

2023 YOU DECIDE

FLEXIBLE BENEFITS PROGRAM



OPEN ENROLLMENT

**STARTS OCTOBER 17, 2022 at 1:00 A.M.
THRU NOVEMBER 5, 2022 at 12:59 A.M. ET**

WWW.GABREEZE.GA.GOV

FLEXIBLE BENEFITS PROGRAM

PHONE DIRECTORY

Who to Contact for Assistance

Contact the Flexible Benefits Vendors

- Benefit questions
- ID cards
- Claims status
- Claims appeals
- Help finding a network provider

Contact GaBreeze

- Eligibility and enrollment questions/changes (QLEs)
- Premiums questions
- Enrolling or removing dependents
- Password reset/access to GaBreeze
- Eligibility Appeals

Contact the Entity

- Updating your contact details (non-Team Works)
- Leave Without Pay questions
- Payroll questions

BENEFIT TYPE	NAME & CONTACT INFORMATION	WEBSITE
Dental Insurance	Cigna DPPO and DHMO 1-888-764-0099 (24/7, 365 days a year)	www.cigna.com
Vision Coverage	Anthem Blue Cross Blue Shield (Anthem) 1-855-556-4844 (7:30 a.m. – 11:00 p.m. M-Sat, ET) (11:00 a.m. – 8 p.m. Sun, ET)	www.anthem.com
Employee, Spouse, Child Life, Insurance and Accidental Death and Dismemberment	MetLife 1-877-255-5862 (8:00 a.m. – 8:00 p.m. ET, M-TH) (8:00 a.m. – 5:00 p.m. ET, Friday)	www.metlife.com/georgia
Flexible Spending Accounts	HealthEquity WageWorks 1-877-924-3967 (8:00 a.m. – 8:00 p.m., ET, M-F)	https://member.my.healthequity.com
Disability Insurance	The Standard 1-888-641-7186 (8:00 a.m. – 8:00 p.m., ET, M-F)	www.standard.com
Long-Term Care Insurance	Unum 1-888-SOG-FLEX (1-888-764-3539) (8:00 a.m. – 8:00 p.m., ET, M-F)	www.unuminfo.com/sog
Critical Illness Insurance	Aflac 1-800-433-3036 (8:00 a.m. – 8:00 p.m., ET, M-F)	www.aflacgroupinsurance.com www.doas-specifiedillness.com
Legal Insurance	MetLife Legal Plans 1-800-821-6400 (8:00 a.m. – 8:00 p.m., ET, M-F)	www.legalplans.com
GaBreeze Benefits Center	GaBreeze 1-877-342-7339 (8:00 a.m. – 5:00 p.m., ET, M-F)	www.GaBreeze.ga.gov

CONTENTS

02	Flexible Benefits Program Phone Directory
04	Welcome
05	Employee Checklist
06	Your 2023 Flexible Benefits Program Enhancements, Changes, Plan Options and Vendors
09	Open Enrollment (OE) and Your Responsibilities
11	Important Information
13	General Eligibility and Enrollment Information
14	Enrollment and Eligibility
14	Dependents Eligible for Coverage
14	Salary for Benefit Purposes (Annual Benefit Base Rate)
15	Pre-Tax Premiums Help You Stretch Your Dollars
15	New Hires
16	After You Enroll
16	When Coverage Begins
17	Confirming Your Choices
17	To Change Your Decisions at Open Enrollment
18	To Change Your Decisions Outside Open Enrollment
18	Separation from Service
20	Your Flexible Benefits Upon Retirement
22	Your Flexible Benefits Upon Termination
24	Your Flexible Benefits Options
25	Dental
31	Vision
35	Employee, Spouse, and Child Life Insurance and AD&D
38	Flexible Spending Accounts
42	Short and Long-Term Disability
44	Long-Term Care
46	Critical Illness
49	Legal Insurance
51	HIPAA Privacy and Security Notice
54	Terms and Conditions

Welcome to the State of Georgia Flexible Benefits Open Enrollment

October 17, 2022 at 1:00 a.m. ET through November 5, 2022 at 12:59 a.m. ET

The State of Georgia is pleased to offer you a competitive Flexible Benefits Program as an integral part of your Total Rewards package. The 2023 *YOU DECIDE* booklet gives you an opportunity to review the Flexible Benefits plan options. This booklet summarizes the options available to you and your eligible dependents, along with the actions you need to take to elect these benefits. You should reference the Summary Plan Descriptions (SPDs) for each Flexible Benefits plan option posted on the websites, www.GaBreeze.ga.gov and www.doas.ga.gov for more details.

Are you planning or expecting the birth or adoption of a child? Getting married soon? Are you caring for an aging parent? How would you replace some of your income if you are out of work due to a personal illness or injury? 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. These are questions you may want to consider when reviewing and electing your Flexible Benefits plan options during this Open Enrollment and as you experience qualifying life events (QLEs).

The 2023 Flexible Benefits Program includes some enhancements. Please read the *YOU DECIDE* booklet to understand the options available to you and reference it as a guide in making the choices that best meet your needs. Choosing the right benefits today can make a real difference toward building a secure future for you and your family tomorrow.



ALERT: Due to anticipated increased call volume and heavy online traffic, we are encouraging participants to enroll early. This Employee Checklist will help you to get started.

EMPLOYEE CHECKLIST

- Review** the *YOU DECIDE BOOKLET* for valuable information for each option, descriptions of required medical underwriting requirements, and Terms and Conditions.
- Confirm** your access to the enrollment portal, www.GaBreeze.ga.gov, in advance of the Open Enrollment start date.
- Update/Change** your beneficiary designation on the GaBreeze website.
- Confirm** on the GaBreeze website if additional documentation is required, such as Statement of Health form(s).
- Select** the “Complete Enrollment” button once you’ve completed your elections.
- Review and print** your “Completed Successfully” page and report discrepancies immediately to GaBreeze Benefits Center by calling 1-877-342-7339. Follow up to ensure that corrections are made.
- Review** your Confirmation Statement to ensure option(s) and dependent(s) selected appear.
- Compare** your paycheck statement(s) against the options you selected. Contact your Human Resources Department if you find any discrepancies.

Additional Information

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. **In the event of conflict between this booklet and the official plan descriptions and/or contracts, the terms of the official plan descriptions and contracts prevail.**

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

YOUR 2023 FLEXIBLE BENEFITS PROGRAM

ENHANCEMENTS, CHANGES, PLAN OPTIONS AND VENDORS

What's New for Plan Year 2023!

Cigna has been awarded the contract to administer the Flexible Benefits Dental PPO plan options. An additional PPO Dental plan option, Select Mid, will be available. The 2023 Dental PPO plan Options are:

- Select
- Select Mid
- Select Plus

2023 Dental PPO Plan Options

- Calendar year maximum increased for the Select plan option (from \$500.00 to \$750.00)
- Orthodontia lifetime maximum will start over in 2023
- New dental mid option – Select Mid
- Implant benefits available under the Select Mid and Select Plus plan options
- Premiums decreased on the Select and Select Plus plan options

2023 Dental PPO Rates

Cigna Dental PPO	Select	Select Mid	Select Plus
Employee Only	\$26.87	\$34.20	\$40.86
Employee + Spouse	\$52.35	\$66.83	\$79.96
Employee + Child(ren)	\$54.89	\$70.09	\$83.87
Employee + Family	\$76.92	\$98.30	\$117.68

Note: The rates include the \$.70 administrative fee.

Alert! Participants currently enrolled in Delta Dental PPO Select and Select Plus plan options will default to Cigna Dental PPO Select and Select Plus plan options if they do not make elections during Open Enrollment for Plan Year 2023.

YOUR 2023 FLEXIBLE BENEFITS PROGRAM

ENHANCEMENTS, CHANGES, PLAN OPTIONS AND VENDORS (CONTINUED)

Important Note for Current Delta Dental Participants

Delta Dental's contract to administer the Dental PPO plans with the Department of Administrative Services terminates on December 31, 2022. If you are enrolled in one of the PPO plan options, you have 12 months from the date of service to submit claims to Delta Dental for processing. Grievances and appeals must be submitted within 180 days from the claim denial. When mailing grievances and appeals, please include ATTN: G&A in the address. Claims and appeals should be mailed to the following address:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

If you need assistance with dental claims incurred prior to January 1, 2023, please contact Delta Dental's Customer Services at 866-496-2384.

Plan Year 2023 Enhancements/Changes

Cigna DHMO will have additional services with no increase in premiums in the following categories:

- Diagnostic/Preventive
- Periodontics
- Implant Services
- Oral and Maxillofacial Surgery
- Adjunctive General Services

Note: Orthodontia benefits are available under the Dental PPO Select Mid, Select Plus and DHMO plan options.

2023 Vision Rates

Anthem Blue Cross Blue Shield Vision plan options premiums decreased. There were no vision plan design changes for Plan Year 2023.

2023 Anthem Vision	Select	Select Plus
Employee Only	\$5.26	\$9.04
Employee + Spouse	\$11.13	\$19.80
Employee + Child(ren)	\$11.65	\$20.72
Employee + Family	\$15.73	\$28.23

Note: The rates include the \$.70 administrative fee.

