

QUESTIONS AND ANSWERS

Welcome!

These are anticipated questions and suggested answers on the Flexible Benefits Program. They are designed to give you a better understanding of the Program and prepare you to answer employee questions. If you think of other questions employees may ask, jot them down on the blank page labeled "Additional Questions and Answers" located in the "Handling Questions on Enrollment" section. Remember, it's all right to say you don't know the answer to a specific question. It is far better to tell employees that you don't know, than to misinform them. That's why the "Employee Question Response Form" has been included. You can use the form to record unanswered questions, and then to follow up with these employees.

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NOTES:

Concept and General Plan Information

Q: Why does the State offer the Flexible Benefits Program?

A: The State developed the benefit program to: 1) offer you a wide range of benefits, 2) provide you with a choice in benefits, and 3) provide you a way to pay for your benefits that helps you save on taxes. The Program also offers a uniform package of benefits for eligible employees in all State departments and participating Educational Institutions.

Q: What's the advantage of uniform benefits?

A: Uniform benefits among all participating State employers and Educational Institutions can provide you with more flexibility: you can transfer between the employing entities and take these benefits with you. Additionally, since the State is such a large group lower premiums can be negotiated by the State.

Q: How was the Program developed?

A: First, an extensive study was done to determine employees' attitudes toward benefits. In that survey, employees expressed an interest in adding disability insurance and life insurance protection in addition to the benefits they may receive through a retirement system. They responded favorably to the idea of choosing the benefits they want. After the benefit areas were identified, competitive bids were sought from insurance companies to provide these benefits at the lowest rates possible for employees. After the first enrollment, a survey found that 92% of surveyed employees liked having these benefit choices.

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Q: Who is eligible for the Program?

A: You will become eligible for insurance on the day you complete the waiting period if:

- You are a full-time Employee of the State of Georgia, or a State Agency, working at least 30 hours per week, on a continuous basis, and whose employment is expected to last at least nine (9) months, or
- You are a public school teacher who is employed in a professionally certificated capacity, working 17.5 hours or more per week, or
- You are the Employee of a local school system who holds a non-certificated position and is eligible to participate in the Teachers Retirement System and working at least 20 hours a week or 60% of the time necessary to carry out the duties of the position, if that is more than 20 hours per week, or
- You are an Employee who is eligible to participate in the Public School Employee Retiree System and who works at least 15 hours per week or 60% of the time necessary to carry out the duties of the position, if that is more than 15 hours per week, or
- You are an Employee of a county or regional library and working 17.5 hours or more per week, and
- Others deemed eligible by Federal or Georgia Law.

Q: What insurance companies are involved with these benefits?

A: Minnesota Life Insurance Company is the carrier for Employee Life, Spouse Life, Child Life, and Accidental Death and Dismemberment.

United Concordia is the carrier for both the Regular dental option and the PPO dental option. Cigna is the carrier for the Dental Care DHMO option.

Signature Legalcare is the carrier for the Legal option.

The Standard is the carrier for Short-term Disability and Long-term Disability options.

OptumHealth is the carrier for the Vision option.

Continental American Insurance Company (CAIC) is the carrier for the Specified Illness options.

UnumProvident Life Insurance Company (Unum) is the carrier for Long-term Care.

The State Health Benefit Plan provides health benefits through the PPO and High Options and several HMO options. The PPO and High Options are self-insured, and claims are processed by Blue Cross and Blue Shield of Georgia.

The HMOs are independent health care corporations.

The Health Care Spending Account, the Child (Dependent) Care Spending Account, and Health Savings Account are not insurance programs, although the Health Care Spending Account is administered like an insurance plan.

Q: How do I know these are good prices for benefits?

A: Periodically, the Employee Benefit Plan Council elects to obtain competitive quotes on the benefits offered through the Flexible Benefit Plan. Bid specifications are sent to numerous insurance companies. Proposals received are evaluated by the consulting firm and representatives of different state departments. The Employee Benefit Plan Council awards the contracts based on those bids which best meets the criteria and objectives established in the specifications, one of which is to maintain competitive rates. As a result of this process, premium costs remain competitive.

Q: How does the State benefit from this Program?

A: You are the one who really benefits from this Program, because you can pay some premiums on a pre-tax basis, which saves you money. In addition, you can choose which benefits are best for you. The State offered this Program to give you those opportunities, and also to provide a uniform package of benefits across all State departments. The State

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does receive savings in the form of the employer's share of FICA taxes. These savings are used to offset the administrative costs of the Flexible Benefits Program.

Q: What does the State contribute toward the cost of these benefits?

A: The State has traditionally paid *about* 75% of the cost for coverage under the State Health Benefit Plan. (The exact percentage may vary among specific options). The State does not contribute to the cost of employee life, dependent life, accidental death and dismemberment, short-term disability, long-term disability, legal, dental, long-term care, vision, and spending accounts.

Q: Why aren't more "department-sponsored" benefits included in the Flexible Benefits Program?

A: The goal is to offer high-quality, uniform benefits. Your department-sponsored benefits are not included in the Flexible Benefits Program because they are not uniform across all State agencies.

Q: Can I enroll in both a department-sponsored plan and the Flexible Benefit Plan?

A: Enrollment in any existing department plan is at the discretion of your department; if you currently participate in department-sponsored plans, you may continue to do so. In addition, you may join the Flexible Benefits Program.

Q: Can I enroll next year?

A: Yes. You can enroll in most benefits every year. It is important to remember that medical underwriting (proof of insurability) will be required for employee life, spouse life, child life, short-term disability, long-term disability, specified illness, and long-term care, if you do not enroll when first eligible. Delayed enrollment in the Regular and PPO options of the dental plan will result in the application of the "Late Entrant" penalty--waiting periods before coverage will be provided for all but preventive treatment charges. (This does not apply for the Prepaid Option).

Q: Can I continue my insurance if I terminate my employment?

A: Upon leaving State employment, you may keep certain coverage, as follows:

- You may convert your employee life, spouse life, and child life insurance at rates in effect for that type of individual policy at that time. A portability option is available for the employee life, spouse life, child life, and AD&D options for employees leaving employment for reasons other than sickness or injury. Call Minnesota Life toll free at 1(800)660-2519 for more information.
- Under federal legislation (COBRA), you may continue your health, dental, and vision coverages, as well as the health care spending account for a period of time. The Dental Care DHMO option has a conversion feature. Call Cigna at 1(800)642-5810 regarding the DHMO option.
- You may continue your legal insurance through the end of the plan year by calling GE Signature toll-free 1(800)848-2012.
- You may continue your long-term care insurance coverage by paying premiums directly to the insurance carrier. To obtain additional information about coverage continuation through direct billing, call Unum toll-free 1(888)764-3539.

For additional information, refer to the section “Options When Leaving State Employment,” beginning on [page 112](#).

Q: Can I continue my insurance when I retire?

A: Upon retiring, you may have the opportunity to continue health coverage and/or dental coverage.

Retirees may continue their *health* options provided that they qualify for a retirement annuity from their retirement system and have had continuous coverage.

Retirees after April 1, 1997 can continue *dental* coverage through deductions from the Employees' Retirement System, Teachers Retirement System, Public School Employees' Retirement System, Superior Court Judges Retirement System, or District Attorney's

Retirement System. Retirees must be eligible to receive an immediate and sufficient retirement benefit from the retirement system. Deductions are after-tax only.

Q: Can I continue the health care spending account when I retire or if I resign?

A: Any covered employee who terminates employment may continue participating in the health care spending account under the COBRA provision for the remainder of the Plan Year. The required contribution payment for this coverage is 102% of the contribution rate paid by active employees. For additional details, contact the Flexible Benefits Program at (404)656-2730, if it is a local call, or toll-free at 1(888)968-0490.

*For additional information, refer to the section “Options When Leaving State Employment,” beginning on **page 112**.*

Q: What if I go on leave without pay?

A: If you want to continue benefits during your leave period, you must continue to pay your premiums. You may pay premiums for a period up to twelve (12) months. If you don't pay the premiums while on leave without pay, depending on your situation, your coverage may be terminated or limited upon your return or your payroll office may be required to collect all missing premiums. Employees going on leave without pay should contact their personnel/payroll office or the Flexible Benefits Program to discuss premium payment while out of pay status.

Q: Why are the premiums on the Electronic Enrollment website higher this year?

A: Several factors affect the premium amount. Some premiums are based on your age, your Benefit Salary, coverage level you choose, and whether or not you are eligible for disability coverage through any State of Georgia retirement plan. Therefore, an increase in the premiums is reflected on the Electronic Enrollment website. Also, some options not based on age, salary and benefit level have higher premiums this year.

Q: If I change departments, can I change my options?

A: No. When you join the Flexible Benefits Program, you're joining a statewide program of benefits that you can take with you from one participating department to another. Internal Revenue Service (IRS) regulations require that you keep the same benefits

throughout the plan year, even if you transfer or terminate and then are rehired during the same plan year. That restriction is in exchange for the benefit of pre-tax premiums.

Q: What other sources of information can I use to get information about my benefits?

A: The *You Decide!* enrollment booklet, benefit Summary Plan Documents, the Team Georgia website, and other communication materials provide additional insight into each of the benefit options. Various Internal Revenue Service (IRS) publications will also be useful if you are interested in the spending accounts. You may also wish to contact:

- An accountant to help you decide which benefits provide the most valuable financial protection and estimated tax savings;
- A financial planner to help you choose benefits that fit your short-term and long-term needs and to help plan your retirement income;
- An insurance broker/agency to provide advice about other benefit choices;
- A lawyer to provide advice if you are required to provide benefit coverage for an ex-spouse or children by an ex-spouse or to help you decide which benefits are best for you from a tax savings perspective;
- Your retirement system

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NOTES:

Pre-tax/After-tax Premiums

Q: Are premiums made through the payroll process?

A: Yes, your premiums will be made automatically through the payroll process. If you are paid semi-monthly, your health benefit premiums will be reduced from your paycheck on the 15th of the month, and your other premiums will be reduced from your paycheck at the end of the month. Your spending account contributions are made every payday beginning December 15.

Q: How do pre-tax premiums work?

A: As the name implies, pre-tax premiums are withheld directly from your salary *before* income and FICA taxes are calculated. This is referred to as a "reduction", since it is pre-tax. If your wage is below the social security wage base of \$76,200 in 2000, you will pay less social security taxes because premiums and spending account amounts are taken out of your salary before taxes are calculated. Every dollar you pay for pre-tax premiums means a dollar on which you don't have to pay taxes.

Q: Which taxes do pre-tax premiums apply to?

A: When you make pre-tax premiums, you save on federal and state income taxes and social security (FICA) taxes. Pre-tax premiums do not apply to any other types of taxes.

