## Flexible Benefits At-A-Glance - 2020 Plan Year

### Vendor Contact Numbers
- **Cigna**: 1-800-642-5810
- **Delta Dental**: 1-866-496-2384
- **Anthem BCBS**: 1-855-556-4844
- **Metlife**: 1-877-255-5862
- **Delta Dental**: 1-800-821-6400
- **Hyatt Legal Plans, Inc.**: 1-800-642-5810
- **AFLAC/CAIC**: 1-866-496-2384
- **Unum**: 1-888-764-3539
- **Metlife**: 2020 Plan Year
- **Cigna**: 1-866-849-2958
- **AFLAC/CAIC**: 1-800-557-3156
- **The Standard**: 1-866-849-2958
- **Unum**: 1-800-821-6400
- **WageWorks**: 1-888-641-7186
- **Hyatt Legal Plans, Inc.**: 1-800-557-3156

### Rate Tier

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<thead>
<tr>
<th>Rate Tier</th>
<th>Dental DHMO</th>
<th>Dental Select &amp; Dental Select Plus</th>
<th>Vision Select &amp; Vision Select Plus</th>
<th>Employee Life, Spouse and Child Life</th>
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<th>FSA (Health Care &amp; Dependent Care)</th>
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### Changes for 2020
- **5.99% Increase for Plan Year 2020**
- **2.3% Increase for Plan Year 2020**

**MetLife will offer a One-Up opportunity for Employees to increase their Life Insurance Coverage one-level without Medical Underwriting. Spouse’s age will be used to calculate Spouse Life premiums and any coverage reductions due to age.**

### Eligibility
Open Enrollment changes are effective January 1, 2020. New hire benefits will begin the first day of the month after one full calendar month of employment.
You Decide
FLEXIBLE BENEFITS PROGRAM

OPEN ENROLLMENT
OCTOBER 21 - NOVEMBER 8, 2019
www.GaBreeze.ga.gov
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Your 2020 Flexible Benefits
Enhancements, Changes, Vendors and Plan Options

What’s New for 2020!
- MetLife’s One-Up campaign is back! All eligible employees can enroll or increase their Employee Life coverage one-level without completing a Statement of Health form.

What’s Changing for Plan Year 2020!
- The 2020 Health care Flexible Spending Account (FSA) limit is being increased to $2,652
- CIGNA DHMO Network expands in the Metro-Atlanta service area
- The spouse’s age will be used to calculate MetLife Spouse Life premiums and any coverage reductions due to age

- Anthem Blue Cross Blue Shield (Anthem) Blue View Vision rates will increase by 2.3%. The rates are below.

<table>
<thead>
<tr>
<th>Tiers</th>
<th>2019 Rates</th>
<th>2020 Rates</th>
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<td>Employee + Family</td>
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Select Plus

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<th>Tiers</th>
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<td>Employee + Family</td>
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<td>$30.37</td>
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- Delta Dental rates will increase by 5.99%. The rates are below.

Select

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<tr>
<th>Tiers</th>
<th>2019 Rates</th>
<th>2020 Rates</th>
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Select Plus

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<td>Employee + Family</td>
<td>$121.01</td>
<td>$128.22</td>
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Flexible Benefits Vendors and Plan Options
Choosing the right benefits makes a difference. The 2020 Flexible Benefits vendors and plan options are listed below. There are no changes to the Flexible Benefits vendors, Plan Options or benefit designs. 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
• Delta Dental PPO
  - Select
  - 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
• Hyatt Legal
  - Select
  - Select Plus
  - Select Premium
**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 the 2020 plan year, you must re-enroll during the 2019 Open Enrollment for plan year 2020.

There is still time to use your 2019 Health care Flexible Spending Account (HCFSA) contributions. If you have any Health care FSA funds remaining on December 31, 2019, you have an additional 2½ months – through March 15, 2020 to deplete your account. You can obtain qualified expenses and/or services through March 15, 2020 using your remaining HCFSA funds from 2019. The list of qualified expenses and/or services is posted at [https://www.wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table/](https://www.wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table/). The deadline for submitting claims is April 30, 2020.

**Note:** All eligible expenses for Dependent care FSA must be incurred by December 31, 2019. The deadline for submitting claims is April 30, 2020.