YOUR 2023 FLEXIBLE BENEFITS PROGRAM

ENHANCEMENTS, CHANGES, PLAN OPTIONS AND VENDORS (CONTINUED)

Legal Plans Changes

MetLife Legal Plans options have enhanced benefits without a premium increase

- Divorce, Dissolutions and Annulments (Select Plus and Select Premium)
 - The \$1000.00 maximum for contested divorces will be removed and replaced with 20 hours of services
- A 25% Reduced Fee Benefit (Select, Select Plus and Select Premium)
 - Added 8 hours of attorney time for non-covered services

Long-Term Care Plan

UNUM’s Long-Term Care premiums will increase by 15% on plan options with compound inflation.

Dependent Verification Process

Effective January 1, 2023, Flexible Benefits’ participants adding new dependents, as well as their current covered dependents, must provide proof to GaBreeze that their dependents meet the eligibility requirements. The Department of Administrative Services (DOAS)/ Human Resources Administration (HRA) will provide more details before the Dependent Verification process changes go into effect.

Flexible Spending Accounts Changes

The Health Care Flexible Spending Account limit will increase from \$2,700.00 to \$2,808.00 for Plan Year 2023.

Flexible Benefits Vendors and Plan Options

Choosing the right Flexible Benefits makes a difference. The 2023 Flexible Benefits vendors and plan options are listed below. The section, “Your Flexible Benefits Options” provides a description of each plan options. Please read this section carefully to help you understand the options available and your out-of-pocket costs under each option.

DENTAL

- **Cigna Dental Care**
 - DHMO
- **Cigna PPO**
 - Select
 - Select Mid
 - Select Plus

VISION

- **Anthem Blue Cross Blue Shield (Anthem)**
 - Vision Select
 - Vision Select Plus

LIFE INSURANCE

- **MetLife**
 - Employee Life
 - Spouse Life
 - Child Life

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

- **MetLife**
 - Employee AD&D

FLEXIBLE SPENDING ACCOUNTS (FSA)

- **WageWorks**
 - Dependent Care
 - Health Care

DISABILITY

- **The Standard**
 - Short-Term
 - Long-Term

LONG-TERM CARE

- UNUM

CRITICAL ILLNESS AND CRITICAL ILLNESS SELECT PLUS

- **AFLAC**
 - Employee
 - Spouse

LEGAL INSURANCE

- **MetLife Legal Plans**
 - Select
 - Select Plus
 - Select Premium



Open Enrollment (OE) and Your Responsibilities

You Decide! It's time to make your 2023 Flexible Benefits elections. Open Enrollment (OE) starts October 17, 2022 at 1:00 a.m. ET and ends November 5, 2022 at 12:59 a.m. ET. During OE, eligible active employees can enroll or make changes in the Flexible Benefits for the 2023 plan year without experiencing a qualifying life event (QLE). If you do not enroll during OE, your existing Flexible Benefits plan options will roll-over to the next plan year, with the exception of Health Care Flexible Spending Account (HCFSA) and Dependent Care Flexible Spending Account (DCFSA). If you want to continue your HCFSA and/or DCFSA contributions for Plan Year 2023, you must re-enroll during this OE period. To get started, visit the enrollment website, www.GaBreeze.ga.gov. When accessing GaBreeze, please use the most current versions of the following browser platforms: Google Chrome, Firefox, Microsoft Edge and Safari. You can also access the mobile app, Alight Mobile, to enroll!

Alight continues to work to improve your experience while on the enrollment portal (GaBreeze) and/or when you contact the Benefits Center. There are several features that are available to reduce your hold times or provide you with an app to enroll while you are on the go!

What is Appointment Scheduling?

Appointment scheduling allows you to make and prepare for an appointment to speak with an Alight Customer Care Specialist. You have an opportunity to schedule a time that is convenient for you, and it allows you to bypass the phone queue. You can easily reschedule or cancel an appointment if needed 24/7 with minimal effort and receive appointment alerts anytime anywhere on your smart device via email or text.

What is Virtual Hold?

Via the phone system, this provides you with an estimated wait time during busy periods. It also offers callback options for the caller:

- Option 1:** Receive a call-back without losing your place in the voice channel queue.
- Option 2:** Receive a call-back at a more convenient time for you.

What is the Mobile App?

The app is an integrated mobile experience that improves the wellbeing of you and your family. Download the free app, Alight Mobile, to enroll while you are on the go!

Your Responsibilities as an Active Employee

1. Confirm your access to the enrollment portal, www.GaBreeze.ga.gov, in advance of the OE start date.
2. Read and review the plan materials posted at www.GaBreeze.ga.gov and other information provided by your HR Department and take the required actions.
3. Make your elections online at www.GaBreeze.ga.gov no later than November 5, 2022 by 12:59 a.m. ET. If you do not have access to a computer or smart device, contact GaBreeze Benefits Center at 1-877-342-7339 no later than November 4, 2022 by 5:00 p.m. ET to make your elections.
4. Notify your Benefits Coordinator or HR Department if your email address or mailing address needs to be updated.
5. Check your payroll deductions to verify that the correct deductions have been taken. Contact your Human Resources/Payroll Office immediately if the correct deductions have not been taken.

During OE, as an eligible Active Employee, you may:

- Enroll in Flexible Benefits coverage
- Change your Plan Option or Vendor
- Enroll eligible dependents
- Drop covered dependents
- Decrease/increase coverage tier
- Discontinue your Flexible Benefits plan option(s)

IMPORTANT NOTES: The elections made during OE will be the coverage you will have for the entire 2023 plan year, unless you have a qualifying life event (QLE) that allows a change to your coverage.

Qualifying life event (QLE) changes made to your State Health Benefits Plan (SHBP) coverage will **not** automatically update your Flexible Benefits coverage. You **must** declare the QLE by accessing the website, www.GaBreeze.ga.gov or contacting the GaBreeze Benefits Center within 31 days of the QLE.

REMINDER: Retiree Option Change Period (ROCP) starts on October 17, 2022 at 1:00 a.m. ET and ends on November 5, 2022 at 12:59 a.m. ET. During this time, retirees **can only** make changes to their dental coverage or discontinue coverage. If you discontinue your Flexible Benefits dental coverage, or fail to pay your monthly premiums through pension deductions or direct bill, you will not be able to re-enroll unless you return to work in a position that offers Flexible Benefits coverage.

IMPORTANT INFORMATION

Flexible Spending Accounts (FSA)

Are you currently enrolled in a Health Care or Dependent Care Flexible Spending Account? Flexible Spending Accounts do not automatically roll over to the next plan year. If you want to continue your FSA(s) for Plan Year 2023, you must re-enroll during the 2023 Open Enrollment for Plan Year 2023. When setting your annual Flexible Spending Account(s) amounts, do not exceed your anticipated annual out-of-pocket expenses.

The Consolidated Appropriations Act of 2021 granted additional temporary relief due to COVID-19 for participants enrolled in Dependent Care Flexible Spending Account (DCFSA) and Health Care Flexible Spending Account (HCFSA). The extended grace period of 12 months for Plan Year ending 2021 for both the DCFSA and HCFSA with respect to remaining contributions in these accounts ends December 31, 2022.

Therefore, there is still time to use your 2021 Dependent care Flexible Spending Account (HCFSA) and Health care Flexible Spending Account (HCFSA) contributions. If you have any DCFSA and/or HCFSA funds remaining on December 31, 2021, you have through December 31, 2022 to deplete your account. You can obtain qualified expenses and/or services through December 31, 2022 using your remaining DCFSA and/or HCFSA funds from 2021. The list of qualified expenses and/or services is posted at <https://www.wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table/>. The deadline for submitting DCFSA and/or HCFSA claims and/receipts for reimbursements of 2021 FSAs balances is December 31, 2022.

Disabled Dependents

Dependent children who are disabled prior to age 26 and incapable of self-sustaining employment by reason of mental incapacity or physical disability are eligible for Flexible Benefits coverage if:

1. The disabled child is already enrolled in the Flexible Benefits Program and turning age 26. You must provide proof by submitting a completed Disabled Dependent Certification Form to Flexible Benefits and include the child's disability within 31 days of the child turning 26 years old and when requested by the Flexible Benefits Program in order to continue coverage or recertify your dependent.
2. To enroll a disabled child as a newly eligible dependent, the child must be disabled prior to age 26. You must provide proof of the child's disability to Flexible Benefits (completed Disabled Dependent Certification Form) within 31 days of enrollment in the Flexible Benefits Program.

IMPORTANT INFORMATION

(CONTINUED)

Note: You must complete the Disabled Dependent Certification form found on <http://doas.ga.gov/human-resources-administration/employee-benefits-information/claim-forms> and return it to Human Resources Administration (HRA) within 31 days of your child turning age 26. Disabled dependents certifications approved by the State Health Benefit Plan (SHBP) do not transfer to the Flexible Benefits Program. Failure to certify or re-certify your disabled dependent, will result in the loss of the dependent's coverage permanently.