Q: Are social security taxes affected?

A: If your pay is below the social security wage base maximum (\$76,200 in 2000) you will pay less in social security taxes. Your pre-tax premiums reduce your taxable pay, so you pay less in FICA taxes.

Q: Which options under the Flexible Benefits Program have pre-tax premiums?

A: Employee life, accidental death & dismemberment, long-term disability, health insurance options, dental, vision, and spending accounts are paid with pre-tax premiums.

Q: How much will I save on taxes with pre-tax premiums?

A: How much you save with pre-tax premiums depends on your premium amount and tax rate. Simply put, pre-tax premiums can save you the same percentage of your pay as your tax bracket. For example, if you are in the 15% federal income tax bracket, you save 15% in federal taxes, 3% in state taxes and 7.65% in FICA taxes, or about \$0.26 on every premium dollar you pay. See your Electronic Enrollment summary screen for an estimate of your tax savings.

Q: How do pre-tax premiums affect my other benefits?

A: Lowering your taxable pay with pre-tax premiums does not lower the pay on which your other benefits, such as life insurance and retirement benefits, are calculated. Those benefits will continue to be based on your full pay--your pay before pre-tax premiums are withheld.

Pre-tax premiums may, however, reduce the maximum amount that you may contribute to a deferred compensation plan. If you are a state employee and your annual taxable salary amount (gross salary less total pre-tax premiums for the year) is less than \$32,000, your maximum deferral under the Deferred Compensation Plan will be 25% of taxable salary, not 25% of gross salary. Pre-tax premiums do not reduce your Deferred Compensation maximum if taxable salary exceeds \$32,000. If you are an Educational Institution employee, check with your personnel/payroll office to determine if your pre-tax premiums will affect the amount that may be contributed to a tax sheltered annuity plan.

If you participate in the social security program, these benefits at retirement may be slightly reduced. (This is mostly true for employees who use pre-tax premiums for many years and may not affect those close to retirement.) The following chart shows an example for an employee whose annual salary is \$25,000 with annual pre-tax premiums of \$2,500 (\$208/month) until age 65.

(Chart on following page.)

Effect of pre-tax premiums on social security benefits

Age Today	Reduction in Social Security Benefits At Age 65
25	2.6%
35	2.3%
45	1.7%
55	0.8%

Q: If I don't pay taxes now, are they due later?

A: Generally, you will not pay taxes on money coming from your spending accounts or medical, dental, vision, life, accidental death, short-term disability, or long-term care benefits. However, you will be responsible for paying income tax when you receive long-term disability benefits. Since your income from long-term disability benefits will be lower than your salary, you will owe less in taxes.

Q: Why is short-term disability after-tax?

A: When federal legislation was changed to include short-term disability benefits in the social security tax base, the taxes more than offset any advantage provided by pre-tax premiums. It is of greater benefit to employees receiving short-term disability benefits to pay for the premiums on an after-tax basis. That way, the benefits received are not taxed.

Q: Why aren't pre-tax premiums available for Departmental/Educational Institution plans?

A: Legislation creating the Employee Benefit Plan Council authorizes the Council to take advantage of tax-favored plans. Tax-favored plans must be uniformly available to all eligible employees. Departmental/Educational Institution plans are not uniform and do not cover all eligible employees.

NOTES:

Life Insurance

Q: What is the name of the insurance company for the Life Insurance option?

A: Minnesota Life Insurance Company is the carrier for the employee life, spouse life, child life, and accidental death & dismemberment (AD&D) insurance plans.

Q: What are my life insurance choices?

A: An employee through age 64 may choose life insurance coverage equal to one times pay (\$300,000 cap) or two, three, four, five, six, seven, eight, or nine (9) times his/her Benefit Salary (as shown on the Electronic Enrollment website), up to \$500,000.

- If you are a *CURRENT* employee enrolling in employee life coverage for the first time or increasing your current coverage level, you must complete the medical underwriting process (see "CURRENT" chart on page 15).
- If you are a *NEW* employee enrolling in life insurance at one times pay, medical underwriting is not required. The one times pay life coverage has a coverage cap of \$300,000. If you enroll in two, three, four, five, six, seven, eight, or nine times pay with a face value greater than \$200,000, you must complete the medical underwriting process (see chart on page 15).

Q: If I want to change my coverage level, what do I need to do?

A: If you choose to increase your coverage level, you will have to complete the online medical underwriting process for the increase in coverage level (see chart on page 15). If you are denied the request for the increase in coverage level, you will still be guaranteed coverage at your current coverage level.

If you choose to decrease your coverage level, you are not required to complete any forms other than your Electronic Enrollment.

Q: Is life insurance available if I am age 65 or older?

A: Yes, but if you are age 65 or older, you are eligible for a percentage of the amount that would apply if you were age 64 as indicated in the table below:

Your Age	Percentage of the amount which would apply if you were age 64
65 but less than 70	65%
70 but less than 75	43%
75 but less than 80	29%
80 but less than 85	19%
85 but less than 90	13%
90 but less than 95	09%
95 but less than 100	05%

The decreased coverage amount will appear on the Option Statement.

Q: How are my choices calculated?

A: First, your Benefit Salary is multiplied by one, two, three, four, five, six, or seven times your pay (as shown on the Electronic Enrollment website), depending on the amount of insurance you choose. Then, it is rounded up to the next higher \$1,000.

Q: What is meant by medical underwriting?

A: Medical underwriting (proof of insurability) refers to the submission of medical information about your or your dependents' health and medical condition. This may include the completion of an online form, a physical examination, an Amplified Blood Test and/or a submission of medical records. Completion of the medical underwriting process is required for employees as outlined in the charts below.

LIFE MEDICAL UNDERWRITING REQUIREMENTS

New Employees Who Choose Coverage	
Amounts	Medical Underwriting Requirements
1 X Pay (coverage is capped at \$300,000)	None
2, 3, 4, 5, 6, 7, 8, or 9 X Pay (less than \$200,000)	None
2, 3, 4, 5, 6, 7, 8, or 9 X Pay (greater than \$200,000)	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage \$200,000 or more.
Spouse Life: coverage up to and including \$30,000	None
Spouse Life: coverage greater than \$30,000	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage \$150,000 or more.
Child Life: any level of coverage	None

Current Employees Who Choose Coverage	
Amounts	Medical Underwriting Requirements
Enrolling for the first time in Employee Life OR Discontinued coverage and re-enrolling	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage \$200,000 or more.
Currently enrolled in Employee Life and increasing coverage.	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage \$200,000 or more.
Spouse Life: Enrolling for the first time, re-enrolling, or increasing coverage.	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage \$150,000 or more.
Child Life: Enrolling for the first time, re-enrolling, or increasing coverage.	Minnesota Life Evidence of Insurability online Form required

When you request new or additional coverage and your medical history warrants, the insurance carrier may ask for additional information--including an Amplified Blood Test--even if your new coverage is for less than \$200,000.

Q: What must I do to complete the medical underwriting process for employee life?

A: Review your *You Decide!* enrollment booklet and the Electronic Enrollment website to determine if medical underwriting is required. Depending on the level and face value of the employee life coverage you are selecting, you may be required to submit an online Minnesota Life Evidence of Insurability Form (E/I) and be required to complete an Amplified Blood Test. Submission of the online Evidence of Insurability Form authorizes Minnesota Life to access additional medical information from other sources.

It is your responsibility to complete and submit the online Minnesota Life E/I Form.

After your completed E/I Form has been received by Minnesota Life, it will be determined if you are required to have the Amplified Blood Test. If you are required to have the Amplified Blood Test, the paramedic company, who is contracted by Minnesota Life to schedule and complete the test, will contact you. You must make arrangements with the paramedic company representative to complete your Amplified Blood Test by the deadline of Friday, January 29, 2010. If you have any questions specific to the testing, please call Minnesota Life toll-free at 1(800)660-2519.

You must complete each phase of the life medical underwriting process as requested in order to have your request for life insurance considered. Coverage is not effective until an approval notice is issued by Minnesota Life, the insurance carrier.

Q: If I am required to complete the Amplified Blood Test, do I have to pay for it?

A: No. Minnesota Life will pay the cost of the Amplified Blood Test. However, you must have the Amplified Blood Test completed by the company contracted by Minnesota Life.

Q: What happens if I complete and submit the Minnesota Life online E/I Form but decide later not to have the Amplified Blood Test?

A: If you are required to complete both the Minnesota Life online E/I Form and Amplified Blood Test, but later decide not to have the Amplified Blood Test, your request for life insurance coverage will be *rejected*. In other words, your requested coverage will not go into effect because you failed to complete all of the phases of the medical underwriting process. If you have any questions about this, please contact the Flexible Benefits

Program at (404)656-2730 or toll free at (888)968-0490.

Q: Can I get copies of the lab reports used to determine the underwriting decision?

A: Yes. Just submit a written request to Minnesota Life Insurance Company – Group Insurance – Atlanta Office – 260 Peachtree Street NW – Suite 1203. A confidential copy of the lab results will be mailed directly to the person who applied for insurance from Minnesota Life Group Underwriting Department.

Q: What if I want to stay with my Departmental/Educational Institution plan?

A: If your Departmental/Educational Institution plan has continued, you may stay with that plan. However, if you also enroll under the Flexible Benefits Program you must complete the medical underwriting process.

Q: Why are my choices based on my October 1 Benefit Salary?

A: If you are a current employee, your Benefit Calculation Date of October 1 is used so your Electronic Enrollment information can be accurate for Open Enrollment.

If you are a new employee, your choices and "Benefit Salary" will be based on your date of hire, which may be after October 1.

Q. What does "Benefit Salary" mean?

A: It is the amount of pay used to calculate certain salary-based coverages (i.e., life, AD&D, and disability). It includes base salary and any salary supplements that are intended to be regular, non-temporary, and do not exceed the amount on which retirement contributions are calculated.

Q: If my pay increases during the year, will my life insurance coverage also increase?

A: No. Your "Benefit Salary" stays the same during the whole Plan Year, even if your pay increases/decreases. Similarly, your premiums for your life insurance will not change if your salary changes during the Plan Year.

Q: What are my life insurance premiums based on?

A: Your premiums for life insurance will be based on your age and salary as of October 1 (or your hire date, if you are hired during the Plan Year), and the amount of insurance you choose. Your premiums will not change during the Plan Year even though your age and salary may change.

Q: Are the benefits from the Flexible Benefits life insurance taxed?

A: No. Benefits received from the life insurance option are generally not taxed. Consult your tax advisor to determine when the receipt of life insurance benefits would be taxable.

Q: Who receives my death benefits?