**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 (completed Disabled Dependent Certification Form) of the child’s disability within 30 days of the child turning 26 and when requested by the Flexible Benefits Program 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 (completed Disabled Dependent Certification Form) within 30 days of enrollment in the Flexible Benefits Program.

**Note:** You must certify your disabled dependents turning age 26 by contacting your local HR department for assistance. 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)
Divorce? Ex-spouses are no longer eligible for Flexible Benefits coverage as a dependent of the employee. Within 30 days of the divorce, you must make the change on the website, www.GaBreeze.ga.gov or call the GaBreeze Benefits Center at 1-877-342-7339. Coverage for the ex-spouse will terminate at the end of the month of the divorce. If an ex-spouse wants to continue coverage, he or she may be eligible for COBRA.
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 is expected to work for at least nine months. Employees who work in a sheltered workshop or work transition program, contingent employees, temporary employees, and student employees are not eligible.
- A public-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. Promotions, demotions, and adjustments due to certifications are not deemed to be errors. Your Annual Benefit Base Rate is the pay used to calculate your coverage for employee life, AD&D, and disability insurance.

The “Total Rewards” website, accessed through GA Breeze, has been enhanced and is now updated monthly. Once on the GaBreeze Home Page, look under the section “Your Information” for the tile “Your Total Rewards”. Click on this tile to link to the personalized “Your Total Rewards” statement.

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. Certain premiums (dental, vision, Flexible Spending Account contributions and at your direction, employee life insurance) 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

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 or by accessing the Team Georgia Connection (www.team.ga.gov) by clicking Flexible Benefits under the My Benefits tab, or calling the GaBreeze Benefits Center at 1-877-342-7339.
Waiting Periods and Evidence of Insurability

Dental Benefits
There is a six-month waiting period for major services under the Delta Dental Select Plan and a six-month waiting period for major and orthodontia services under the Delta Dental Select Plus plan. The Cigna DHMO option does not have waiting periods or late enrollment penalties but requires that you use a DHMO network provider. Go to www.cigna.com for a list of DHMO network providers.

Flexible Spending Accounts (FSA)
Your contributions to Health care and Dependent care Flexible Spending Accounts will start on the 15th day of your first full calendar month of employment. 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.

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 Critical Illness for yourself, for your spouse to be eligible.

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 30-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 30-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 30-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 and verify your elections 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 Benefits 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 30-day enrollment window, you will need to contact the GaBreeze Benefits Center at 1-877-342-7339.

Your request for enrollment or a change in coverage under the Flexible Benefits Program must be entered on the GaBreeze website, or by calling the GaBreeze Benefits Center, within 30 days after the qualifying life event (QLE). No refund of premiums will be issued if the change was not made within 30 days of the QLE and premiums were withheld.

The effective date for changes due to QLE is the first of the month following the date the QLE was reported. 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. 50-52.

30-Day Window

If you have a qualifying life event (QLE), the IRS allows you a limited period of 30 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. For all other QLEs, the effective date is based on when GaBreeze is notified of the QLE change. If you do not make any changes within 30 days, you will have to wait until the next Open Enrollment to make changes to your Flexible Benefits.

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 Benefits 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).
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 provider 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.

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. **Note: Once cancelled, dental coverage cannot be reinstated.**

If enrolled in vision and/or Health care Flexible Spending Account, COBRA is available.

- **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.

- **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 20 for a list of benefits eligible to be continued, on a post-tax basis, either through COBRA or by arrangement with a carrier.
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 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, 2020 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 2018 Open Enrollment for plan year 2019.

If you retire and you and your dependents are currently enrolled in Dental coverage, your coverage will continue automatically through pension deductions. 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.
## RETIREMENT BENEFITS

