fixed, preset charges for all covered services. See your Patient Charge Schedule for Specific Charges
Type III Major Crowns, Dentures, Bridgework, Surgical periodontal	60% Reduced, fixed, preset charges for all covered services. See your Patient Charge Schedule for Specific Charges
Orthodontic Benefits Cephalometric x-rays, Treatment study, Bands, appliances	50% for employee and dependent orthodontia 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

For additional information about Cigna, please visit www.cigna.com

Vision

Vision coverage is available through Blue Cross Blue Shield 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 Blue Cross Blue Shield 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, transitional lenses, etc., are not covered, but are provided to Blue Cross Blue Shield 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 Blue Cross Blue Shield 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.

Below is a chart for the Select Plan:

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 2 years.		
Basic Lenses (Pair) • Single Vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses Includes: • Factory scratch coating • Polycarbonate and Photo chromic lenses (for children under age 19)	$20 Copayment	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 2 years.	No Copayment Allowable Amount up to $130 retail allowance	Reimbursed up to $45
Prescription Contact Lenses (traditional or disposable) • Non-Elective Contact Lenses (Availability once every Calendar Year.)	No Copayment Covered in full	Non-Network providers are Reimbursed up to $210
• Elective Contact Lenses (Availability once every Calendar Year.)	No Copayment $105 plan allowance	Non-Network providers are Reimbursed up to $105

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

Below is a chart for the Select Plus Plan:

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) • Single Vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses Includes the following Lens Options: • UV coating • Tint (solid & gradient) • Polycarbonate lenses • Transitions Photochromic lenses • Standard & Premium Progressive lenses • Standard Anti-Reflective coating (Not Covered For Non-Network Providers)	$25 Copayment	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 Calendar Year.	No Copayment Allowable Amount up to $150 retail allowance	Reimbursed up to $45
Prescription Contact Lenses (traditional or disposable) • Non-Elective Contact Lenses (Availability once every Calendar Year.)	No Copayment Covered in full	Non-Network providers are Reimbursed up to $210
• Elective Contact Lenses (Availability once every Calendar Year.)	No Copayment $200 plan allowance	Non-Network providers are Reimbursed up to $200

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

Vision

Important Information for Select 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 will be $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.

Important Information for 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 will be $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.

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

The State of Georgia's Life insurance options are offered by MetLife. MetLife has the expertise to help you understand your life insurance needs and the financial strength that you can count on.

Your 2015 Annual Enrollment Highlights

- **Employee Life Coverage** – you may elect up to ten times your pay to a maximum benefit of $2,000,000
- **Premium Waiver** – provides continuation of Employee Life without further premium payment if 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
- **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

Employee Life Insurance with MetLife

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
- 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
- ten times your pay

If you are a newly eligible employee, you may elect Employee Life Insurance at one (1) times through Ten (10) times your Benefit Salary, up to a maximum of $2,000,000. If you apply for an amount of insurance in excess of (1) times your pay or $200,000, you will be subject to medical underwriting.

If you are an eligible active employee, you may elect to increase your current coverage amount, however you will also be subject to medical underwriting. If you are age 65 or older, the amount of your life coverage is reduced.

Spouse Life Insurance with MetLife

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's age. Premiums for spouse coverage are after-tax. However, if you are age 65 or older, the amount of your spouse life coverage is reduced.

Available Spouse Life Coverage Amounts

$ 6,000	$ 12,000	$ 30,000	$ 60,000
$100,000	$150,000	$200,000	$250,000

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

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. If you have spouse life coverage and elect to increase the amount, your spouse will be subject to medical underwriting.

Child Life Insurance with MetLife
If you choose life insurance for yourself, you may also choose child life insurance coverage for your child(ren). Child life insurance premiums are after-tax.

Available Child Life Coverage Amounts

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

- Child Life coverage cannot exceed 100% of your amount of Employee Life coverage.
- 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 MetLife
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 the permanent and total disability benefit under AD&D, you are eligible for the benefit 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
- ten times your pay

The coverage maximum is $2,000,000. If you are age 75 but less than 80, the value of your coverage is reduced to 50%.

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

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

- The life and AD&D insurance amounts you choose will be based on your Benefit Salary as of October 1, 2014. 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. An approval by MetLife must be made before coverage can be in effect.
- NOTE: No paper Statement of Health form will be mailed for the employee and/or the spouse to complete. A pre-registration process will need to be completed for a spouse requiring medical underwriting before the Statement of Health form will be available online.
- 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.