A: When you choose life insurance, you should name a beneficiary to receive your life and accidental death insurance benefits. You may name anyone you wish and may change your beneficiary designation at any time. If no beneficiary is named, benefits will be paid to your estate. If a minor beneficiary is named, certified letters of guardianship for the minor's estate issued by the court is required. Be sure to keep your beneficiary information current by updating your information by accessing Minnesota Life's Beneficiary Management application, www.lifebenefits.com, through the Team Georgia website.

Q: What exactly is the "Accelerated Death Benefit"?

A: If you become terminally ill while you are insured through the employee group term life insurance plan, you may access up to 100% of your coverage amount. Prior to any benefit being paid, you must provide medical information that certifies your doctor's opinion that your life expectancy has been reduced to less than 12 months.

Q: What is a "waiver of premium"?

A: If an employee becomes totally disabled as defined by the Group Term Life Summary

Plan Document, (s)he may continue coverage without premium payment for a period of one (1) year and further periods of one (1) year by submitting proof of total disability and having it approved on an annual basis. The first proof must be filed after you have been disabled for nine (9) months, but before being disabled for twelve (12) months. Premium payments must be continued where applicable until the claim is approved by Minnesota Life.

Q: What is the "one year continuance"?

A: If your death occurs within one (1) year after premium payments are stopped, your life coverage amount will be paid if you became totally disabled prior to age 65 while insured and you stayed totally disabled until your death. Additionally, proof must be provided to Minnesota Life within one (1) year of your death in accordance with the plan policy.

Q: How much life insurance do I have under my retirement system?

A: The amount of retirement system life insurance you have depends on the retirement system to which you belong. If you are a member of the Teachers Retirement System or Public School Employee Retirement System, you are not provided life insurance coverage. If you are a member of the Employees' Retirement System (ERS), see the current Explanation of Benefits pamphlet issued by the Employees' Retirement System.

Q: What is my amount of life insurance coverage through the Employees' Retirement System (ERS)?

A: If you are under age 60, your life insurance coverage is equal to 18 times your monthly salary. If you are age 60 or older, your base insurance amount freezes at 18 times your monthly salary. Even if you work past age 60, the multiple does not increase and the monthly salary used does not change. (Refer to the current ERS Explanation of Benefits for additional information.)

Q: How much life insurance should I choose?

A: The amount of life insurance you choose depends on several things, such as the income needs of your family if you should die, the other sources of income they would have, any other life insurance you may have including ERS coverage, and how much you can

afford. See the *You Decide!* enrollment booklet for some other considerations.

Q: Can I continue my group term life coverage when I terminate employment with the State?

A: After leaving State employment, both a portability and conversion provision provide you with the opportunity to continue an amount of life insurance coverage without submitting medical evidence of insurability. You may be eligible for the portability provision if you are leaving employment for reasons other than sickness or injury. Minnesota Life offers conversion to an individual whole life policy (at rates available for that kind of policy at that time) to employees who wish to continue coverage regardless of medical condition. For additional information, contact Minnesota Life Branch Office at (404)522-1660.

Q: What is the difference between portability and conversion?

A: The portability option is term life coverage; conversion is to a whole life policy. Rates will differ between the two options, with rates for conversion to a whole life policy being higher. Another key difference between the two is that in order to be eligible for the portability provision, you cannot be leaving employment for reasons of sickness or injury.

Q: What is "imputed income"?

A: Imputed income describes the *value* of life insurance above \$50,000 that you receive from your employer. Since the Flexible Benefits Program permits you to have your employer purchase benefits for you, any life insurance you select over \$50,000 is subject to imputed income. It's important to remember that imputed income is not tax; it is income that will be added to your W-2. That means you pay tax on the imputed income at the same tax rate as your salary.

Remember, if you are a state employee and select *less than \$50,000* of life insurance, you will *not* have any imputed income. If you are an employee of an educational entity and that entity provides employer paid life insurance, the amount paid for by the employee plus any remaining difference, up to a total of \$50,000 of life insurance, will *not* have any imputed income.

Q: How and when do I pay taxes on imputed income?

A: FICA (social security) taxes will be withheld each month on the imputed income for that month. The decision to include imputed income as an amount subject to monthly withholding of State and Federal income taxes is at the discretion of the employer. Whether or not your employer withholds taxes on your imputed income, you will have an end-of-year tax liability for the imputed income amount. At the end of the year, your W-2 will show the imputed income for the entire year and this amount will be included in taxable Federal and State wages. Employers are responsible for reviewing IRS tax regulations at the beginning of the tax year to ensure obligations are met.

Q: How can I avoid imputed income?

A: If you select more than \$50,000 of life insurance, you may avoid imputed income by writing your personnel office to request after-tax premiums. Your life insurance premiums will be paid with after-tax dollars, and imputed income will be avoided. However, unless you earn in excess of \$100,000 and are age 65 or older, it will generally be to your advantage to pay for life insurance on a pre-tax basis.

Q: How can I determine how imputed income will affect me?

A: If you select less than \$50,000 of life insurance, you will not have any imputed income. If you select over \$50,000 in life insurance, consider the tax savings offered by pre-tax premiums together with imputed income. For nearly all employees with over \$50,000 of life insurance, the tax savings on the premium will more than offset any tax on the imputed income.

Spouse Life Insurance

Q: What is the name of the insurance company for the spouse life insurance option?

A: Minnesota Life Insurance Company is the carrier for life, spouse life, child life, and accidental death & dismemberment (AD&D) insurance plans

Q: What are my options?

A: You may choose a coverage amount of \$6,000, \$12,000, \$30,000, \$60,000, \$100,000, \$150,000, \$200,000, or \$250,000. Or, you may choose not to have this coverage.

Newly eligible employees can select up to \$30,000 of spouse life without medical underwriting. Medical underwriting is required for current employees, who did not select spouse life when first eligible.

Q: Can I choose spouse life insurance coverage without having to choose employee life insurance?

A: No. To choose spouse life, you must enroll in employee life coverage.

Q: What is the spouse life premium based on?

A: Your premium for spouse life insurance is based on the employee's age and based on the level of coverage chosen.

Q: How do I know if my spouse is eligible?

A: Generally, your spouse is eligible for coverage if you are legally married.

Q: Why should I choose this insurance?

A: Spouse life insurance can help you pay for unexpected expenses that would result from the death of your spouse.

Q: Is the spouse life premium pre-tax or after-tax?

A: Spouse life insurance is an after tax premium.

Q: If I didn't take spouse life insurance last year, can I pick it up this year?

A: Yes; if you are enrolled in employee life insurance. However, your spouse must undergo the medical underwriting process. A blood test may also be required for your spouse. Be sure to complete the online Minnesota Life Evidence of Insurability Form on behalf of your spouse and respond to the questions on the form regarding your spouse.

Child Life Insurance

Q: What is the name of the insurance company for the child life insurance option?

A: Minnesota Life Insurance Company is the carrier for life, spouse life, child life, and accidental death & dismemberment (AD&D) insurance plans

Q: What are my options?

A: You may choose a coverage amount of \$3,000, \$6,000, \$10,000, \$15,000, or \$20,000. Or, you may choose not to have this coverage.

Newly eligible employees can select any level of child life without medical underwriting. Medical underwriting is required for current employees, who did not select child life when first eligible.

Q: Can I choose child life insurance coverage without having to choose employee life insurance?

A: No. To choose child life, you must enroll in employee life coverage.

Q: Do I have to cover every eligible dependent?

A: Child life insurance is designed to cover *every eligible dependent*; however, if you have an uninsurable dependent, the insurance carrier can waive coverage for that specific dependent and allow coverage for all other dependents.

Q: What are my premiums based on?

A: Your premiums for child life insurance are based on a flat group rate regardless of the number of dependents you cover and based on the level of coverage chosen.

Q: Is the child life premium pre-tax or after-tax?

A: Child life insurance is an after tax premium.

Q: How do I know if my dependents are eligible?

A: Your children are eligible if they are dependent on you for support and are under age 19, or if they are unmarried, full-time students under age 26.

Physically and/or mentally handicapped children may be eligible for *continued* coverage beyond age 19 upon approval by Minnesota Life. If coverage for a handicapped child is to be continued, you must file a request with Minnesota Life within sixty days following the child's 19th birthday. Call Minnesota Life toll-free at 1(800)660-2519 and ask for a representative.

Q: Why should I choose this insurance?

A: Child life insurance can help you pay for unexpected expenses that would result from the death of one of your dependents.

Q: If I didn't take child life insurance last year, can I pick it up this year?

A: Yes; if you are enrolled in employee life insurance. However, your dependents must undergo the medical underwriting process. No blood test is required for dependents. Be sure to complete the online Minnesota Life Evidence of Insurability Form on behalf of your dependents and respond to the questions on the form regarding your dependents.

Accidental Death and Dismemberment (AD&D) Insurance

Q: What is the name of the insurance company for the Accidental Death and Dismemberment (AD&D) insurance option?

A: Minnesota Life Insurance Company is the carrier for the life, spouse life, child life, and accidental death & dismemberment (AD&D) insurance plans.

Q: What are my AD&D insurance choices?

A: Employees through age 74 may choose accidental death and dismemberment insurance equal to one (1), two (2), three (3), four (4), five (5), six (6), or seven (7) times their Benefit Salary, up to \$500,000.

Q: Is accidental death and dismemberment coverage available if I am age 75 or older?

A: Yes, but it is available at a reduced percentage of the amount which would apply at age 74. The reduction factor for ages 75-79 is 50%; for ages 80 or older is 75%.

Q: How are my AD&D insurance choices figured?

A: First, your Benefit Salary is multiplied by the amount you choose: one (1), two (2), three (3), four (4), five (5), six (6), or seven (7) times pay. Then, that amount is rounded up to the next higher \$1,000. For example, if you earn \$14,400 and choose insurance of one (1) times your pay, your insurance will be \$15,000. If you are over age 74, the \$15,000 would be reduced by the applicable % reduction factor, and under this example, coverage would be \$8,000.

Q: What are my premiums based on?

A: Your premiums for AD&D insurance will be based on your salary as of October 1 (or your date of hire, if that is later than October 1) and the amount of insurance you choose. The October 1 salary is referred to as the "Benefit Salary." These premiums and your coverage amount will remain constant for the duration of the plan year.

Q: What's the difference between life insurance and accidental death and dismemberment insurance?

A: Life insurance will be paid to your beneficiary if you die for any reason (except suicide within the first year). The death benefit of AD&D insurance is paid to your beneficiary only if your death is a result of a covered accident; the dismemberment benefit is paid to you only if you are disabled or dismembered as a result of a covered accident.

Q: What is accidental dismemberment?

A: Accidental dismemberment means that, as a result of a covered accident, you lose:

- One or more limbs (hand, foot or sight);
- Hearing or speech; or
- Thumb and index finger on the same hand.