<table>
<thead>
<tr>
<th>Flexible Benefits Options</th>
<th>Flexible Benefits Options Available Through Pension Deductions</th>
<th>Coverage Continued Through COBRA</th>
<th>Coverage Can Be Direct Billed by the Vendor or, Converted or Ported to an Individual Policy</th>
<th>You Must Complete Vendor Forms Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Select &amp; Select Plus</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>60 Days (COBRA)</td>
</tr>
<tr>
<td>DHMO</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Convert within 31 days (DHMO only)</td>
</tr>
<tr>
<td>Vision Coverage</td>
<td>No</td>
<td></td>
<td></td>
<td>60 days (COBRA)</td>
</tr>
<tr>
<td>Employee/Spouse/Child Life Insurance</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>31 days</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment (AD&amp;D)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>31 days</td>
</tr>
<tr>
<td>Health Care Flexible Spending Account (FSA)</td>
<td>No</td>
<td>Yes (through end of plan year)</td>
<td>No</td>
<td>60 days (COBRA)</td>
</tr>
<tr>
<td>Dependent Care Flexible Spending Account (FSA)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Disability Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Long-Term</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Long-Term Care Insurance</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>60 days</td>
</tr>
<tr>
<td>Critical Illness</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>31 days</td>
</tr>
<tr>
<td>Legal Insurance</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>60 days</td>
</tr>
</tbody>
</table>
Your Flexible Benefits typically end 30 days 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 (FSA) 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

<table>
<thead>
<tr>
<th>Flexible Benefits Options</th>
<th>Coverage Continued Through COBRA</th>
<th>Coverage Can Be Direct Billed by the Vendor or Converted or Ported to an Individual Policy</th>
<th>You Must Complete Vendor Forms Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Select &amp; Select Plus</td>
<td>Yes</td>
<td>No</td>
<td>60 Days (COBRA)</td>
</tr>
<tr>
<td>• DHMO</td>
<td>Yes</td>
<td>Yes</td>
<td>Convert within 31 days (DHMO only)</td>
</tr>
<tr>
<td>Vision Coverage</td>
<td>Yes</td>
<td>No</td>
<td>60 days (COBRA)</td>
</tr>
<tr>
<td>Employee/Spouse/Child Life Insurance</td>
<td>No</td>
<td>Yes</td>
<td>31 days</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment (AD&amp;D)</td>
<td>No</td>
<td>Yes</td>
<td>31 days</td>
</tr>
<tr>
<td>Health Care Flexible Spending Account (FSA)</td>
<td>Yes (through end of plan year)</td>
<td>No</td>
<td>60 days (COBRA)</td>
</tr>
<tr>
<td>Dependent Care Flexible Spending Account (FSA)</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Disability Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Short-Term</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>• Long-Term</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Long-Term Care Insurance</td>
<td>No</td>
<td>Yes</td>
<td>60 days</td>
</tr>
<tr>
<td>Critical Illness</td>
<td>No</td>
<td>Yes</td>
<td>31 days</td>
</tr>
<tr>
<td>Legal Insurance</td>
<td>No</td>
<td>Yes</td>
<td>60 days</td>
</tr>
</tbody>
</table>
YOUR FLEXIBLE BENEFITS OPTIONS
You can choose among three dental plans:
- Cigna Dental Care ® (DHMO)
- Delta Dental Select
- Delta Dental Select Plus

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

- **Cigna Dental Care® (DHMO)** – Designed specifically for employees who live or work in the metropolitan Atlanta and other designated areas. Check for providers in your area, before enrolling in the DHMO. The DHMO is not available statewide.

- **Delta Dental Select and Delta Dental Select Plus PPO** – Delta Dental plan options are available statewide.

## 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

The Cigna DHMO is available to employees who live or work in metropolitan Atlanta and other designated areas. With the Cigna DHMO, you'll know exactly what you'll pay (“copays”) for covered services – even for specialty care with a referral approved for payment. Just choose a general dentist from the Cigna DHMO network at enrollment and visit that dentist for all your dental care needs. Network dentists aren’t allowed to charge you more than the co-pay for covered services. Most preventive services, such as exams, x-rays and cleanings, are covered 100% (frequency limits may apply). Dental treatments, such as fillings, crowns and root canals are covered at reduced, fixed co-pays.
Keep in mind that there is no out-of-network coverage with a DHMO plan. Finding a network dentist near you is easy when you use the Provider Directory at www.cigna.com and click on Find a Dentist at the top of the screen. Then select If your Insurance Plan is Offered Through Work and click Find a Dentist. Enter the geographic location you want to search – by city, state, or zip code. Click on Select a Plan, then select Cigna Dental Care Access Plus under the Dental Plans section. Click Choose and you are done. Your covered family members can each select their own general dentists. After you enroll, you can change your general dentist at any time, online or by phone.