Unpaid Leave of Absence (LOA)

Employees on unpaid LOA who are enrolled in the Flexible Benefits Program will be direct billed by GaBreeze. You are responsible for payment of premiums directly to GaBreeze. Failure to make payment to GaBreeze timely, will result in the termination of your Flexible Benefits coverage.

Qualifying Life Events (QLE)

Divorced or experienced loss of another group coverage? If you experience a Qualifying Life Event (QLE), you have 31 days to declare your QLE by accessing GaBreeze at www.GaBreeze.ga.gov or calling GaBreeze Benefits Center at 877-342-7339. For additional information regarding QLEs, please see the Terms and Conditions section of this booklet.



A man and a woman are sitting at a table in a kitchen, looking at a tablet together. The man is on the left, wearing a white t-shirt, and the woman is on the right, wearing a light blue sweater. They are both looking at the tablet with interest. The background shows a kitchen with wooden cabinets and pendant lights.

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

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

Dependents Eligible for Coverage

Eligible dependents include your:

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

Salary for Benefit Purposes (Annual Benefit Base Rate)

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

Pre-Tax Premiums Help You Stretch Your Dollars

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

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

New Hires

New Hire Electronic Enrollment

New hires have 31 days from the date of hire to enroll in the Flexible Benefits Program. You will receive an enrollment worksheet, mailed to your home address, to prepare you to enroll. You can select your benefits using the enrollment website, www.GaBreeze.ga.gov, the mobile app, Alight Mobile, or calling the GaBreeze Benefits Center at 1-877-342-7339.

Waiting Periods and Evidence of Insurability

Flexible Spending Accounts (FSA)

Flexible Spending Account coverage begins on the first day of the month following one full calendar month of employment provided you are actively working. The contribution is deducted from your paycheck in the calendar month before the actual month in which your coverage becomes effective and in each calendar month thereafter through the end of the Plan Year. For monthly payroll, 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

During your new-hire eligibility period, you have a one-time opportunity to sign up for Long-Term Care insurance without providing evidence of insurability.

“Your Total Rewards” includes your pay, plus annual employer contributions to your benefit programs. This can be accessed through GABreeze. Once on the GABreeze Home Page, look for the icon for “Your Total Rewards” in the bottom row.

Employee Life, Spouse Life, and Child Life

During your new-hire eligibility period, you have a one-time opportunity to choose designated levels of employee and spouse life insurance coverage without providing evidence of insurability. Please see the Employee, Spouse, and Child Life section for specific limits.

Employee Critical Illness and Spousal Critical Illness

During your new-hire eligibility period, you have a one-time opportunity to sign up for guaranteed levels of Critical Illness insurance, up to \$30,000, without providing evidence of insurability. Coverage for children is included with the Employee Benefit.

You also have a one-time opportunity to sign up for Spousal Critical Illness coverage, guaranteed up to \$30,000, without providing evidence of insurability. You must elect Employee Critical Illness benefits in order for your spouse to be eligible to enroll in spouse Critical Illness benefits.

Short-Term Disability

During your new-hire eligibility period, you have a one-time opportunity to sign up for short-term disability coverage without being subject to a late entrant waiting period (Late Enrollment Penalty). If you do not enroll within this 31-day period, you will be subject to the Late Enrollment Penalty.

Long-Term Disability

During your new-hire eligibility period, you have a one-time opportunity to sign up for long-term disability coverage without

providing evidence of insurability. If you do not enroll within this 31-day period, you will need to complete a Statement of Health form. Your requested long-term disability coverage will not become effective until your evidence of insurability is approved by Standard Insurance Company (The Standard).

Other Coverage

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

After You Enroll

Be sure to consider your options carefully when you first enroll. If you decline or drop some of your flexible benefits coverage and want to re-enroll again in a future Open Enrollment, you may have to provide evidence of insurability through medical underwriting to be covered again or complete longer waiting periods to receive full benefits.

When Coverage Begins

If you are a new employee, your benefit election(s) and any necessary forms must be completed no later than 31-days after your hire date. Your coverage will begin on the first day of the following month after you have completed a full calendar month of continuous employment.

Coverage for new options selected during Open Enrollment will begin on January 1st of the following year if you have met all contractual and administrative requirements. See specific plan descriptions for information

about when your coverage begins. Summary Plan Descriptions (SPDs) are posted on the Georgia Department of Administrative Services (DOAS) website: <http://doas.ga.gov/human-resources-administration/employee-benefits-information/flexible-benefits/flexible-benefits-resources> and www.GaBreeze.ga.gov.

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

Confirming Your Choices

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

- Entering elections on the GaBreeze website, www.GaBreeze.ga.gov, or
- Calling the GaBreeze Benefits Center at 1-877-342-7339.

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

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

To Change Your Decisions at Open Enrollment

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

For new hires, if you have made your benefit elections on the GaBreeze website and wish to make a change within your 31-day enrollment window, you will need to contact the GaBreeze Benefits Center at 1-877-342-7339.

To Change Your Decisions Outside of Open Enrollment

Qualifying Life Event

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

Your request for enrollment or a change in coverage under the Flexible Benefits Program must be entered on the GaBreeze website, or by calling the GaBreeze Benefits Center, within 31 days after the qualifying life event (QLE). No refund of premiums will be issued if the change was not made within 31 days of the QLE and premiums were withheld.

The effective date for changes due to QLE is the first of the month following the QLE. For birth or adoption of a child, the effective date of the change will be the date of the event.

Examples of Qualifying Life Event (QLE)

- Marriage or divorce
- Birth, adoption, or legal guardianship
- Death of a dependent
- Gain or Loss of coverage under spouse's employer's plan

For more information, see Terms and Conditions, pp. 54-56.

31-Day Window

If you have a qualifying life event (QLE), you have 31 days to make changes to your Flexible Benefits. For birth or adoption, the effective date of the change will be retroactive to the date of the event. The request must be made within 90 days of the event. For all other QLEs, the effective date of the change is the first of the month following the QLE. If you do not make any changes within 31 days, you will have to wait until the next Open Enrollment to make changes to your Flexible Benefits.

Separation from Service

- **Unpaid Leave**

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

- **Retirement**

It is the employee's responsibility to contact the Flexible Benefits vendor directly, within the required timeframe, to continue coverage for Employee/ Spouse/ Child Life, AD&D, Long-Term Care, Employee/Spouse Critical Illness, or Legal Insurance, as applicable into retirement.

If you retire and are currently enrolled in dental, your coverage will continue automatically. Your premiums will be deducted from your pension. If you wish to cancel your dental coverage, contact the GaBreeze Benefits Center.

If you are paying your retiree dental premiums through direct bill to GaBreeze, you must pay your premiums timely to avoid cancellation of your dental benefits.

Note: Once cancelled, dental coverage cannot be reinstated.

If enrolled in vision and/or Health care Flexible Spending Account, COBRA is available. COBRA is only available through the end of the current plan year that you are enrolled, if you are enrolled in the Health Care Spending account.

- **Breaks in Employment**

If you leave active State employment and return within a 30-day period during the same plan year, your previous benefit choices will remain in effect unless you report a qualifying life event (QLE). If you leave active State employment and return in the same plan year *beyond* a 30-day period, you will be treated as a new hire and must make new benefit elections.

If you are a rehired retiree and returning to a benefits-eligible position, you must re-elect dental to continue coverage. Also, you are eligible to enroll in the Flexible Benefits Program other plan options.

Important Note: Upon returning to work in a benefits-eligible position, your retiree dental coverage will automatically terminate. You must enroll in dental coverage as an active employee and be enrolled at the time you retire again in order to carry the dental coverage into retirement.

- **Termination of Employment**

If you stop working for the State, your benefits typically end 30 days after your most recent premium or contribution has been paid. See **page 23** for a list of benefits eligible to be continued, on a post-tax basis, either through COBRA or by arrangement with a Flexible Benefits vendor.



YOUR FLEXIBLE BENEFITS UPON RETIREMENT



You can continue certain Flexible Benefits as a retiree for you and your dependents, if you were already enrolled as an active employee prior to your retirement. If you are not enrolled in the Flexible Benefits Program and want to carry dental coverage as a retiree, you will need to enroll during Open Enrollment the year prior to your retirement.

Example: Employee is retiring on January 1, 2023 and is not enrolled in the Flexible Benefits Program. In order to have Flexible Benefits coverage as a retiree, you must have enrolled in the Flexible Benefits Program during the 2021 Open Enrollment for Plan Year 2022.

If you retire and you and your dependents are currently enrolled in Dental coverage, your coverage will continue automatically through pension deductions, if eligible. If you and your dependents are enrolled in Vision coverage or Health care Flexible Spending Account (FSA), COBRA coverage will be available. The Health care FSA can only be extended through the end of the plan year you retire.

If you are enrolled in, Employee/Spouse/Child Life, Accidental Death & Dismemberment (AD&D), Long-Term Care, Employee/Spouse Critical Illness plan, or Legal Insurance, you may be eligible to port or convert these options by contacting the Flexible Benefits vendors upon retiring. You will be direct billed by the vendors. Short-Term and Long-Term Disability coverage terminates at the end of the month you retire.