Benefits for accidental dismemberment are paid to the employee.

Q: What is meant by covered accident?

A: Generally, a covered accident results in a loss as outlined above and occurs while your insurance is in effect. Please refer to the AD&D section of the Group Term Life Summary Plan Document, which lists certain exclusions from the definition of covered accident.

Q: When will AD&D insurance be paid?

A: AD&D benefits will be paid to you or your beneficiary only if your injury is the result of a covered accident. The following chart shows the different percentages that the AD&D plan will pay depending on the extent of the injury.

AD&D BENEFIT SCHEDULE	
For example, if you ...	The benefit would be ...
Die	100% of your coverage
Become permanently and totally disabled	100% of your coverage*
Lose two or more limbs**	100% of your coverage
Lose hearing and speech	100% of your coverage
Lose one limb	50% of your coverage
Lose hearing or speech	50% of your coverage
Lose thumb and index finger from the same hand	25% of your coverage

* Paid in monthly installments over the period of your disability.

** A "limb" is a hand, foot, or sight in one eye.

Q: Are there any special provisions to the AD&D plan?

A: Yes. First, a "seatbelt" provision will pay an additional \$10,000 accidental death benefit if an employee dies in an automobile accident while wearing a seatbelt; an additional \$5,000 will be paid if the car is equipped with an airbag. Second, a "repatriation" benefit will pay the cost of moving the deceased employee's body if death occurs more than 75 miles from the mortuary of request. There is no additional cost to the employee for these supplemental benefits.

Q: How is the insurance paid when a covered accident causes an employee to become permanently and totally disabled?

A: If you become permanently and totally disabled as defined by the accidental death and dismemberment policy, you will be paid 1% of your coverage amount each month up to the coverage amount. The amount paid will be reduced by any benefit previously paid or payable as the result of the same covered accident.

Q: Is the benefit for total and permanent disability different after age 75?

A: Yes. If you are age 75 through 79, the amount paid is reduced to 20% of the age 74 coverage amounts. If you are age 80 or older, the amount paid is reduced to 10% of the age 74 coverage amounts.

Q: Do I have to name a separate beneficiary for accidental death insurance?

A: No. The beneficiary you name under the Flexible Benefits Program life insurance coverage will be your beneficiary under the accidental death insurance plan.

Q: Are employees who pilot State owned aircraft or fly as crewmembers of State owned aircraft covered if an accident occurs in their occupations?

A: Yes. If the State owned aircraft are maintained and operated in accordance with federal standards, employees who pilot such aircraft or fly as crewmembers on such aircraft are covered under this plan.

Short-Term Disability Insurance

Q: What is the name of the insurance company for the Short-term Disability option?

A: The Standard Insurance Company is the carrier for the short-term disability option.

Q: How does short-term disability insurance work?

A: If you choose short-term disability coverage, this plan will work with other benefits you are eligible to receive including social security, workers' compensation, other government benefit programs (e.g., retirement due to disability), other group disability plans, or special injury benefits, to replace 60% of the first \$1,333 of your weekly Pre-disability Earnings, up to a maximum of \$800 per week.

If you become disabled and cannot work, you are eligible to receive these benefits after you have been disabled for seven (7) or thirty (30) calendar days. You may choose whether to use sick leave or receive these benefits. If you choose to receive these benefits, your use of sick leave would stop at that time.

The short-term disability plan works with other benefit plans to replace 60% of the Benefit Salary shown on Electronic Enrollment in effect at the time of your disability. Your short-term disability benefits can continue until you recover, return to work full-time, or receive benefits for a maximum of 150 calendar days, whichever is first. The 150 calendar day maximum is reduced by any days of paid sick leave, donated leave or special injury leave that you use which exceeds the 7 or 30 calendar day elimination period.

Q: What is my "Benefit Salary"?

A: The Benefit Salary is the amount of pay used to calculate certain salary-based coverage, such as disability. This pay includes base salary and any salary supplements that are intended to be regular, non-temporary, and do not exceed the amount on which retirement contributions are calculated. The Benefit Salary is calculated on October 1 (or your hire date, if later) and is effective for the entire Plan Year regardless of any changes in salary.

Q: Why should I choose this coverage?

A: Short-term disability insurance can help you meet your financial obligations if you are ill or injured and cannot work. If you don't have any other income sources to help you pay your bills if you become disabled, consider short-term disability insurance.

Q: Can other family members choose coverage?

A: No. Disability insurance is designed to provide protection for *your* paycheck. If you have a family member who also works for the State of Georgia, he or she may be eligible for his or her own coverage.

Q: I have a second job. Is that income also covered?

A: No. This plan is designed and priced to help protect your income earned through the State of Georgia.

Q: If I drop my coverage or never use it, do I get my money back?

A: No. This group insurance product is priced to pay claims but does not build cash value. Similar to car insurance, this coverage protects you as long as you pay premiums.

Q: What determines the cost of my coverage?

A: Your cost is based on your age and on your "Benefit Salary."

Q: Do I have to make premium payments while I'm disabled?

A: No. It is understood that during a disability you will have lesser income and need all of your funds to cover a variety of expenses. You will not be required to make premium payments as long as you are receiving a benefit for short-term disability. This is called a Waiver of Premium.

Q: If I leave my job with the State of Georgia, can I take this coverage with me?

A: No. The short-term disability insurance cannot be continued as an individual policy after the end of state employment.

Q: Are the benefits I receive from the short-term disability plan taxable?

A: No. Since you pay for this coverage with after-tax premiums, you will not be taxed on the disability benefits you receive.

Q: What if I have a large sick and annual/personal leave balance?

A: If you have a large sick and annual/personal leave balance, you may not need short-term disability protection. Your sick and annual/personal leave replaces 100% of your pay.

Q: Since my department has a donated leave program, why do I need short-term disability coverage?

A: Even if your department has a donated leave program, you may not be guaranteed receipt of donated leave. Your department may require you to formally request and apply for receipt of this leave. Your department, however, may approve not all applications for donated leave.

Please be aware that the donated leave program is not designed to replace the short-term disability plan. You may want to consider the State Personnel Board Rule 30, Leave Donation, Section 30.400, which states that an employee must: (1) be employed in a position entitled to earn and use leave, (2) have exhausted all accrued and forfeited leave and all available compensatory time, (3) have been on authorized leave without pay for 80 consecutive hours. The rule further stipulates that donations are not to exceed 520 hours; however, multiple donations are allowed provided no recipient is credited with more than 1040 hours of donated leave in any consecutive two calendar year period.

If your department has a donated leave program, see your personnel office for details.

Q: If I have a disability and apply for donated leave, will my disability benefits be affected?

A: Yes. Donated leave is considered sick leave for the disability plan. Short-term disability benefits will be reduced by any use of sick leave or donated leave paid by your department. Therefore, disability benefits will not be paid at the same time donated leave is paid.

Q: I would like to enroll for short-term disability. Is medical underwriting (proof of insurability) required for short-term disability?

A: No, medical underwriting is not required for new or current employees. If you are a current employee and choosing coverage for the first time or re-enrolling after discontinuing coverage, you are considered a late entrant. During the 12-month period after the date your short-term disability becomes effective, benefits for sickness related disabilities will not begin until after you have been disabled for 60 days. If your disability is caused by an accident, benefits will begin after you have met the 7 or 30-day waiting period.

Q: If I file a claim for disability benefits, how does the insurance carrier determine whether or not I am disabled?

A: Certification and medical documentation provided by a licensed physician is required to initially verify the period of disability and may be required periodically to maintain benefits.

Disabled or disability means that, due to sickness, pregnancy or injury, you are receiving Appropriate Care and Treatment from a doctor on a continuing basis; and

(1) during your Elimination Period, you are unable to perform the essential duties of your Own Occupation for any employer in your National Economy; and

(2) after your Elimination Period, you are unable to earn more than 80% of your Weekly Benefit Salary at your Own Occupation for any employer in your National Economy.

Q: When am I eligible to receive these benefits?

A: Short-term disability benefits are paid if you are ill or injured and unable to work for longer than your waiting period of seven (7) or thirty (30) calendar days. If you are on sick leave beyond the seven (7) or thirty (30) calendar days, benefits will be reduced by any additional use of sick leave.

Q: How often are short-term disability benefit checks issued, once I have been approved for benefits?

A: Short-term disability benefits are paid weekly once you have been approved for benefits.

Q: If I have a pre-existing condition, how will it affect my benefits?

A: There is no pre-existing condition clause for Short Term Disability. There is, however, a late entrant penalty.

A current employee choosing STD coverage for the first time or re-enrolling after discontinuing coverage is considered a late entrant, unless a disability is caused by an accidental injury.

Benefits for STD late entrants who become disabled due to Physical Disease, Pregnancy, or Mental Disorder during the 12-month period after the effective date will not be eligible to receive STD until after they have been disabled for 60 days

Q: Can I use my short-term disability coverage if I become pregnant?

A: You can apply to receive benefits from this plan. Please remember that late entrant limitations would be applicable. It is important to remember that in order to receive benefits under this plan, a medical physician (not a midwife) must certify and provide documentation of a medical disability.

Q: How does my insurance work with other benefits?

A: If you are eligible to receive other disability benefits from workers' compensation, other government benefit plans (e.g., retirement due to disability), other group disability plans, social security, special injury benefit plans, or sick leave (unless you choose not to use sick leave), the amount of those benefits will be calculated first. Then, your short-term

disability insurance will make up the difference between that amount and 60% of your Benefit Salary.

Short-term disability benefits are not offset by the use of annual/personal leave. If you are eligible to receive short-term disability benefits, you may use annual/personal leave and receive short-term disability benefits at the same time.

Q: How do I know if I'm eligible for those other benefits?

A: Workers' compensation and special injury benefit plans are available for injuries and disabilities that occur as a result of an accident while at work. Your department personnel/payroll representative can provide you with more detailed information about these benefits.

Q: What is the "Work Incentive - Partial" benefit?

A: To encourage employees to return to work, even on a limited basis, The Standard includes several features in the disability plan, which makes it easier for you to return to work.

For example:

- While participating in a Rehabilitation Program, your weekly benefit may be increased by 10%.
- You may receive up to a maximum of 80% of your Benefit Salary, which may include earnings received from the disability plan, employment earnings, and other income sources (i.e., Workers Compensation, Social Security, etc.)

Q: What is the "Mandatory Rehabilitation" benefit?

A: The Mandatory Rehabilitation benefit is based upon your participation in a Rehabilitation Program approved by The Standard. If you participate in the Mandatory Rehabilitation Program, your weekly disability benefit (prior to other income offsets, i.e., Workers' Compensation) is increased.

Q: What is the "Rehabilitation Program"?