Cigna Dental Oral Health Integration Program®
This program reimburses out-of-pocket costs for specific dental services used to treat or help prevent gum disease and tooth decay. The program is for people with certain medical conditions that may be impacted by dental care. The only requirement is that you’re currently being treated by a doctor for heart disease, stroke, diabetes, head and neck cancer radiation, maternity, chronic kidney disease, or organ transplant. For additional information regarding Cigna’s Oral Health Integration Program, please visit www.cigna.com.

CIGNA DENTAL CARE DHMO PLAN

<table>
<thead>
<tr>
<th>BENEFITS &amp; COVERED SERVICES</th>
<th>IN NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type I</strong></td>
<td>Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges (amalgam [silver] fillings only)</td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive Services Oral Exams, Cleanings, X-rays</td>
<td></td>
</tr>
<tr>
<td><strong>Type II</strong></td>
<td>Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges (amalgam [silver] fillings only)</td>
</tr>
<tr>
<td>Basic Services, Fillings, Root Canals, Extractions, Scaling and Root Planning, Repairs to Dentures, Bridges and Crowns Sealants</td>
<td></td>
</tr>
<tr>
<td><strong>Type III</strong></td>
<td>Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges</td>
</tr>
<tr>
<td>Major Crowns, Dentures, Bridgework, Surgical Periodontal</td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontic Benefits</strong></td>
<td>Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges</td>
</tr>
<tr>
<td>Cephalometric X-rays, Treatment Study, Bands, Appliances</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>NONE</td>
</tr>
<tr>
<td><strong>Maximum Benefits</strong></td>
<td>No Maximum</td>
</tr>
<tr>
<td><strong>Waiting Period for Benefits</strong></td>
<td>No Waiting Period</td>
</tr>
</tbody>
</table>
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

**DELTA DENTAL SELECT AND DELTA DENTAL SELECT PLUS**

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

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

Consider downloading Delta Dental free mobile app titled, Delta Dental by Delta Dental Plans Association, to review your plan details, pull up your ID card and try out the musical toothbrush timer.

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

**Important Information for Select and Select Plus Options**

**Six (6) Month Wait Period**

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

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

If an employee switches from the Select to the Select Plus option, the employee and any eligible dependents will be required to meet the Six (6) Month Waiting Period for services not covered under the Select Plan, such as Orthodontia services (for adults and children under the Select Plus Plan).
# DELTA DENTAL PPO

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

<table>
<thead>
<tr>
<th>Benefits and Covered Services**</th>
<th>Dental Select Plan</th>
<th>Dental Select Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PPO Dentists</td>
<td>Premier Dentists</td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive Services (D &amp; P) \ Exams, cleanings, x-rays</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services \ Fillings, simple tooth extractions sealants</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics (root canals) \ Covered Under Basic Services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Periodontics (gum treatment) \ Covered Under Basic Services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Oral Surgery \ Covered Under Basic Services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Major Services \ Crowns, inlays, onlays and cast restorations, bridges, dentures &amp; TMJ, surgical periodontics</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic Benefits \ Adults and dependent Children</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Orthodontic Maximums \ Lifetime</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*If you switch plans during the calendar year, your Deductible and Annual Maximum may be adjusted accordingly.  
**Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist’s actual fees.  
†Reimbursement is based on PPO contracted fees for PPO dentists. Premier contracted fees for Premier dentists and 80th percentile for non-Delta Dental Dentists.

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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.
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, JCPenney Optical, Sears 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 multifocal 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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>CoPayments/Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Providers</td>
</tr>
<tr>
<td><strong>Eye Exam</strong></td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Limited to one exam per Member every Calendar Year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Prescription Lenses</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to one set of lenses per Member every Calendar Year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Basic Lenses (Pair)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Limited to one set of lenses per Member every Calendar Year</em></td>
<td></td>
</tr>
</tbody>
</table>

- Single Vision lenses
- Bifocal lenses
- Trifocal lenses
- Lenticular lenses

Copayment: $20
Reimbursed up to $40

**Includes:**

- Factory Scratch Coating
- Tint (solid and gradient)
- Polycarbonate and Photochromic lenses (adults)
- UV Coating

Copayment:
- Factory Scratch Coating: $0
- Tint (solid and gradient): $0
- Polycarbonate and Photochromic lenses (adults): $40
- UV Coating: $15

**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

**Non-Elective Contact Lenses**

Covered in Full

**Elective Contact Lenses**

- Elective Disposable Lenses
- Elective Conventional Lenses

Retail allowance:
- $105

Reimbursed up to $210

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.