Important Note: If you experience a Qualifying Life Event (QLE), e.g., marriage or spouse loses other group coverage, you must declare the QLE within 31 days of the event by entering the information on GaBreeze at www.GaBreeze.ga.gov, making changes on the mobile app, Alight Mobile, or contacting GaBreeze Benefits Center at 1-877-342-7339.

FLEXIBLE BENEFITS UPON RETIREMENT

Flexible Benefits Options	Flexible Benefits Options Available Through Pension Deductions	Coverage Continued Through COBRA	Coverage Can Be Direct Billed by the Vendor or, Converted or Ported to an Individual Policy	You Must Complete Vendor Forms Within
Dental Coverage				
• Select, Select Mid, & Select Plus	Yes	Yes	No	60 Days (COBRA)
• DHMO	Yes	Yes	Yes	Convert within 31 days (DHMO only)
Vision Coverage	No			60 days (COBRA)
Employee/Spouse/Child Life Insurance	No	No	Yes	31 days
Accidental Death & Dismemberment (AD&D)	No	No	Yes	31 days
Health Care Flexible Spending Account (FSA)	No	Yes (through end of plan year)	No	60 days (COBRA)
Dependent Care Flexible Spending Account (FSA)	No	No	No	N/A
Disability Coverage				
• Short-Term	No	No	No	N/A
• Long-Term	No	No	No	N/A
Long-Term Care Insurance	No	No	Yes	60 days
Critical Illness	No	No	Yes	31 days
Legal Insurance	No	No	Yes	60 days



YOUR FLEXIBLE BENEFITS UPON TERMINATION

Your Flexible Benefits typically terminate at the end of the following month after your most recent premium or contribution has been paid. If you and your dependents are enrolled in Dental, Vision or Health Care Flexible Spending Account (HCFSA) plan options, COBRA coverage will be available. If you are enrolled in, Employee/Spouse/Child Life, Accidental Death & Dismemberment (AD&D), Long-Term Care, Employee/Spouse Critical Illness plan or Legal Insurance, you may be eligible to port or convert these options by contacting the Flexible Benefits vendors upon termination. However, Short-Term and Long-Term Disability coverage terminates at the end of the month you terminate.

FLEXIBLE BENEFITS UPON TERMINATION

Flexible Benefits Options	Coverage Continued Through COBRA	Coverage Can Be Direct Billed by the Vendor or Converted or Ported to an Individual Policy	You Must Complete Vendor Forms Within
Dental Coverage			
• Select, Select Mid & Select Plus	Yes	No	60 Days (COBRA)
• DHMO	Yes	Yes	Convert within 31 days (DHMO only)
Vision Coverage	Yes	No	60 days (COBRA)
Employee/Spouse/Child Life Insurance	No	Yes	31 days
Accidental Death & Dismemberment (AD&D)	No	Yes	31 days
Health Care Flexible Spending Account (FSA)	Yes (through end of plan year)	No	60 days (COBRA)
Dependent Care Flexible Spending Account (FSA)	No	No	N/A
Disability Coverage			
• Short-Term	No	No	N/A
• Long-Term	No	Yes	Apply in writing within 45 days
Long-Term Care Insurance	No	Yes	60 days
Critical Illness	No	Yes	31 days
Legal Insurance	No	Yes	60 days



**YOUR FLEXIBLE
BENEFITS OPTIONS**

DENTAL

You can choose among three dental plans:

- Cigna Dental Care® (DHMO)
- Cigna Healthcare (PPO)
 - Select
 - Select Mid
 - Select Plus

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

- **Cigna Dental Care® (DHMO)** – Designed specifically for employees who live or work in the metropolitan Atlanta and other designated areas. Check for providers in your area, before enrolling in the DHMO. The DHMO is not available statewide. See the DHMO service map on page 26.
- **Cigna Healthcare Select, Select Mid and Select Plus PPO** – Cigna plan options are available statewide in Georgia and across most of the U.S. Most of the prior vendor's (Delta Dental) providers are also in the Cigna DPPO network, but some are not so make sure you check the participation status of your provider before scheduling services. Cigna's national DPPO network, the nation's largest, includes many providers who were not in the Delta Dental network. Please contact Cigna's State of Georgia dedicated number at 888.764.0099 for assistance in finding the right provider for you.

Cigna Dental Care® (DHMO) Plan

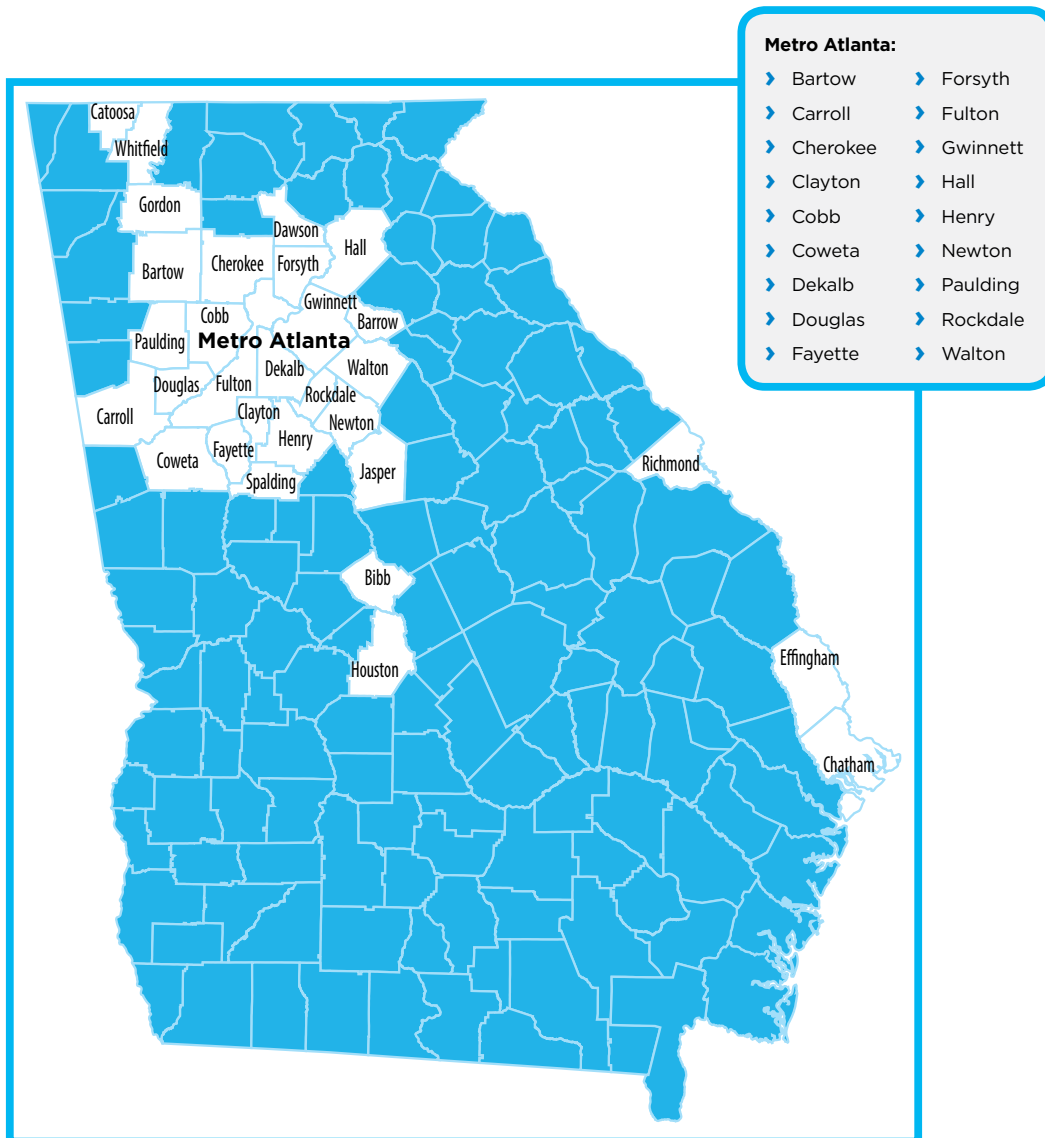
Cigna Dental Care® (DHMO) plan features:

- No deductibles to pay before you can use your plan
- No annual dollar maximums that limit benefits
- No claim forms to file
- No ID cards required to receive care
- No age limit on sealants to prevent cavities
- No referrals required to visit a network orthodontist or for children under seven to visit a network pediatric dentist
- Orthodontia coverage is available for children and adults