A: The goal of a Rehabilitation Program is to return employees to work on a full-time or part-time basis. As part of the disability plan, The Standard works with your doctor to determine the training and therapy necessary to aid in the return to work. The Program includes services such as vocational assessment and analysis, retraining in job skills, and/or on-site job analysis for job modifications or accommodations.

Q: Whom can I contact if I have questions about the Short Term Disability Plan?

A: You may contact The Standard toll free at 1(888)641-7186, if you have any questions.

Long-Term Disability Insurance

Q: What is the name of the insurance company for the Long-term Disability option?

A: The Standard Insurance Company is the carrier for the long-term disability option.

Q: What is long-term disability insurance?

A: Long-term disability insurance can provide income protection for you and your family if you become disabled for a period longer than six (6) months. The plan works with other benefits you're eligible to receive to replace 60% of the first \$6,667 of your monthly Pre-Disability Earning up to a maximum of \$4,000 per month.

These benefits will begin after you are disabled from performing your occupation for 180 calendar days. These benefits will cease when you are no longer disabled or you reach age 65. However, if you become disabled after age 60, your benefits may continue for a limited time past age 65. Additionally, benefits for mental and nervous disorders are limited to a two (2) year period.

Q: What is my "Benefit Salary"?

A: The Benefit Salary is the amount of pay used to calculate certain salary-based coverages, such as long-term disability. This pay includes base salary and any salary supplements that are intended to be regular, non-temporary, and do not exceed the amount on which retirement contributions are calculated. The Benefit Salary shown on electronic enrollment is calculated on October 1 (or your date of hire, if later) and is effective for the entire Plan Year regardless of any changes in salary.

Q: Is there a lag between short-term disability benefits and long-term disability benefits or are they continuous?

A: If you are enrolled in both short-term and long-term disability options, benefits are intended to be continuous, assuming that the disability is continuous. However, if the insurance company prior to making a decision about the long-term disability benefits requires additional medical information, there may be a lag in the actual receipt of benefit payments. Long-term disability benefits are paid monthly.

Q: If I have short-term and long-term disability coverage, and am out of work longer than six (6) months, do I have to complete two (2) claim forms?

A: No. The Disability Claim Statement is intended to unify the claims processing, so that for both coverages, only one (1) form is required to be completed.

Q: Why should I choose this coverage?

A: Long-term disability insurance is designed to replace a portion of your income if you are unable to work and earn that income. Consider what other income you may have during a disability when you are deciding whether or not to choose this coverage. If you believe you would have adequate income without this coverage, you may not need it. However, if you don't know how you would continue to pay your bills if you did become disabled, long-term disability insurance can help.

Q: Can other family members choose coverage?

A: No. Disability insurance is designed to provide protection for *your* paycheck. If you have a family member who also works for the State of Georgia, he or she may be eligible for his or her own coverage.

Q: I have a second job. Is that income also covered?

A: No. This plan is designed and priced to help protect your income earned through the State of Georgia.

Q: If I drop my coverage or never use it, do I get my money back?

A: No. This group insurance product is priced to pay claims but does not build cash value. Similar to car insurance, this coverage protects you as long as you pay premiums.

Q: What determines the cost of my coverage?

A: Your cost is based on your age, your Benefit Salary, and disability retirement eligibility status.

Q: Do I have to make premium payments while I'm disabled?

A: No. It is understood that during a disability you will have lesser income and need all of your funds to cover a variety of expenses. You will not be required to make premium payments as long as you are receiving a benefit for long-term disability. This is called a "Waiver of Premium."

Q: If I leave my job with the State of Georgia, can I take this coverage with me?

A: Yes. The long-term disability insurance can be continued as an individual policy after the end of state employment, if you are terminating for any reason except retirement.

Q: Should I sign up for this coverage if I don't think I'll need it this year?

A: Before you decline coverage, you should know that disability coverage requires a statement of good health (medical underwriting)--and that is difficult to predict from year to year. So, if you think you might need it in the future, you may want to sign up for it now.

Q: Are the benefits I receive from the long-term disability plan taxable?

A: Yes. The Internal Revenue Service requires that any long-term disability benefits paid by a plan that allows pre-tax premiums be considered taxable income. You will be responsible for paying income tax on your benefits from this long-term disability plan.

Q: I would like to enroll for long-term disability. Is medical underwriting (proof of insurability) required for long-term disability?

A: Medical underwriting is not required for new employees. Current employees not previously enrolled or discontinued coverage and re-enrolling are required to complete the online medical underwriting process.

Q: When am I eligible to receive these benefits?

A: Upon approval by The Standard, long-term disability benefits are paid when an employee is disabled longer than 180 calendar days. If you are on sick leave beyond the 180 calendar day period, your benefits will not begin until the date the sick leave is to end.

Q: What does the "Temporary Recovery" provision mean?

A: "Temporary Recovery" during your elimination period means that you are attempting to return to work from a disability on a full-time basis. However, a recurrence of your disability may prevent you from returning to work for an extended period of time. If you are unable to continue your attempt at a return to work due to your disability, The Standard will not require you to begin satisfying a new 180 day elimination period as long as your return to work does not exceed 30 days. Days of temporary recovery will count towards the 180-day elimination period, subject to a maximum of 30 days. If you return to work for more than 30 days, you must satisfy a new 180-day elimination period.

Q: How long will benefits be paid?

A: Long-term disability benefits will cease when you are no longer disabled or reach age 65. If you become disabled after age 60, however, your benefits can continue as shown in the following table:

Age at Disablement	Maximum Duration of Benefits
60 or younger	Up to age 65
61	Up to age 65
62	For 3½ years
63	For 3 years
64	For 2½ years
65	For 2 years
66	For 1¾ years
67	For 1½ years
68	For 1¼ years
69	For 1 year
Over 69	For 1 year

NOTE: Monthly benefits shall not be paid with respect to a Total Disability for more than twenty-four (24) months during your lifetime for mental disorders.

Q: How does it work with other benefits?

A: If you are eligible to receive disability benefits from one of the State sponsored retirement systems or local school retirement systems, social security, workers' compensation, other government disability programs, other group disability plans, or any special injury benefit programs, the amount of these benefits would be calculated first. Then, the long-term disability plan would make up the difference between the amount these benefits would pay and 60% of your pay, up to \$4,000 a month. The plan will not pay less than \$100 a month, regardless of what the other benefits pay. Monthly benefits will not commence as long as the employee is using sick leave or special injury leave.

Q: If I am a member of the Employees' Retirement System (ERS), how much disability retirement benefit will I get?

A: The amount of disability benefit depends on whether you are an **active member** of either the Old Plan, New Plan or "Georgia State Employees Pension and Savings Plan" (GSEPS). Old Plan members with membership dates prior to July 1, 1982 and New Plan Members with membership dates prior to July 1, 2007, with a minimum 13 years and 4 months of service are eligible to apply for disability retirement. New Plan members with membership dates on and after July 1, 2007 with a minimum 13 years and 4 months of service and GSEPS members with a membership date on and after January 1, 2009 with a minimum 15 years of service are eligible to apply for disability retirement. If you are in the membership of ERS on December 31, 2008, you may opt in to the new GSEPS plan with ERS, so pay close attention to any differences in the disability service qualifier and benefits information provided herein for GSEPS. All disability retirement applications are subject to ERS Board of Trustees' approval. The amount of your disability coverage through the Employees' Retirement System (ERS) depends on your retirement plan, your age and years of service. The following chart provides a few examples of what your benefits could be from ERS for those who are currently active Old Plan or New Plan members with a membership date prior to July 1, 2007.

If you are under age 60 & have service of ...	the Retirement System would pay ...
13 years + 4 months to 18 years,	75% of age 60 service retirement allowance

Flexible Benefits Program

18 years + 1 month to 22 years + 9 months,	100% of age 60 service retirement allowance
22 years + 10 months to 27 years + 6 months,	75% of age 65 service retirement allowance
27 years + 7 months or more,	100% of age 65 service retirement allowance

*Includes a projection of service and compensation.

Remember, if you are age 60 at the time of disability, the disability retirement allowance is the equivalent of a regular service retirement allowance.

If you are an active New Plan member with a membership date on or after July 1, 2007 or a GSEPS member under age 60, disability benefits are based on your actual service at the time of retirement for any member under age 60. Disability would not apply if your age and/or years of service qualify you for a service retirement.

Of course, the amount of your ERS disability benefit you will receive at a specific retirement date is anticipated to increase as your pay and service increase while a state employee. For more details about how the ERS works or a benefit estimate, visit the ERS website at www.ersga.org.

Keep in mind that the ERS program has no provisions for rehabilitation (the long-term disability program does offer this). Also, to receive disability benefits from the Retirement System, you must be determined by the ERS Medical Board and the Board of Trustees to be totally and permanently disabled from performing the responsibilities of your position.

Q: Can you give me a quick way to estimate the amount that I may receive from ERS as a disability benefit?

A: The following charts may help. Chart A is for members of the Old Plan with membership dates prior to July 1, 1982; Chart B is for members of the New Plan with New Plan membership dates July 1, 1982 through December 31, 2008; Chart C is for members of the New Plan with New Plan membership dates on or after July 1, 2007. Chart D is for members of the Georgia State Employees Pension and Savings Plan (GSEPS) with GSEPS membership dates on and after January 1, 2009). Locate the columns, which most closely represent your current age and total creditable service. The corresponding percentage is the estimated maximum percentage of salary replaced by a disability

retirement allowance and no continuing monthly benefit to a survivor. If you wish to select a joint and survivor benefit, your monthly benefit will be actuarially reduced.

Chart A: OLD Plan Estimated Disability Benefits As Percentage of Salary Replaced						
Age at Disability	Years of Service at Disability					
	10	15	20	25	30	35
35	NA	68%	--	--	--	--
40	NA	60%	88%	--	--	--
45	NA	48%	79%	90%	--	--
50	NA	39%	64%	85%	90%	--
55	NA	30%	51%	72%	88%	SR
60	SR	SR	SR	SR	SR	SR
65	SR	SR	SR	SR	SR	SR

Chart B: NEW Plan with Membership Date On or After July 1, 1982 through June 1 2007 Estimated Disability Benefits As Percentage of Salary Replaced						
Age at Disability	Years of Service at Disability					
	10	15	20	25	30	35
35	NA	60%	--	--	--	--
40	NA	53%	80%	--	--	--
45	NA	45%	70%	85%	--	--
50	NA	38%	60%	75%	90%	--
55	NA	30%	50%	65%	80%	90%
60	SR	SR	SR	SR	SR	SR
65	SR	SR	SR	SR	SR	SR

NA means Not Available until 13 years and 4 months creditable service.

SR means Service Retirement rather than Disability Retirement.