*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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>CoPayments/Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Providers</td>
</tr>
<tr>
<td><strong>Eye Exam</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to one exam per Member every Calendar Year</td>
<td>$20 Copayment</td>
</tr>
<tr>
<td><strong>Prescription Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to one set of lenses per Member every Calendar Year</td>
<td></td>
</tr>
<tr>
<td><strong>Basic Lenses (Pair)</strong></td>
<td></td>
</tr>
<tr>
<td>• Single Vision lenses</td>
<td>$25 Copayment</td>
</tr>
<tr>
<td>• Bifocal lenses</td>
<td>$25 Copayment</td>
</tr>
<tr>
<td>• Trifocal lenses</td>
<td>$25 Copayment</td>
</tr>
<tr>
<td>• Lenticular lenses</td>
<td>$25 Copayment</td>
</tr>
<tr>
<td><strong>Includes the following Lens Options:</strong></td>
<td></td>
</tr>
<tr>
<td>• Factory Scratch Coating</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• UV coating</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• Tint (solid &amp; gradient)</td>
<td>$0 Copayment</td>
</tr>
<tr>
<td>• Polycarbonate lenses (Adults)</td>
<td>$20 Copayment</td>
</tr>
<tr>
<td>• Transitions</td>
<td>$20 Copayment</td>
</tr>
<tr>
<td>• Standard &amp; Premium Progressive lenses</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>• Standard Anti-Reflective coating (Not Covered for Non-Network Providers)</td>
<td>$0-$23 Copayment</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to one set of frames per Member every Calendar Year</td>
<td>Allowable Amount up to $150 retail allowance, 20% remaining balance</td>
</tr>
<tr>
<td><strong>Prescription Contact Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>(Once per Calendar Year)</td>
<td>No Copayment</td>
</tr>
<tr>
<td>• Non-Elective Contact Lenses</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>• Elective Disposable Lenses</td>
<td>$150 retail allowance</td>
</tr>
<tr>
<td>• Elective Conventional Lenses</td>
<td>$150 retail allowance, 15% off remaining balance</td>
</tr>
</tbody>
</table>

### Still have questions?

Please contact Georgia Breeze or Anthem BCBS (Anthem) Vision Customer Service at 1-855-556-4844.
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 Hyatt Legal Plan attorney, who will complete a will, living will, or power of attorney for you and your legal spouse, at no charge to you.

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

If You are a New Employee

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

Coverage for you is available in increments of your pay – from one to 10 times pay, up to $2,000,000. Amounts of one-times pay, up to $200,000, are 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 30 days, from date of birth. To continue the life insurance coverage beyond 30 days, you must enroll the newborn before the end of the 30 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 WageWorks. Flexible Spending Accounts do not roll over to the new plan year.

For the 2020 plan year, the annual amounts you may contribute are:

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Care</td>
<td>$120</td>
<td>$4,992</td>
</tr>
<tr>
<td>Health Care</td>
<td>$120</td>
<td>$2,652</td>
</tr>
</tbody>
</table>

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

Important Information About 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 Health Care Flexible Spending Account has a grace period that can help you avoid losing money for unclaimed expenses. See page 35 for more information.

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

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 2020 plan year.

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 IRS-eligible dependents (such as a disabled child of any age or an elderly parent) while you and your spouse work or attend school full time.

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.

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 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.

HCFSA Grace Period of 2½ Months

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

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

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

Examples of Ineligible Expenses

- Cosmetic procedures/drugs
- Electrolysis
- Hair transplants
- Herbal supplements
- Insurance premiums
- Nicotine patches and gum
- Nutritional supplements
- Teeth whitening/bonding
- Vitamins
- Over-the-counter medications
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 30 days of employment). Your STD benefits are calculated on the Annual Benefit Base Rate that is in effect during the plan year your disability began, less other income benefits. For example, if your first day of disability is December 3, 2019, your disability benefit will be calculated from the 2018 Annual Benefit Base Rate, not your 2019 Annual Benefit Base Rate. The Annual Benefit Base Rate for Plan Year 2020 will be based on your weekly rate of earnings in effect on October 1, 2019, or your hire date, if after this date.