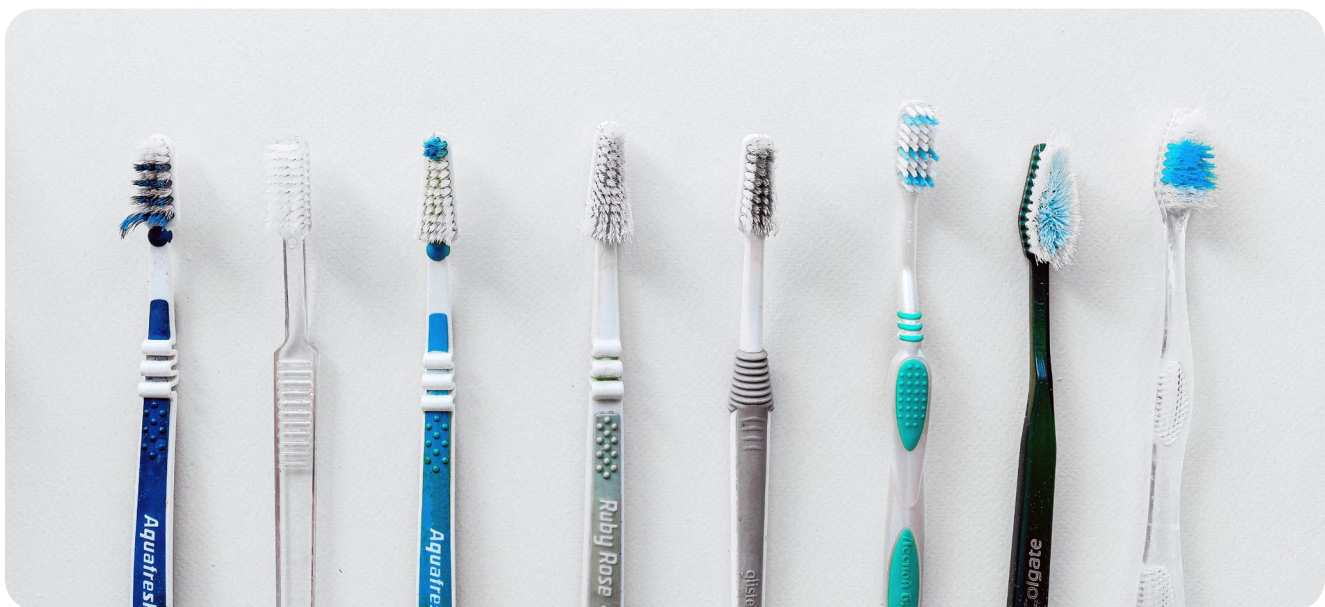
The Cigna DHMO is primarily available to employees who live or work in metropolitan Atlanta but also services the Macon, Augusta and Savannah areas. With the Cigna DHMO, you'll know exactly what you'll pay ("copays") for covered services – even for specialty care with a referral approved for payment. Just choose a general dentist from the Cigna DHMO network at enrollment and visit that dentist for all your dental care needs. Network dentists aren't allowed to charge you more than the co-pay for covered services. Most preventive services, such as exams, x-rays and cleanings, are covered 100% (frequency limits may apply). Dental treatments, such as fillings, crowns and root canals are covered at reduced, fixed co-pays. Cigna's Patient Charge Schedule (PCS) which has the fixed co-pays, can be found on Cigna's page of the virtual Benefits Fair on Team Georgia website. *Keep in mind that there is no out-of-network coverage with a DHMO plan.* Finding a network dentist near you is easy when you use the **Provider Directory** at www.cigna.com.

Cigna Dental Care DHMO – GA Network Access



CIGNA DENTAL CARE DHMO PLAN

BENEFITS & COVERED SERVICES	IN NETWORK
Type I Diagnostic & Preventive Services Oral Exams, Cleanings, X-rays	Reduced, fixed, preset charges for all covered services. See your Patient Charge Schedule for specific charges
Type II Basic Services, Fillings, Root Canals, Extractions, Scaling and Root Planning, Repairs to Dentures, Bridges and Crowns Sealants	Reduced, fixed, preset charges for all covered services. See your Patient Charge Schedule for specific charges
Type III Major Crowns, Dentures, Bridgework, Surgical Periodontal	Reduced, fixed, preset charges for all covered services. See your Patient Charge Schedule for specific charges
Orthodontic Benefits Cephalometric X-rays, Treatment Study, Bands, Appliances	Reduced, fixed, preset charges for all covered services. See your Patient Charge Schedule for specific charges
Annual Deductible	NONE
Maximum Benefits	No Maximum
Waiting Period for Benefits	No Waiting Period



Cigna Dental PPO (DPPO) Select, Select Mid and Select Plus



If you choose Select, Select Mid or Select Plus plan option with Cigna:

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

Once enrolled, consider downloading the myCigna free mobile app to:

- Manage and track claims
- View, fax or email ID card information
- Find network dentists and compare cost and quality information
- Review your coverage
- Track your account balances and deductibles

Note: Orthodontia services for adults and dependent children are available only through the Select Mid and Select Plus plan options.

Important Information for Select, Select Mid and Select Plus Plan Options

There are no waiting periods. All covered services are available on your first day of coverage.

The Select Mid & Select Plus plan options provide:

- 1) Orthodontia services, for employees & their enrolled eligible dependents, with a life time maximum, depending on the plan selected. (no annual deductible applies)
- 2) Implants are covered, after the annual deductibles are met and limited to 1 per 60 Consecutive Months (annual maximum applies)

CIGNA DENTAL PPO

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26
Deductibles*	\$50 per person / \$150 per family each calendar year *Deductible is waived for Diagnostic & Preventative
Maximums*	\$750 per person each calendar year Select Plan \$1,500 per person each calendar year Select Mid Plan \$2,000 per person each calendar year Select Plus Plan *Diagnostic & Preventative does not count towards the maximum • Implants are subject to the annual maximum

Benefits and Covered Services**	Dental Select Plan		Dental Select Mid Plan		Dental Select Plus Plan	
	In-Network	Non-Network*	In-Network	Non-Network	In-Network	Non-Network
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%	80%	90%	90%
Endodontics (root canals) Covered Under Basic Services	80%	80%	80%	80%	90%	90%
Periodontics (gum treatment) Coverd Under Basic Services	80%	80%	80%	80%	90%	90%
Oral Surgery Covered Under Basic Services	80%	80%	80%	80%	90%	90%
Major Services Crowns, inlays, onlays and cast restorations, bridges, dentures & TMJ, surgical periodontics	50%	50%	50%	50%	60%	60%
Implants	Not Covered	Not Covered	50%	50%	50%	50%
Orthodontic Benefits Adults and dependent children	Not Covered	Not Covered	\$1,500	\$1,500	\$2,000	\$2,000
Orthodontic Maximums Lifetime	Not Covered	Not Covered	\$1,500	\$1,500	\$2,000	\$2,000

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

**Limitations 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.

*Reimbursements are based on PPO contracted fees for PPO dentists and 80th percentile for Non-Network dentists.

Cigna Healthcare	Customer Service	Claims Address
	888-764-0099 www.cigna.com	Cigna (for PPO Claims) P.O. Box 188037 Chattanooga, TN 37422

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



Consider downloading Cigna free mobile app, MYCIGNA. Use the mobile app to:

- Find an in-network dentist
- Manage and track your dental claims
- Store, organize and manage your dental information in one private location

Cigna Dental Oral Health Integration Program®

This program is available to all Cigna DPPO or DHMO members and reimburses out-of-pocket costs for specific dental services used to treat or help prevent gum disease and tooth decay. The program is for people with certain medical conditions that may be impacted by dental care. The only requirement is that you're currently being treated by a doctor for one of the 14 conditions covered under Oral Health Integration Program. For additional information regarding Cigna's Oral Health Integration Program, please visit www.cigna.com.



VISION

Blue View Vision coverage is available through Anthem Blue Cross Blue Shield (Anthem). You have a choice between two plan options – Vision Select and Vision Select Plus. Both plans offer these features:

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

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

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

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

Your Vision Plan Options

Vision Select Plan

The Vision Select Plan covers standard single vision and standard lined multi-focal lenses for glasses. Cosmetic lens options, such as tinting, UV coating, and transitional lenses are also available.

You will receive an annual \$105 allowance towards the purchase of contact lenses.

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

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

Important Information for the Vision Select Plan

Benefits are provided every calendar year for exams, lenses and/or contacts.

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

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



VISION SELECT PLAN

Covered Services	CoPayments/Maximums	
	Network Providers	Non-Network Providers
Eye Exam Limited to one exam per Member every Calendar Year	\$10 Copayment	Reimbursed up to \$40
Prescription Lenses Limited to one set of lenses per Member every Calendar Year		
Basic Lenses (Pair)		
<ul style="list-style-type: none"> • Single Vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses 	<ul style="list-style-type: none"> \$20 Copayment \$20 Copayment \$20 Copayment \$20 Copayment 	<ul style="list-style-type: none"> Reimbursed up to \$40 Reimbursed up to \$60 Reimbursed up to \$80 Reimbursed up to \$80
Includes:		
<ul style="list-style-type: none"> • Factory Scratch Coating • Tint (solid and gradient) • Polycarbonate lenses (Adults) • UV Coating • Transition lenses 	<ul style="list-style-type: none"> \$0 Copayment \$0 Copayment \$40 Copayment \$15 Copayment \$75 Copayment 	<ul style="list-style-type: none"> No allowance No allowance No allowance No allowance No allowance
Frames Limited to one set of frames per Member every two years	\$130 Retail Allowance, 20% off any remaining balance	Reimbursed up to \$45
Prescription Contact Lenses* (Once per Calendar Year)	No Copayment	*If you choose contact lenses, no benefits will be available for eyeglass lenses during that period.
<ul style="list-style-type: none"> • Non-Elective Contact Lenses 	Covered in Full	Non-Network providers are reimbursed up to \$210
<ul style="list-style-type: none"> • Elective Contact Lenses • Elective Disposable Lenses • Elective Conventional Lenses 	<ul style="list-style-type: none"> \$105 retail allowance \$105 retail allowance, 15% off remaining balance 	Non-Network providers are reimbursed up to \$105

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

Vision Select Plus Plan

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

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

You must submit all receipts at the same time. Any balance remaining, and not used during the calendar year when the purchase occurred, will be forfeited.