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 The Standard

If you choose short-term disability (STD) coverage, this plan will work in coordination with other income benefits to replace 60% of your Benefit Salary (in effect during the Plan Year the disability began) up to $1000 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) that total 60% or more of your Benefit Salary, 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
In general:
- 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 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, 2014, your disability benefit will be calculated from the 2014 Benefit Salary, not your 2015 Benefit Salary. The 2014 Benefit Salary is based on your weekly rate of earnings in effect on October 1, 2014, 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).
- When changing from the 30-day Benefit Waiting Period to the 7-day Benefit Waiting Period, a Pre-Existing Condition exclusion is applicable: If you have a condition for which you should have sought medical care or which originated in the 90 days prior to the 7-day Benefit Waiting Period effective date, 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 7-day Benefit Waiting Period for at least 12 consecutive months. The Pre-Existing Condition exclusion does not apply to accidental injuries.

Short and Long Term Disability

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 (7 or 30 continuous calendar days, as applicable) is satisfied.

Enrolling For Short-Term Disability Coverage
Your premiums will be based on your age, coverage level and Benefit Salary. This premium is an after-tax deduction. You won't pay taxes on the benefits you receive.

NOTE: You should check with your agency concerning leave usage policies when disabled. Agency policy may impact 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 but not limited to Social Security, workers' compensation, other disability plans 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 Benefit Salary up to $5,000 per month.

How Long LTD Benefits May Be Payable
If you qualify for benefits, they 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 your Social Security Normal Retirement Age, except 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.

NOTE: For claims initiated prior to January 1, 2014, benefits will end when you are no longer disabled or reach age 65.

Short and Long Term Disability

Enrolling For Long-Term Disability Coverage
Your cost for long-term disability coverage is based on your age, your FICA Status, Benefit Salary, 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 after-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 1-888-641-7186.

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 $20,000 per year, and nursing home care can range in cost from $20,000 to $60,000 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) or your hire date, whichever is later. 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 your payroll.

Long Term Care

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 who is 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 Aflac/CAIC:

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. (See the chart below 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+
- Benefits for participants will not reduce due to age!

Spouse coverage levels:

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

- No medical underwriting required for up to $30,000 in coverage, and simplified medical underwriting process with only a few health questions.
- Employee must have coverage for the spouse to have coverage.
- Available to spouses age 18+
- Rates are based on employee age.

Child coverage:

- Children covered at no additional cost
- All children are covered at 50% of employee benefit amount
- Children ages 0-26, if a dependent, are eligible.
- Child coverage automatically included in existing employee coverage.

Dependent Child Benefits

Illnesses Covered Under Plan	Percentage of Maximum Benefit
• Cystic Fibrosis	100%
• Cerebral Palsy	100%
• Cleft Lip or Cleft Palate	100%
• Spina Bifida	100%
• Down Syndrome	100%
• Spina Bifida	100%

Covered Critical Illnesses*

Illnesses Covered under	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	100%
• Loss of Sight, Hearing, or Speech	100%
• Carcinoma in situ	25%
• Coronary artery	25%
• Advanced Alzheimer's Disease	25%

Specified Illness

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, we will pay the full benefit amount for any additional illness. The two dates of diagnosis must be separated by at least 90 days (or, for cancer, be at least 12-months treatment free); additional Critical Illnesses cannot be caused by or contributed to by a Critical Illness for which benefits have been paid.

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. Occurrences must be separated by at least 90 days (or, for cancer, be at least 12-months treatment free). Cancer that has spread (metastasized) even though there is a new tumor will not be considered an additional occurrence unless the Insured has been Treatment Free for at least 12 months.

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. 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 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.

Specified Illness

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.

Did you know? The Number of emergency department visits for unintentional injuries in 2008 was: 28.4 million. (Injury Facts, Center of Disease and Control)

- 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* - take your coverage with you if you leave your job
- Available to employees and spouses age 18+
- Wellness Benefit $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.

Legal Insurance

Legal Insurance Plan 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 easy access to experienced, local network attorneys for a low, affordable rate

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

Legal Benefits

The legal services covered by the plan are fully covered legal services, as defined by your Summary Plan Description (SPD), when you see a Participating Plan Attorney. You can use the plan as often as you need legal representation. There are no waiting periods, copayments, or deductibles.