Chart C: New Plan with Membership Date On or After July 1, 2007 through December 1, 2008 - Estimated Disability Benefits As Percentage of Salary Replaced						
Years of Service at	5	10	15	20	25	29

Flexible Benefits Program

Disability						
% of Salary Replaced	NA	NA	30%	40%	50%	58%

NA means Not Available until 13 years and 4 months of service.
 *Benefits are based on the retirement benefit formula – 2% x the years of service x the average monthly salary.
 Disability under ERS would not apply if your age and/or years of service qualify you for a service retirement.

Chart D: GSEPS with Membership Date On or After January 1, 2009						
Estimated Disability Benefits						
As Percentage of Salary Replaced						
Years of Service at Disability	5	10	15	20	25	29
% of Salary Replaced	NA	NA	15%	20%	25%	29%

NA means Not Available until 15 years of service.
 *Benefits are based on the retirement benefit formula – 1% x the years of service x the average monthly salary.
 Disability under ERS would not apply if your age and/or years of service qualify you for a service retirement.

The percentages shown in the previous charts are based on your formula salary. Effective July 1, 1998, the formula salary is the member’s highest average monthly earnable compensation during a period of 24 consecutive calendar months while a member of the retirement system. For Old Plan members, the formula salary is increased by 4.75% less \$7.

You may wish to consider an early service retirement if you have 25 years or more creditable service and are under age 60 at the time of your disability. Consult the retirement system staff regarding these benefits.

Q: I am not a member of ERS. Can you give me a quick way to estimate the amount that I may receive from the Teachers Retirement System (TRS) or Public School Employees' Retirement System (PSERS) as a disability benefit?

A: The following charts may be helpful. Chart E is for members of TRS; Chart F is for members of PSERS. These charts are ESTIMATES of the maximum benefit offered to the employee and nothing to surviving spouse.

Chart E: Teachers Retirement System						
Years of Service at Disability	5	10	15	20	25	29
% of Salary Replaced	NA	20%	30%	40%	50%	58%

NA means Not Available until 10 years of service.

*Benefits are based on the retirement benefit formula – 2% x the years of service x the average monthly salary. Disability under TRS would not apply if your age and/or years of service qualify you for a service retirement.

Chart F: Public School Employees' Retirement System							
Years of Service at Disability	5	10	15	20	25	30	35
Monthly Benefit Paid**	NA	NA	\$221	\$295	\$368	\$442	\$516

NA means Not Available until 15 years of service.

** Effective July 1, 2008, PSERS disability retirement benefits are based on the formula of \$14.75 times years of service. PSERS benefits are not calculated based on a percentage of salary.

NOTE: Respective retirement laws and regulations have precedence over any conflicting information. For additional information contact your retirement system.

Q: What is considered disability under the long-term disability plan?

A: Disabled or Disability means that, due to sickness, pregnancy or injury, you are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and

(1) during your elimination Period and the next 24 month period, you are unable to earn more than 80% of your Monthly Benefit Salary at your Own Occupation from any employer in your Local Economy; or

(2) after the 24 month period, you are unable to earn more than 60% of your Monthly Benefit Salary from any employer in your Local Economy at any gainful occupation for which you are reasonably qualified, taking into account your training, education, experience and Monthly Benefit Salary.

Benefits are limited for a Disability related to Mental or Nervous Disorder or Disease.

Q: Are there any exclusions for pre-existing conditions?

A: Yes. Long-term disability payments as a result of a disability for a pre-existing condition will *not* be allowed unless the employee has been covered under the long-term disability plan for twelve (12) calendar months.

Q: How is a pre-existing condition defined?

A: A pre-existing condition for the long-term disability plan is an injury or sickness for which you incurred expenses, consulted a physician, or received medical treatment, or a condition for which it is reasonable to conclude that you should have had treatment, during the six (6) month period just prior to your coverage going into effect.

Q: What is the "Rehabilitation Incentive" under the long-term disability plan?

A: The Rehabilitation Incentive is based upon your participation in a Rehabilitation Program approved by the Standard. If you participate in the Rehabilitation Program, your monthly benefit (prior to other income offsets, i.e., Workers' Compensation, Social Security, Retirement) is increased by 10%.

Q: What is a "Rehabilitation Program"?

A: The goal of a Rehabilitation Program is to return employees to work on a full-time or part-time basis. As part of the disability plan, The Standard works with your doctor to determine the training and therapy necessary to aid in the return to work. The Program includes services such as vocational assessment and analysis, retraining in job skills, and/or on-site job analysis for job modifications or accommodations.

Q: What is the "Work Incentive - Partial" benefit?

A: To encourage employees to return to work, even on a limited basis, The Standard

includes features in the disability plan, which makes it easier for you to return to work. For example, you may receive up to 100% of your Benefit Salary, which may include earnings from the disability plan, employment earnings, and other income sources (i.e., Workers Compensation, Social Security, etc.).

Q: Who can I contact if I have questions about the Long Term Disability Plan?

A: You may contact The Standard toll free at 1(888)641-7186 if you have any questions.

Legal Insurance

Q: What is legal insurance?

A: The legal plan provides access to attorneys to assist you when you need personal legal representation or advice.

Q: Why is the legal insurance benefit an after-tax benefit?

A: Section 120 of the Internal Revenue Code presently does not allow for the offering of legal insurance on a pre-tax basis. This benefit can only be offered on an after-tax basis.

Q: Why would I want legal insurance?

A: The legal insurance plan provides protection against many unexpected situations when you may want legal representation. You also have unlimited access via a toll-free telephone line (800)848-2012 to an attorney who can answer a legal question or advise you when you do not know legally what you should do in a situation. At other times, the legal plan will help you in anticipated legal expenses, like the preparation of a will or documents for buying a home or adopting a child.

Q: How does the legal insurance plan work?

A: The legal plan provides assistance in three ways:

- A toll-free telephone number for consultation and advice by attorneys at the Preventive LegalCare Office (PLCO);
- Access to attorneys in your area who participate in this insurance plan's network of attorneys; and
- Benefits for covered legal services.

Q: What is the role of the PLCO?

A: The Preventive LegalCare Office (PLCO) provides unlimited advice and consultation. The PLCO may also provide help on simple matters, such as reviewing a simple document or making a phone call on your behalf. If the PLCO determines that you have a more complex case or need assistance other than simple advice, the PLCO will arrange

for you to receive a list of attorneys who have contracted as network attorneys.

You simply call the Signature LegalCare Customer Service Center when a legal matter arises. The Customer Service Representative will confirm your coverage eligibility and arrange for you to speak with a PLCO attorney in your state of residence.

Q: Are the PLCO attorneys employed by the Signature LegalCare Plan?

A: No. The PLCO attorneys are contracted with the Signature LegalCare Plan to provide the phone counseling. These attorneys are privately practicing attorneys; however, a PLCO attorney will not refer you to another attorney in the PLCO law firm.

Q: What is meant by a network attorney?

A: A network attorney is an attorney who is licensed in the State of Georgia (or adjacent states), who has gone through a screening process by Signature LegalCare, and who has agreed by contract to provide legal services to members of the group legal service plan. These attorneys have agreed to provide the services in accordance with the benefit category at no additional cost to the members of the legal service plan.

Q: How do I access a network attorney?

A: For a list of network attorneys, call the Signature LegalCare Customer Service Center. You may choose a network attorney or you may choose an attorney outside the network. If you use a network attorney most legal services are covered in full.

Q: How do I know that a network attorney is a "good" attorney?

A: The network attorneys' licenses and credentials have been verified. These attorneys have also agreed to provide the services in accordance with the benefit schedules. Any complaints received from members are researched, and if the complaint pinpoints a problem with the attorney, his/her contract will be discontinued.

Q: I have used the same attorney for years. Can I still use my personal attorney?

A: Yes. If your attorney is not in the network, the plan will reimburse you for the attorney fees at the rate of \$70 per hour up to the scheduled benefit maximum for the type of legal

service being provided. You will be responsible for the rest of the bill. You may also request that your attorney be sent an application to become a network attorney in the event he/she is interested.

Q: What if my legal problem is more complex than is provided for in the benefit category or if I need additional court representation?

A: You and the network attorney should discuss the additional cost of continuing the representation. If you expect any court representation, discuss this possibility and the expected fees with the attorney in an early meeting.

Q: What do you mean by a scheduled benefit maximum?

A: Most personal legal services can be categorized in types of services, such as simple wills, complex wills, child adoption, real estate matters, etc. The Council's consultants reviewed several plans and developed a scheduled amount that each of these categories of services should cost. These categories and amounts were then approved by the Council as the scheduled benefit maximum under this legal insurance plan for that type of service.

Q: How do I know what the scheduled benefit maximum is?

A: Your Legal Insurance Summary Plan Document will provide the benefit maximum for the type of service when using a non-network attorney.

Q: How are benefits paid for a network attorney versus a non-network attorney?

A: A Participating Attorney will charge no more than the limit shown for a covered legal service. If a Non-Participating Attorney is used, the amounts payable under the Coverage will be up to a specified limit. This example assumes that the covered person is provided legal services for a matrimonial matter.

<p>Matrimonial Matters as a Petitioner/Non-Petitioner</p> <p>The legal services rendered by an attorney as required to reach the final disposition of:</p> <p>A separation agreement not in conjunction with an action for annulment or dissolution of marriage with or without property settlement, child custody, support or alimony without court appearance.</p>	Network Attorney	Non-Network Attorney
	<p>Charge (if any)</p> <p>NONE</p>	<p>Maximum Paid</p> <p>\$385</p>

Q: How does the attorney get paid when I use the plan?

A: Upon completion of a legal matter, the Network Attorney will submit a fully documented claim form to Signature LegalCare for reimbursement consideration. Claim forms can be obtained through the Signature LegalCare Service Center and are also made available through the web site location (www.legalcareplan.com). If a non-network attorney is used, the covered member is responsible for the filing of a claim form upon completion of services.

Network Attorneys are compensated based on their contractual agreements with Signature LegalCare. Signature LegalCare will also pay non-network attorneys for eligible benefits up to a scheduled maximum amount.

Q: Where should I send the Claim Form for payment consideration when legal services have been completed by my attorney?

A: The Claim Form should be sent to the address shown below for payment consideration.

*Signature LegalCare
PO Box 8130
Fort Washington, PA 19034*

This address also appears in the upper right hand corner of the Claim Form.

Q: Are all legal expenses covered?

A: No. There are some items and services that are excluded. For example, a person covered under this plan cannot use plan benefits to take civil or criminal legal actions against the employer or the State of Georgia or any of its agencies or departments. Additionally, there could be court costs and/or filing fees, copying services, etc. that the plan would not cover. Refer to the Legal Insurance Summary Plan Document for a detailed schedule of benefits, including the list of exclusions.