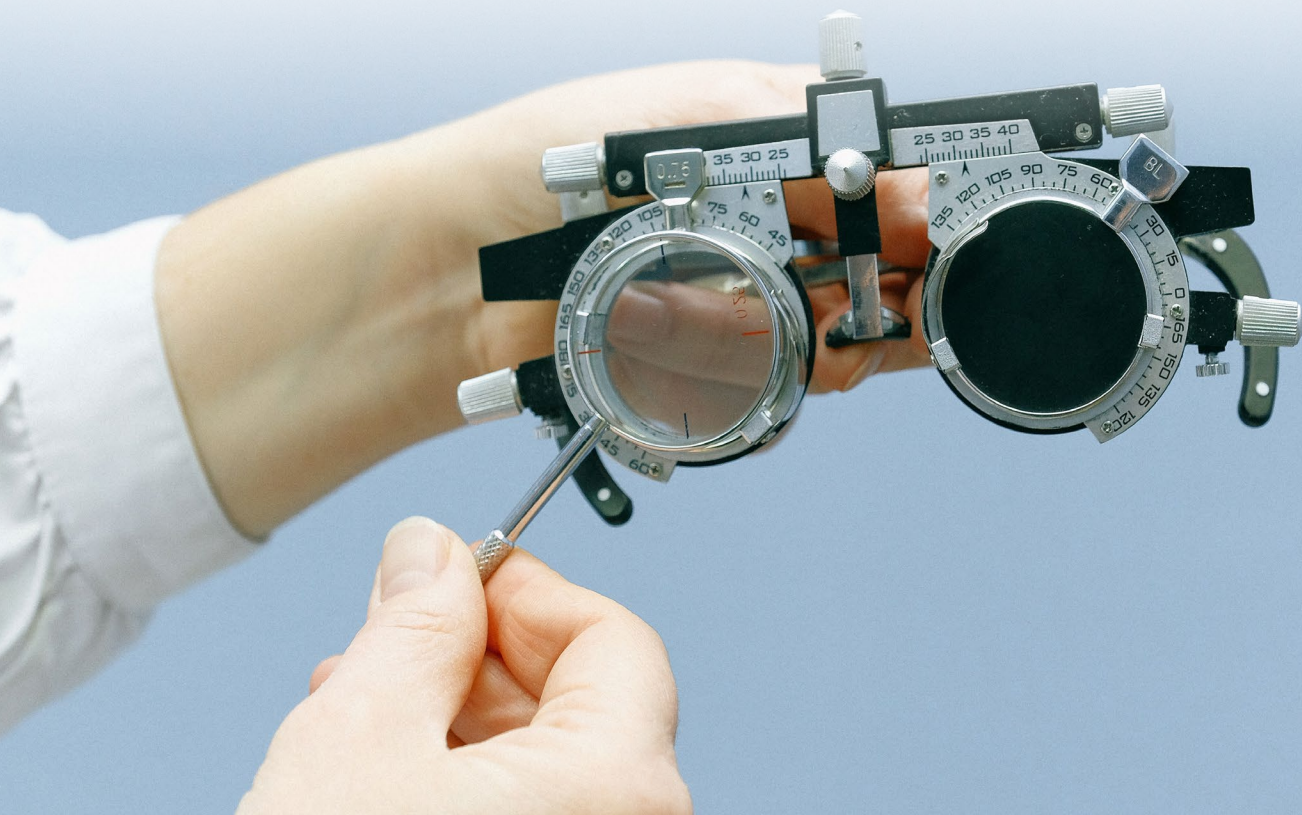
Important Information for the Vision Select Plus Plan

Benefits are provided every Calendar Year for exams, lenses and/or contacts, and for frames.

The allowance for contact lenses is \$150.

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

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



VISION SELECT PLUS PLAN

Covered Services	CoPayments/Maximums	
	Network Providers	Non-Network Providers
Eye Exam Limited to one exam per Member every Calendar Year	\$20 Copayment	Reimbursed up to \$40
Prescription Lenses Limited to one set of lenses per Member every Calendar Year		
Basic Lenses (Pair) <ul style="list-style-type: none"> • Single Vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses 	\$25 Copayment \$25 Copayment \$25 Copayment \$25 Copayment	Reimbursed up to \$40 Reimbursed up to \$60 Reimbursed up to \$80 Reimbursed up to \$80
Includes the following Lens Options: <ul style="list-style-type: none"> • Factory Scratch Coating • UV coating • Tint (solid & gradient) • Polycarbonate lenses (Adults) • Transitions • Standard & Premium Progressive lenses • Standard Anti-Reflective coating (Not Covered for Non-Network Providers) 	\$0 Copayment \$0 Copayment \$0 Copayment \$20 Copayment \$20 Copayment \$50 Copayment \$0-\$23 Copayment	No Allowance on lens enhancements when obtained from out-of-network providers
Frames Limited to one set of frames per Member every Calendar Year	Allowable Amount up to \$150 retail allowance, 20% remaining balance	Reimbursed up to \$45
Prescription Contact Lenses* (Once per Calendar Year)	No Copayment	*If you choose contact lenses, no benefits will be available for eyeglass lenses during that period.
<ul style="list-style-type: none"> • Non-Elective Contact Lenses • Elective Disposable Lenses • Elective Conventional Lenses 	Covered in Full \$150 retail allowance \$150 retail allowance, 15% off remaining balance	Non-Network providers are reimbursed up to \$210 Non-Network providers are reimbursed up to \$150

Still have questions?
 Please contact Anthem BCBS (Anthem) Vision Customer Service at 1-855-556-4844.



EMPLOYEE, SPOUSE, CHILD LIFE, AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

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

It is the employee's responsibility to update his/her beneficiary designation. Otherwise, the benefit will be paid out in the following order: (1) spouse; (2) Children; (3) Parent(s); and (4) Estate.

Life Insurance Options

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

Spouse Life Insurance

If you choose employee life insurance for yourself, you may also select coverage for your spouse. Spouse life insurance premiums are based on the coverage level and your spouse's age. Your premiums for Spouse Life are paid on a post-tax basis.

Spouse Life coverage cannot exceed 100% of your amount of Employee Life coverage. If your spouse is 65 or older, the amount of spouse life coverage is reduced.

You are the beneficiary of spouse life insurance coverage and will receive the insurance benefit in the event of your spouse's death.

Child Life Insurance

If you choose life insurance for yourself, you may also elect child life insurance for your child(ren) under age 26. This coverage, which is guaranteed (without medical underwriting) is paid for on a post-tax basis.

Additional Covered Services

Premium Waiver – provides continuation of Employee Life insurance without premium payment should you become disabled.

Will Preparation Service – allows you to consult, in person or via phone, with a participating MetLife Legal Plan attorney, who will complete a will, living will, or power of attorney for you and your legal spouse, at no charge to you.

Estate Resolution Services – gives your beneficiaries the support of a MetLife Legal Plan attorney, in-person or via telephone, to discuss matters related to probating your estate.



If You are a New Employee

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

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

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

Important Notes about Child Life:

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

- Newborns are covered for the first 31 days, from date of birth. To continue the life insurance coverage beyond 31 days, you must enroll the newborn before the end of the 31 days.
- Child Life coverage cannot exceed your amount of Employee Life benefits.
- You are the beneficiary of child life insurance coverage and you will receive the benefit in the event of the child's death.

Accidental Death and Dismemberment Insurance

The Flexible Benefits Program offers accidental death and dismemberment (AD&D) insurance to be paid to you or your beneficiary if your injury or death is the result of a covered accident. In case of permanent and total disability, you are eligible for AD&D benefits if your injury prevents you from working at any job for which you are qualified by education, training, or experience.

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

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

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

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

Be sure to designate your beneficiaries by accessing the GaBreeze website or calling the GaBreeze Benefits Center at 1-877-342-7339. Also, you can change and update your beneficiaries at any time.

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



Flexible Spending Accounts

The Flexible Spending Account plans are administered by HealthEquity/WageWorks. Flexible Spending Accounts do not roll over to the new plan year.

For Plan Year 2023, the annual amounts you may contribute are:

	Minimum	Maximum
Dependent Care	\$120	\$4,992
Health Care	\$120	\$2,808*

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

Important Information About Flexible Spending Accounts

- Deductions for spending accounts are made on a pre-tax basis every pay period.
- Your spending account elections are binding for the plan year. You may be

able to make limited changes if you have a qualified status change.