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

**What Is A Late Enrollment Penalty for Late Entrants?**

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

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 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**

<table>
<thead>
<tr>
<th>Amount</th>
<th>$5,000</th>
<th>$10,000</th>
<th>$20,000</th>
<th>$30,000</th>
<th>$40,000</th>
<th>$50,000</th>
</tr>
</thead>
</table>

- 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**

<table>
<thead>
<tr>
<th>Amount</th>
<th>$5,000</th>
<th>$10,000</th>
<th>$20,000</th>
<th>$30,000</th>
<th>$40,000</th>
<th>$50,000</th>
</tr>
</thead>
</table>

- 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
Covered Critical Illnesses*

* 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.

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%

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

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

Benefits Include:

- Medical Fees (Physician Charges, X-Rays, Emergency Room Services and Supplies)
- Hospital Fees (Hospital Admission, Daily Hospital Confinement and Intensive Care)
- Accidental Injuries (Fractures/Dislocations, Lacerations, Tendons/Ligaments, Ruptured Disk, Torn Knee Cartilage, Burns, Eye Injuries)
- Accident Follow-up Benefits (Physical Therapy, In-patient Rehab, Follow-up treatments)
- Additional Benefits (Family Lodging, Transportation, Gunshot Wound, Paralysis, Prosthesis)
For a complete list of benefits and descriptions, please refer to the Critical Illness Select Plus PDF Brochure or your certificate of coverage. Premiums for the Critical Illness coverages in this section are paid on a post-tax basis – which allows you to receive benefits tax-free.

**Legal Insurance**

**Legal Insurance with Hyatt Legal Plans**

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

**Legal Benefits**

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

**Access to Over 14,000 Attorneys**

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

**Your Legal Benefit Options**

Review the coverages below 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
- Living Trusts
- Boundary Title Disputes (Primary Residence)

What Are the Exclusions?
The legal plan excludes appeals; class actions and appeals; matters that Hyatt Legal Plans deem frivolous, non-meritorious, or unethical; farm and business matters; patent, trademark, and copyright matters; costs and fines; matters for which an attorney-client relationship 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 Hyatt's mobile app or visit the website www.info.legalplans.com. Enter the appropriate access code, as follows:

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

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

Select Premium
7621001 Employee Only
7631001 Employee w/Dependents
# FLEXIBLE BENEFITS PROGRAM

**PHONE DIRECTORY**

**GaBreeze Benefits Center**  
[www.GaBreeze.ga.gov](http://www.GaBreeze.ga.gov) | 1-877-342-7339 | 8:00 a.m. ET to 5:00 p.m. ET, M-F

<table>
<thead>
<tr>
<th>BENEFIT TYPE</th>
<th>NAME &amp; CONTACT INFORMATION</th>
</tr>
</thead>
</table>
| Dental Insurance | CIGNA  
1-800-642-5810 (24/7, 365 days a year)  
[www.cigna.com](http://www.cigna.com)  
Delta Dental  
1-866-496-2384 (7:15 a.m. to 8:00 p.m., M-F, ET)  
[www.deltadentalins.com](http://www.deltadentalins.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](http://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. M-TH, ET)  
(8:00 a.m. – 5:00 p.m. Friday, ET)  
[www.metlife.com/sog](http://www.metlife.com/sog) |
| Disability Insurance | The Standard  
1-888-641-7186 (8:00 a.m. – 6:00 p.m., M-F, ET)  
[www.standard.com](http://www.standard.com) |
| Long-Term Care Insurance | Unum  
1-888-SOG-FLEX (1-888-764-3539)  
(8:00 a.m. – 8:00 p.m., M-F, ET)  
[www.unuminfo.com/sog](http://www.unuminfo.com/sog) |
| Critical Illness Insurance | Aflac  
1-800-433-3036 (8:00 a.m. – 8:00 p.m., M-F, ET)  
[www.aflacgroupinsurance.com](http://www.aflacgroupinsurance.com)  
[www.doas-specifiedillness.com](http://www.doas-specifiedillness.com) |
| Legal Insurance | Hyatt Legal Plans  
1-800-821-6400 (8:00 a.m. – 8:00 p.m., M-F, ET)  
[www.legalplans.com](http://www.legalplans.com) |
| Spending Accounts | WageWorks  
1-888-557-3156 (8:00 a.m. – 8:00 p.m., M-F, ET)  
[www.myspendingaccount.wageworks.com](http://www.myspendingaccount.wageworks.com/) |