Q: May I use the legal insurance plan for an attorney to write letters or represent me in any administrative review or hearing against my department or any other department of the State?

A: No. However, coverage is available for Administrative Hearings involving zoning or housing code matters.

Q: How do I enroll in the legal insurance plan?

A: You can enroll in the group legal insurance plan by marking the appropriate box for single or family legal insurance coverage on your online enrollment; premiums will be deducted from your pay on an after-tax basis.

Q: If I enroll in family coverage, who is covered?

A: If you enroll in family coverage, all of your eligible dependents will be covered. Each eligible dependent will have access to the PLCO toll-free telephone number at no extra charge. Refer to the Legal Insurance Summary Plan Document to review the definition of eligible dependent.

Q: Will my employer learn about my legal problems because I use this insurance?

A: No; unless you tell them.

Q: When will I receive an I.D. card for the legal insurance plan?

A: A Signature LegalCare Welcome Booklet will be mailed to your home address in early February if you enroll during an Open Enrollment period or about forty-five (45) days following enrollment if you enroll as a new employee during the Plan Year. The Welcome Booklet provides a brief description of the program and contains an I.D. card with the 800 toll-free number shown.

Q: Does Signature LegalCare have a web site address?

A: Yes. Access Signature LegalCare's web site at <http://www.signaturelegalcare.com>. You may access the web site to verify plan details for the State of Georgia account or to obtain network attorney information. From the drop down menu, select State of Georgia Basic or State of Georgia Premium and input the appropriate password.

Basic = 43315

Premium = 43215

Q: Who should I call for additional information about coverage, benefit, or claim information?

A: The Signature LegalCare Plan provides a toll-free number for servicing the legal insurance plans. If you need information regarding claim payments, an explanation of the benefit maximum, or other type of service questions, you must call: 1(800)848-2012.

Q: What is the 800 toll free number for Signature LegalCare?

A: Contact the Allstate Signature LegalCare Customer Service Center, at 1(800)848-2012, when you :

- Have coverage questions
- Wish to speak with a PLCO attorney
- Need a list of network attorneys
- Need a claim form or claim payment information

Q: What are the Hours of Operation for the Signature LegalCare Customer Service

Center?

A: You may call the Signature LegalCare Customer Service Center any time between 5:00 am and 11:00 pm (ET), Monday through Saturday and 5:00 am and 4:00 pm (ET) on Sundays by dialing 1(800)848-2012, when a legal issue or question arises. Your call will be handled by the Interactive Customer Assistance System (ICAS). The ICAS system lets you:

- Verify your membership in the plan
- Order a claim form
- Order a Participating Attorney Directory
- Check the status on your claim

During the ICAS session, you may choose to speak directly with a Customer Service Representative between the hours of 8 AM to 9 PM (ET), Monday - Friday (except holidays) to obtain answers to other questions or speak with a Preventive LegalCare Office Attorney.

In emergency situations, the toll-free number 1(800)848-2012 can be used 24 hours a day, everyday.

Dental Insurance

Q: What is the name of the insurance company for the dental plan?

A: United Concordia is the dental carrier for the Regular option and the Preferred Provider option. CIGNA is the carrier for the CIGNA Dental Care Dental HMO option (DHMO).

Q: What option choices do I have under the dental plan?

A: The Regular option is available statewide to all eligible employees. In addition to the choice of the Regular option, employees in metropolitan Atlanta and in the Augusta, Savannah, Macon, Columbus, and Valdosta areas may choose the Preferred Provider Organization (PPO) option. Employees in the metropolitan Atlanta area may also choose the CIGNA Dental Care option.

Q: I am enrolling in the dental insurance plan for the first time this year. Are there any "penalties" for not enrolling when I was first eligible?

A: If you are a current employee who did not enroll in the Regular option or the DPPO option when you were first eligible, you will be subject to the Late Entrant Limitation if you enroll in one of these options during Open Enrollment.

The CIGNA Dental Care option does not have Late Entrant Limitations. If you live in the metropolitan Atlanta area, you may choose this option without Late Entrant Limitations.

Q: What exactly is the "Late Entrant Limitation"?

A: Under the Late Entrant Limitation, which applies only to the Regular and DPPO options, benefits will be paid as follows:

- Benefits for the first twelve (12) months will be limited to Preventive (Type I) covered dental expenses only.
- Benefits for the second twelve (12) months will be limited to Preventive and Basic (Type I and Type II) covered dental expenses only.
- At the end of two (2) years, you and your eligible dependents, assuming you have family coverage, will be eligible for Major (Type III) covered dental expenses.
- At the end of two (2) years, your eligible dependents under age 19, assuming you

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have family coverage, will be eligible for Orthodontia (Type IV) benefits.

Q: What is a dental PPO (DPPO)?

A: A DPPO is an organization of dentists who have contracted with the dental carrier (United Concordia Insurance Company) and who have agreed to charge a lower fee for their services. United Concordia Insurance Company is able to pass cost savings on to you in the form of a higher level of reimbursement, lower expenses, and lower premiums.

Q: How does the DPPO work?

A: If you enroll in the DPPO and use a DPPO dentist, your dentist will charge you only the difference between the benefits paid by United Concordia and the scheduled fee amount. Also, Preventive (Type I) expenses are payable at 100% (UCR) and Basic (Type II) expenses are payable at 90% coinsurance. The following example illustrates how the PPO works:

	Regular Dental Insurance Option	DPPO Option	
		DPPO Dentist	Non-DPPO Dentist
Dentist's normal charge	\$500	\$500	\$500
Discounted PPO fee	Does Not apply	\$350	Does Not Apply
Covered Expense	\$500	\$350	\$350
Plan pays (Basic Expense: Type II)	80%	90%	90%
	\$400	\$315	\$315
Maximum amount dentist can bill you	\$500	\$350	\$500
Your out-of-pocket expense	\$100	\$ 35	\$185

Q: Does this mean that I will receive lower quality care?

A: No. The DPPO is a good arrangement for the dentist and the patient. The dentist agrees to provide services at a lower fee, while the DPPO assures a higher number of patients. United Concordia Insurance Company included the requirement that the dentist must provide the same quality of care to DPPO patients as other patients.

Q: Do I have to use a Preferred Provider?

A: No. You can use a non-Preferred Provider, but may be subject to reasonable and customary charges, and you may have to file your own claim with United Concordia.

Q: How do I find out which dentists are members of the DPPO?

A: A list of members is available online. You can obtain a copy by calling United Concordia Insurance Company at 1(866)215-2356 or you can go on line at <http://team.georgia.gov/portal/site/FLEX> and access the participating dentists by clicking on "Flexible Benefits."

Q: How do I know that the Dental PPO (DPPO) and CIGNA Dental Care DHMO dentists are good dentists?

A: United Concordia Insurance Company and CIGNA have verified with the Dental Board that the dentist is in good standing. To ensure quality care, dentists participating under the CIGNA Dental Care option must undergo a thorough review, including unannounced site visits.

Q: What if my DPPO or DHMO dentist discontinues his/her arrangement with the DPPO or DHMO plan?

A: Your enrollment in the DPPO option is *not* with a particular dentist, but with the DPPO program. In order to continue to receive benefits under the DPPO benefit schedule, you would be required to choose another DPPO dentist. To continue to receive benefits under the DHMO option, you must select a Network General Dentist at enrollment. In either case, you would not be able to change to another dental option or to drop coverage until the next Open Enrollment.

Q: What happens if I enroll in the DPPO, but use a dentist who is NOT a member of the DPPO?

A: Receiving dental care from a non-preferred provider under the DPPO option can result in a large out-of-pocket expense for you. Non-preferred providers will be paid by United Concordia at the same discount rate that the DPPO dentist would have been paid. The non-DPPO dentist can charge you, the patient, for the difference between the amount paid by United Concordia and their normal billing amount for that service.

Q: My dentist has two offices, but only one of the offices is listed on the DPPO list. Can I go to my dentist at any office and receive DPPO benefits?

A: No. In order to receive benefits under the DPPO, you must receive dental care by a member of the DPPO *at the location specified on the listing*. If you receive treatment at a non-DPPO listed location, you will be considered to have received treatment by a non-DPPO dentist.

Q: If I enroll in the DPPO and am referred to a specialist who is not on the list, how will benefits be determined?

A: Ask your dentist to refer you to a DPPO specialist; but if you receive treatment from a non-DPPO specialist, United Concordia will pay the provider at a rate equal to what the DPPO dentist would have been paid. The specialist can charge you the difference between the amount paid by United Concordia and their normal billing amount for that service.

Q: What is a CIGNA Dental Care dental plan?

A: The CIGNA Dental Care dental plan makes benefits available to you from your selected Network General Dentist and Network Specialists. You must select a Network General Dentist at enrollment and visit that Network Dentist in order for your coverage to apply. Your selected General Dentist will then coordinate any needed referrals for specialty dental care. No referral is required to visit a network orthodontist or for children under 7 to visit a network pediatric dentist.

Q: How do I determine if a dentist is in the CIGNA Dental Care DHMO network?

A: You can consult CIGNA's online Provider Directory at <http://provider.healthcare.cigna.com/gms.html>. You may also request a Network Dentist list by calling CIGNA Customer Service toll-free at 1(800)642-5810.

You must fill out and submit a Dentist Selection Form in order to be eligible for coverage from your Network General Dentist. You may only seek treatment from the Network General Dentist that you have selected. Only CIGNA Network General Dentists within the State of Georgia may be selected. Each family member may select a different Network General Dentist, if desired.

Q. How can I change my CIGNA Dental Care Network General Dentist?

A: You may call CIGNA Customer Service toll-free at 1(800)642-5810. If you request a change by the 15th of the month, your change will be effective on the first day of the following month. If you request a change after the 15th, the change will be effective the first day of the second following month.

Q. How does the CIGNA Dental Care plan work?

A: If you enroll in the CIGNA Dental Care option, you must select a Network Dentist at enrollment and visit that Network General Dentist to receive the discounted rates. There are no deductibles (*An amount you pay before the plan begins to help pay for dental care*), waiting periods, Late Entrant Limitations, pre-existing conditions or maximum benefit limitations (*The limit to what a plan will pay for your dental care*). For many covered services, there is no charge or copay. For services that have a copay, your payment is due at the time of service. You do not submit claim forms for reimbursement with the CIGNA Dental Care plan. Consult the Patient Charge Schedule for a complete list of covered services and copays.

Q. What if I need to see a DHMO Specialist?

A: Your benefits are only available from your selected Network General Dentist and Network Specialists. Not all areas of the State of Georgia have dentists who participate. Your Network General Dentist will provide most, if not all, of the care you need.