- You cannot carry over expenses that you have incurred in one plan year into the next plan year for reimbursement.
- You cannot transfer money from one account to another.
- Claims should be submitted only after services have been provided.
- You may submit claims at any time for any amount, but payment will not be made until your claims total \$25 or more. Reimbursement may be by check or by direct deposit to your bank account.
- During the year, you will receive statements showing how much you have in each account.
- Reimbursements are issued daily.
- 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.

***The monthly administrative fee of \$3.20 is not included in this amount.**

2023 HCFSA Grace Period of 2½ Months

Under the HCFSA, the IRS gives you a grace period to avoid the “Use It or Lose It” provision. If you have any 2022 HCFSA funds remaining on December 31, 2022, you have an additional 2½ months – through March 15, 2023 to deplete your account. You can continue to use your debit card, or submit qualified expenses for reimbursement, for products and services purchased through March 15, 2023. You’ll have until April 30, 2023 to submit such claims to HealthEquity/WageWorks. Remember, if a claim is mailed, the envelope must be postmarked by April

30, 2023. The fastest way to get claims to HealthEquity/WageWorks is to file your claim online at www.HealthEquity.com/Wageworks or fax to 877-353-9236.

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

Note: There is no grace period for Plan Year 2022 Dependent Care Flexible Spending Account balances.

Important Note: Please be aware that if you are currently contributing to a Flexible Spending Account, your annual allocation will not roll over into the new plan year. You must make a new election during Open Enrollment, if you want to contribute to the Flexible Benefits Spending Account(s) for Plan Year 2023.

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

Dependent Care Flexible Spending Account (DCFSA)

The Dependent Care Flexible 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 Health Care dependents (such as a disabled child of any age or an elderly parent) while you and your spouse work or attend school full time.

Eligible 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 elder care facility or have someone care for them in your home.

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



Dependent Care Flexible 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 childcare provider
- Tuition for private school

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

Dependent Care Flexible Spending Account Limits

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

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

Health Care Flexible Spending Account (HCFSA)

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

Debit Card

When you enroll in a Health Care Flexible Spending Account, you'll receive a VISA® Spending Account Card for purchases of eligible health care services. Your FSA card will arrive prior to the new plan year and you will have full access to your Health Care FSA annual contribution. You may request additional cards for your eligible dependents.

Keeping Receipts

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

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



Examples of Eligible Expenses

- Deductibles and co-payments not paid by any health or dental insurance in which you or your family members participate
- Costs for procedures not covered or not covered fully by a health, dental, or vision plan
- Specialized equipment for disabled persons
- Preventive care screenings
- Contact lens and glasses
- Laser eye surgery
- Prescription
- Mental health services
- Physical therapy
- Certain other IRS approved expenses
- Nicotine patches and gum
- Over-the-counter medications (subject to change)

Examples of *Ineligible* Expenses

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



Short and Long-Term Disability

To help provide income protection against the unexpected, the Flexible Benefits Program offers you the following:

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

Short-Term Disability with The Standard Insurance Company

If you choose short-term disability (STD) coverage, the plan will work in coordination with other deductible income to replace 60% of your Annual Benefit Base Rate during the plan year the disability began, up to \$1,000 per week. Your STD benefits will be calculated using your Annual Benefit Base Rate, up to an annual **maximum salary** of \$86,684. If you receive other deductible income which replaces a total of 60% or more of your Annual Benefit Base Rate, the short-term disability plan will not pay a benefit for this disability. Benefits received include but are not limited to: workers' compensation; other disability plans and/or programs; earnings from a State retirement system; or earnings from work you perform while disabled.

Your Options

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



How STD Benefits Work

A late enrollment penalty will apply for late entrants to the STD plan (employees who do not elect STD within 31 days of employment). Your STD benefits are calculated on the Annual Benefit Base Rate that is in effect during the plan year your disability began, less other income benefits. For example, if your first day of disability is December 3, 2022, your disability benefit will be calculated from the 2021 Annual Benefit Base Rate, not your 2022 Annual Benefit Base Rate. The Annual Benefit Base Rate for Plan Year 2023 will be based on your weekly rate of earnings in effect on October 1, 2022, or your hire date, if after this date.

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

What Is A Late Enrollment Penalty for Late Entrants?

An employee choosing coverage for the first time more than 31 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.

When changing from the 30-day Benefit Waiting Period to the 7-day Benefit Waiting Period, your Benefit Waiting Period for a disability resulting from physical disease, pregnancy, or mental disorder will be extended to 30 days, until you have been insured under the 7-day Benefit Waiting Period for at least 12 consecutive months. *This does not apply to accidental injuries.*

Enrolling for Short-Term Disability Coverage

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

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

Long-Term Disability with The Standard Insurance Company

The Flexible Benefits Program's Long-Term Disability (LTD) coverage works with other deductible income you are eligible to receive, including but not limited to Social Security, Workers' Compensation, other disability plans benefit and programs, including State retirement. The plan assures that your combined disability benefits and deductible

income from other sources will equal 60% of your Annual Benefit Base Rate, up to \$5,000 per month. Your LTD benefits will be calculated using your Annual Benefit Base Rate, up to an annual **maximum salary** of \$100,000. There is a minimum monthly benefit of \$100.00.

How LTD Benefits Work

If you qualify for benefits, they will begin after you have been continuously disabled for 180 calendar days. LTD benefits end when you are no longer disabled, or you reach your Social Security Normal Retirement Age. Benefits for disabilities caused by mental disorders, substance abuse and other limited conditions will not be paid for more than two years. If you become disabled after reaching age 62, an age-graded maximum benefit period will apply.

Enrolling for Long-Term Disability Coverage

Your cost for long-term disability coverage is based on your age, your FICA Status, Annual Benefit Base Rate, and whether you are eligible for disability coverage through any State of Georgia retirement plan, and/or through Social Security.

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

***Note:** *Other exclusions and limitations apply to these coverages. Refer to the Certificates of Insurance for more information.*

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

Long-Term Care

Long-Term Care Insurance with Unum

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

Your Long-Term Care Options

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

PLAN 1	PLAN 2	PLAN 3	PLAN 4
Nursing Home Facility Care	Nursing Home Facility Care	Nursing Home Facility Care	Nursing Home Facility Care
Professional Home Care	Professional Home Care	Professional Home Care	Professional Home Care
Total Home Care	Total Home Care	Total Home Care	Total Home Care
Return of Premium	Return of Premium	Return of Premium	Return of Premium
	Compound Inflation	Paid Up	Compound Inflation
			Paid Up

FACILITY DAILY BENEFIT AMOUNT

Nursing Home Facility Care	Assisted Living Facility & Home Care	Lifetime Maximum
\$75.00	\$45.00	\$136,875.00
\$100.00	\$60.00	\$182,500.00
\$125.00	\$75.00	\$228,128.00

Facility Benefit Duration is 5 Years

Note: Duration of benefits may vary depending on where benefits are received.

Who Can Be Covered

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

When Benefits Are Paid

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

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

About Your Premiums and Enrolling

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

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

For more information about long-term care coverage, visit www.unuminfo.com/sog or call Unum at 1-888-SOG-FLEX (1- 888-764-3539) from 8:00 a.m. to 8:00 p.m., ET.



Critical Illness

Critical Illness Plan with Aflac Underwritten by Continental American Insurance Co.

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

Employee Coverage Levels

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

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

Spouse Coverage Levels

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

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

Child Coverage

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

Dependent Child Illnesses Covered at 100% of Maximum Benefit

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



Note: The illnesses listed above are in addition to those listed on the next page.

COVERED CRITICAL ILLNESSES*	
Illnesses Covered	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%

* 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.

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 you collect full benefits for a critical illness under the plan and later have one of the remaining covered critical illnesses, then we will pay 50% of the benefit amount for each additional illness. Occurrences must be separated by at least 12 months and not caused by or contributed to by a critical illness for which benefits have been paid.

Re-Occurrence Benefit

If an insured individual collects full benefits for a covered critical illness and is later diagnosed with the same condition/critical illness, 50% of the benefit is paid again. Once benefits are paid for a critical illness, additional benefits are payable for a new event of the same critical illness is at 50% of benefits, provided the reoccurrence is diagnosed at least 12 months or 12 months of treatment free for cancer.

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

Health Screening Benefits

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

The covered health screening tests include:

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

Critical Illness Select Plus Plan

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

- Indemnity benefits paid as the result of an accidental injury
- 24-hour coverage
- Over 50 accident indemnity benefits included
- No medical underwriting required up to Guaranteed Issue amount
- Rates cannot be individually increased due to change in age, health or individual claim
- The plan is portable, subject to certain stipulations, so you may be able to take your coverage with you if you leave your job
- Wellness Benefit of \$60 (1 year waiting period for wellness)

Plan Benefits Summary

Please refer to your Certificate of Coverage for definitions, limitations and exclusions.