Access to Over 13,000 Attorneys

The Hyatt Legal Plan provides members with access to a national network of more than 13,000 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 or visit www.legalplans.com to view participating attorneys in the area.

Your Legal Benefit Options

View the plan coverages below 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 Consultation
- 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

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 Consultation
- Probate Proceedings
- Consumer Protection Matters
- Debt Collection Defense

Legal Insurance

- 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* ($1000 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
- NEW Security Deposit Assistance (Tenant)
- NEW Protection from Domestic Violence

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

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

What Are the Exclusions?

The legal plan excludes appeals; class actions and appeals; matters which Hyatt Legal Plans deems 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 becoming eligible for plan benefits and any employment-related matters. For a complete list of exclusions, contact your local human resources representative for a copy of the plan document.

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 website www.legalplans.com. Click on "Employees/ Members Click Here" and enter a password:

Select Plan
7600001 - Employee Only
7610001 - Employee w/Dependents

Select Plus Plan
7620001 - Employee Only
7630001 - Employee w/Dependents

Spending Accounts

The Spending Account plans are administered by ADP.

For the 2015 Plan Year, the spending accounts being offered are:		
	Health Care Spending Account	Dependent (Child) Care Spending Account
Annual Maximum	$2,460	$4,992
Annual Minimum	$ 120	$ 120

The IRS rules and the rules of the Employee Benefits Plan Council designate eligible expenses and the Employee Benefits 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;
- Prescription;
- 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
- Over-the-counter medications

- **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 ADP at 1-800-893-0763.

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

- **2-1/2 Month Grace Period**
  Employees have an additional 2-1/2 months to spend the money in their Health Care Spending Account. This means qualified expenses may be reimbursed for services provided through March 15th. Employees will have until April 30 to send their claims to ADP for reimbursement. 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, 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.

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.
- 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.

Spending Accounts

- 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

- Deductions 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 2014 Plan Year (January 1 - December 31, 2014) must be faxed or mailed with correct documentation and postmarked on or before April 30, 2015.
- Spending account claims for the 2015 Plan Year (January 1 - December 31, 2015) must be faxed or mailed with correct documentation and postmarked by April 30, 2016.
- 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.
- 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 there is a significant change to the FSA plans. If you have a current contribution elected for the plan, it will not automatically rollover into the new plan year. You must make an election if you want to contribute to the FSA plans for the new Plan Year.

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

Path2College 529 Plan
Save for the future. Today.

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.

Now, 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 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 GA529@otfs.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 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 very personal. As such, DOAS is committed to protecting and securing your information.

This notice tells you how DOAS 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 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.

Privacy And Security Notice

Your Health Information Rights
You have the following rights regarding the health information maintained by DOAS 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 DOAS.
- You have the right to ask DOAS to change health information that is incorrect or incomplete. DOAS may deny your request under certain circumstances or request additional documentation.
- You have the right to request a list of the disclosures that DOAS 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. DOAS is not required to agree with your request.
- You have the right to request that DOAS 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 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
  Suite 502-B, 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 DOAS changes its privacy or security practices significantly, DOAS will post the new notice on its web site at www.doas.ga.gov.

Benefit Phone Directory

Flexible Benefits Program

GaBreeze Benefits Center Website: GaBreeze.ga.gov	1-877-342-7339
Employee, Spouse, Child Life Insurance and Accidental Death and Dismemberment Life conversion and Portability information	1-877-255-5862
Dental Insurance CIGNA - www.cigna.com Delta – Select and Select Plus www.deltadentalins.com	 1-800-642-5810 1-866-496-2384
Vision Coverage www.bcbsga.com	1-855-556-4844
Disability Insurance	1-888-641-7186
Long-Term Care Insurance	1-888-227-4165 or 1-800-227-4165
Legal Insurance www.legalplans.com	1-800-821-6400
Spending Accounts Hearing Impaired https://myspendingaccount.adp.com	1-800-893-0763 1-800-952-0452
Specified Illness Insurance Portability Information	1-800-433-3036 1-800-433-3036

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 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 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 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; or
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.

Terms and Conditions

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 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) 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 after-tax dollars to avoid having to pay imputed income; this will eliminate any tax savings on the life insurance premium.

12) 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.

Georgia™

Department of
Administrative Services