Benefits Include:

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

For a complete list of benefits and descriptions, please refer to the Critical Illness Select Plus PDF Brochure or your certificate of coverage. Premiums for the Critical Illness coverages in this section are paid on a post-tax basis – which allows you to receive benefits tax-free.

Legal Insurance

Legal Insurance with MetLife Legal Plans

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

Legal Benefits

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

Access to Over 18,000 Attorneys

The MetLife Legal Plans provide members with access to a national network of more than 18,000 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 MetLife Client Service Center at 800-821-6400, visit www.legalplans.com, or download MetLife Legal Plan's mobile app to locate participating attorneys in the area.

Your Legal Benefit Options

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

Select

The Select option provides benefits for the following services:

- Wills and codicils
- Living wills
- Powers of Attorney
- Unlimited phone and office advice and consultations
- Traffic ticket defense (no DUI)
- Document review
- Affidavits
- Deeds
- Mortgages
- Promissory notes
- Elder law matters
- Personal Injury (25% maximum fee)
- Sale, purchase and refinancing of your primary residence and second or vacation home
- Home equity loans for your primary residence and second or vacation home
- Debt collection defense
- Identity theft defense
- Reduced fee Benefit (25% discount)

Select Plus

The Select Plus option offers the same services as the Select Plan, plus the additional services listed below.

- Probate proceedings
- Consumer protection matters
- Personal bankruptcy or Wage Earner Plan

- Tax audits
- Civil litigation defense
- Administrative hearing representation
- Incompetency defense
- Change or establishment of custody order or visitation rights
- Adoption and legitimization
- Divorce/Dissolution/Annulment (\$1,000 maximum for contested)
- Enforcement or modification of support orders
- Guardianship/conservatorship
- Immigration assistance
- Eviction and tenant problems (tenant only)
- Name change
- Juvenile court defense
- Security deposit assistance (tenant)
- Protection from domestic violence

Select Premium

The Select Premium includes the services of the Select and Select Plus with the following additional services:

- Personal Property Protection
- Small Claim Assistance
- Demand Letters
- Prenuptial Agreement
- Property Tax Assessments
- Zoning applications
- Restoration of Driving Privileges
- Living Trusts
- Boundary Title Disputes (Primary Residence)

What Are the Exclusions?

The legal plan excludes appeals; class actions and appeals; matters that MetLife Legal Plans deem frivolous, non-meritorious, or unethical; farm and business matters; patent, trademark,

and copyright matters; costs and fines; matters for which an attorney-client relationship exists prior to your becoming eligible for plan benefits, and any employment-related matters.

For a complete list of exclusions, visit www.GaBreeze.ga.gov.

What if I have More Questions?

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

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

Accessing MetLife Legal Plans Website is Easy!

Visit members.legalplans.com to create an account with the email of your choice, personal or work, and password to begin setting up your account. Once you do this, you will be asked to provide some personal information,

including your full name, address and the employer or organization offering the legal plan to confirm your eligibility.

You have the option to set up Multi-Factor Authentication to enhance the security of your account. To set this up, go to "Login settings" and select "Enable" for "Multi-factor Authentication." You will receive a security code by email that you will use to log in. Once this is enabled, going forward you will receive a code each time you log in that will need to be entered to access the site.

HIPAA PRIVACY AND SECURITY NOTICE

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

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



Overview

What is HIPAA?

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

What is PHI?

PHI, Protected Health Information, is individually identifiable health information that is maintained or transmitted by a covered entity. It is information related to a person's health, provision of care, or payment. Examples of items containing PHI include a bill for health services, an explanation of benefits statement, receipts for reimbursement from a health care spending account, or any list showing the amount of benefits paid with a breakdown by social security number. This also includes your employer (e.g., state agency, school system, authority) transmitting information about you to DOAS. This information may include your name, address, birth date, social security number, employee identification number, and certain health information.

How DOAS Uses and Discloses Protected Health Information

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

Privacy and Security Law Requirements

DOAS is required by law to:

- Maintain the privacy of your information.
- Protect electronic PHI by implementing reasonable and appropriate physical administrative and technical safeguards.
- Provide this notice of DOAS' legal duties and privacy and security practices regarding the information that DOAS has about you.
- Abide by the terms of this notice.
- Refrain from using or disclosing any information about you without your written permission, except for the reasons given in this notice.

You may revoke your permission at any time, in writing. That revocation will not apply to information that DOAS disclosed prior to receiving your written request. If you are unable to give your permission due to an emergency, DOAS may release information, if it is in your best interest. DOAS must notify you as soon as possible after releasing the information.

Your Health Information Rights

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

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

For More Information and To Report a Problem

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

DOAS does not discriminate based on 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 below. For TDD relay service only: 1-800-255-0056 (text-telephone) or 1-800-255-0135 (voice).

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

- You may file a complaint in writing to the DOAS Privacy Unit at:
*Department of Administrative Services
Attn: Privacy Officer
200 Piedmont Avenue SE West Tower
Suite 1801
Atlanta, GA 30334-9010*
- You can file a complaint with the Secretary of Health and Human Services by writing to: Secretary of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201. For additional information, call 1-877-696-6775.
- You may file a grievance with the United States Office of Health and Human Services 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.



TERMS AND CONDITIONS

The Flexible Benefits Program is offered by the Employee Benefit Plan Council and participating departments and authorities. The Flexible Benefit Program is governed by the Internal Revenue Code, section 125, and rules issued by the Employee Benefit Plan Council. The Flexible Benefits Program provides you with a method to have your employer purchase benefits with money that would have been paid to you. You do not receive the premium amounts and contributions for the pre-tax options you select as taxable income. Therefore do not pay taxes on that amount; and you receive the benefits as an employer paid benefit. The election is a binding salary agreement. Failure to comply with all contractual and administrative requirements will result in any excess salary reductions being retained by the Plan. The following statements apply to the benefit options listed on the Open 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 base salary, your age, your spouse's age, your eligibility for disability retirement benefits, and FICA status on your date of hire or the Benefit Calculation Date, whichever is deemed appropriate by the Plan Administrator. Any adjustments to the Annual Benefit Base Rate, except for 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 Human Resources 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 and the Employee Benefit Plan Council. 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 enrollment period. Your request for enrollment or a change outside of the enrollment period will only be considered if you declare your Qualifying Life event and submit the proper documentation, if applicable, 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 31 days. A list of events that might permit you to enroll or change one or more coverages under the Flexible Benefits Program:
 - a) Marriage or Divorce
 - b) Birth, adoption, placement for adoption or legal guardianship
 - c) Employee gain eligibility for another employer's plan or loses eligibility for another employer's plan, or

- significant change in price or loss of employer's subsidy under the other plan
 - d) Employee starts paid FMLA leave or returns from paid FMLA leave
 - e) Employee starts unpaid FMLA leave or Military leave or returns from unpaid FMLA or Military Leave
 - f) Employee or Retiree address changes (no longer in service area) only if enrolled in DHMO
 - g) Judgment, decree, or court order, e.g., QMCSO, requiring employee or spouse to provide dental and vision coverage for dependent
 - h) Mid-year expiration of employee's, spouse, or dependent's COBRA coverage from another employer
 - i) Employee loses employer's subsidy
 - j) Employee terminates and is rehired within 30 days
 - k) Employee terminates and is rehired after 30 days
 - l) Employee loses other governmental institutional coverage such as tribal coverage, state health benefits risk pool, or foreign government plan
 - m) Employee, spouse or dependent is eligible for financial assistance under SCHIP or Medicaid
 - n) Employee, spouse and/or dependent's entitlement to Medicare or Medicaid coverage
 - o) Employee, spouse and/or dependent lose SCHIP, Medicaid, or Medicare coverage
 - p) Death of dependent, loss of dependent status, loss of legal guardianship
 - q) Death of spouse
 - r) Spouse or dependent child(ren) gain or lose eligibility in another group plan
 - s) Spouse's or dependent's open enrollment does not correspond with employee's open enrollment
 - t) Dependent Care provider cost changes or provider changes
- 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 except for 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 Benefit Plan Council related to Spending Accounts. In particular, you are agreeing to the following provisions:
- a) Money contributed to the Health Care Spending Account cannot be used to pay claims for the Dependent Care expenses. Money contributed to the Dependent Care Spending Account cannot be used to pay claims for the Health Care expenses.
 - b) In general, the amount contributed for a Dependent Care Account cannot be greater than the earned salary of you or your spouse, whichever is less.
 - c) If you are married filing separately, the amount contributed for a Dependent Care Account cannot be greater than \$2,500.
 - d) The validity of a claim against a Spending Account is determined in accordance with the Plan, Internal Revenue Code, and IRS regulations as interpreted by the Administrator subject to the appeal provisions of the Plan.
 - e) Any money not reimbursable to you will be forfeited to the Flexible Benefits Program. Forfeited money

will not be returned or paid to the employee but will be used to reduce the costs associated with providing this benefit. NOTE: This rule is intended to ensure you allocate only those expenses you expect to incur. See p. 31 for information about the grace period that can help you avoid having to forfeit Health Care Spending Account funds.

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



TEAM GEORGIA REWARDS

Georgia™ Compensation. Benefits. Career.