If specialty care treatment is recommended, your Network General Dentist will handle the referral paperwork for you. Written referrals are required for all network specialists (except Orthodontists and Pediatric Dentists) in order to receive a benefit.

Q: How does dental coverage coordinate with the State Health Benefit Plan?

A: The State Health Benefit Plan PPO and High Options provide limited coverage for dental treatment. This includes: repair of injured tissue or natural teeth, repair of tissue or natural teeth with reconstructive surgery following an acute illness, and selected surgical procedures for periodontal disease. If you have the State Health Benefit Plan PPO or High Option coverage, these treatments are considered to be covered expenses.

The dental plan will not pay benefits for any treatment covered by the State Health Benefit Plan, *even if you are enrolled in an HMO*. See the Health Plan Decision Guide for details on dental services covered by the HMO. The Dental Summary Plan Document will provide additional details on any exclusions under the dental plan.

Q: What types of dental benefits are covered by the HMOs?

A: Generally, HMOs cover repair caused by accidental injuries. See your specific HMO booklet for more information.

Q: Does the dental plan exclude dental surgery?

A: The Dental plans are available under the State Personnel Administration. You should contact the dental plan directly for specific questions regarding dental surgery. The State Health Benefit Plan options provide limited dental coverage as outlined in the summary plan descriptions. You should contact the customer service number on the back of your ID card or refer to your summary plan description for more detailed information related to dental or oral care.

Q: What is preventive dental work?

A: Preventive treatments include: exams, prophylaxis (cleaning), space maintainers, and X-rays.

Q: What is basic dental work?

A: Basic treatments include: sealants for children under age 16 (limited to once for each permanent molar), fillings, root canals, extractions, scaling and root planing, and *repairs* to crowns, dentures, and bridges.

Q: What is major dental work?

A: Major treatments include: crowns, dentures, bridgework, surgical periodontics.

Q: If I choose dental coverage this year, can I drop it next year?

A: Yes. You may drop coverage during Open Enrollment; however, if you drop it and then choose to re-enroll in the Regular option or the DPPO option during a later Open Enrollment, you will be subject to the Late Entrant Limitation. The CIGNA Dental Care option does not have Late Entrant Limitations.

Q: Are there maximums on the amount the dental plan will pay?

A: The Regular option and the DPPO option plans will pay up to \$1,000 per covered person each plan year. There is a separate orthodontia lifetime maximum of \$1,500 per dependent child under age 19.

The CIGNA Dental Care option has no annual or lifetime maximums.

Q: Does the plan cover braces for adults?

A: The Regular option and the DPPO option plans do not provide benefits for adult orthodontia. The CIGNA Dental Care option provides benefits for both children (to age 19) and adults. The co-payment is slightly higher for adults.

Q: Do the orthodontia costs apply to my annual maximum of \$1,000 for dental coverage?

A: No, under the Regular option and the DPPO option there is a separate lifetime maximum for orthodontia. There are no annual or lifetime maximums under the CIGNA Dental Care option.

Q: How do I file a dental claim?

A: For the Regular option and the DPPO option, obtain a dental claim form from your personnel/payroll office. Complete the employee section before you go to the dentist. Have your dentist complete the dentist section of the form and file it with United Concordia.

For the CIGNA Dental Care option you do not need to file a claim. If your Patient Charge Schedule lists a copay for the services you received, you pay the dentist directly.

Q: If my dependent child (under age 19) began orthodontic treatment before I enroll in this plan, will it be considered a pre-existing condition?

A: Assuming you have dependent coverage and you are not a late entrant, under the Regular and DPPO option, even though the child already has the braces, the dental plan will pay, for ongoing ortho treatment, according to the Schedule of Benefits in the Dental Summary Plan Document applying the six (6) month waiting period for orthodontics. Although the CIGNA Dental Care plan has no pre-existing conditions clauses, the plan does exclude any work which is currently in progress.

Q: Must I get a pre-determination on dental expenses?

A: A pre-determination is not necessary under the Regular or DPPO plan, however, you should consider asking your dentist to request a pre-determination of benefits before treatment for complex procedures, such as crowns and root canals. If you use a non-DPPO dentist, you should consider submitting a pre-determination of benefits before you begin treatment. That way, you will know if the service is covered, and what your financial obligation will be.

A pre-estimate is not necessary under the CIGNA Dental Care plan, however, it is a good idea to go over the treatment plan established by your Network General Dentist.

Q: How is the "90th Percentile rate" determined?

A: The 90th Percentile rate is the rate charged for that procedure by 90% of dentists in the area. Such data is accumulated by many dental insurers and compiled by a third party.

Q: How can I find out more about dental benefits?

A: Representatives from United Concordia's Customer Services department are available Monday through Friday from 8:00 a.m. to 8:00 p.m. to answer any questions you may have concerning the dental plan. They can be reached at 1(866)215-2356.

For information regarding the CIGNA Dental Care option, you may call CIGNA Customer Service at 1(800)642-5810.

Q: Can I continue dental insurance when I retire or if I resign?

A: Any covered employee who terminates employment may continue dental coverage under the COBRA provision. The premium for this coverage is 102% of the premium rate paid by active employees.

Retirees after April 1, 1997 can continue dental coverage through deductions from the Employees' Retirement System, Teachers Retirement System, Public School Employees' Retirement System, Superior Court Judges Retirement System, or District Attorney's Retirement System. Retirees must be eligible to receive an immediate and sufficient retirement benefit from the retirement system. Deductions are after-tax only.

For additional details contact the Flexible Benefits Program at (404) 656-2730, if the call is local, or call toll free at 1(888)968-0490 outside the local area.

Q: When will I receive a dental I.D. card?

A: If you are a current employee enrolling in the Regular or DPPO option, United Concordia will mail your I.D. card to your home address in middle to late February. If you are a new employee, you will receive a card within three (3) to four (4) weeks.

If you are a new employee or enrolling in the CIGNA Dental Care option for the first time, your I.D. card will be mailed to your home address.

Q: What do I do if I need a replacement dental I.D. card?

A: If you are enrolled in the Regular or DPPO option, contact United Concordia at the toll-free number 1(866)215-2356 to order a replacement card.

If you are enrolled in the CIGNA Dental Care option, contact CIGNA Customer Service toll-free at 1(800)642-5810.

Long-Term Care

Q: Which insurance company is offering the long-term care insurance plan?

A: UnumProvident Life Insurance Company (Unum) is the insurance carrier for the long-term care insurance plan.

Q: What is long-term care insurance?

A: Long-term care insurance is coverage designed to assist with the cost of long-term care. Long-term care is the type of care received when someone needs assistance with daily living, either at home or in a facility, due to a condition related to the natural course of aging, or a chronic illness, severe long lasting physical impairment or disease, an accident, or because of a cognitive impairment, such as Alzheimer's disease.

Q: Who can participate in the long-term care option?

A: All employees who are eligible to participate in the State of Georgia Flexible Benefits Program are eligible to participate in the long-term care option through payroll deduction. Additionally, the plan is being offered on a direct-billed basis to spouses (you must be legally married), parents, and parents-in-law of eligible employees.

Q: Does the employee have to enroll in order for the spouse, parents and/or parents-in-law to be eligible to enroll?

A: No. The enrollment of the spouse and/or parents or parents-in-law is independent on the enrollment of the employee. As long as the employee is eligible to participate, the opportunity to enroll is also available to the spouse, parents, and parents-in-law.

Q: What is the definition of eligible "parents"?

A: Eligible parents are biological (natural), adoptive, or stepparents of eligible employees.

Q: Is there a medical underwriting process required for enrollment?

A: Current employees, who wish to enroll now, will need to obtain Unum's Application for Long Term Care Insurance and complete the medical questionnaire. Please refer to your Unum Enrollment Kit for further details. All subsequent annual enrollments will have the standard medical underwriting requirements for anyone electing for the first time or making changes.

You will be required to complete the LTC Insurance Application [medical underwriting form] and return to Unum postmarked by Tuesday, November 10, 2009 for approval.

Medical underwriting is always required for spouses, parents, and parents-in-law.

Q: How do I enroll in the long-term care plan?

A: Be sure to review the Unum Enrollment Kit prior to enrolling in the plan. You may obtain a kit from your personnel/payroll office or by calling Unum toll-free 1(888)764-3539. As an eligible employee, you may enroll by selecting the long-term care option on Electronic Enrollment.

For spouses, the LTC Enrollment Kit contains a Benefit Election form [enrollment form] and LTC Insurance Application [medical underwriting form].

Q: How do(es) my spouse, parents, or parents-in-law enroll?

A: If your spouse, parents, or parents-in-law want to enroll in the long-term care plan, they must complete a Benefit Election form (enrollment form) and a LTC Insurance Application (medical underwriting form), and forward them directly to Unum. Spouse forms are included in the employee's Enrollment Kit and parents (in-law) may obtain an Enrollment Kit from Unum by calling toll-free 1(888)764-3539, Monday - Friday, 8:00 am - 8:00 pm.

Q: What does long-term care insurance coverage pay?

A: UNUM's plan pays benefits based on the Benefit Level amount chosen as well as where care is received. The percent of your Monthly Benefit based on where you receive care is as follows:

- Care provided in a long-term care facility or nursing home--monthly benefit based on **100%** of your long-term care Benefit Level amount shown on electronic enrollment.
 - ✓ generally an institution or distinctly separate part of a hospital that provides skilled, intermediate and/or custodial care under state licensing and certification laws
- Care in an assisted living facility--monthly benefit based on **60%** of your long-term care Benefit Level amount
 - ✓ is licensed by the appropriate agency to provide ongoing care and services to a minimum of 10 inpatients in one location
- Professional Home Care Services--monthly benefit based on **60%** of your long-term care Benefit Level amount
 - ✓ includes visits to your home during which skilled nursing care, physical, respiratory, occupational, dietary or speech therapy or homemaker services are provided
- Total Home Care Services--monthly benefit based on **60%** of your long-term care Benefit Level amount
 - ✓ includes professional home care services as well as care received from any care providers of your choosing -- including relatives and friends who provide care in your home

Q: What are the benefit levels available?

A: There are three Benefit Levels from which you may choose:

- \$75 per day *with* a lifetime maximum benefit of \$136,875; or
- \$100 per day *with* a lifetime maximum benefit of \$182,500; or
- \$125 per day *with* a lifetime maximum benefit of \$228,125

For the Benefit Level selected, you may receive care in a(n):

- Long-term care facility at a Monthly Benefit of 100% of the Benefit Level;
- Assisted living facility at a Monthly Benefit of 60% of the Benefit Level; or
- Home care services at a Monthly Benefit of 60% of the Benefit Level.

Q: How are premiums determined for the long-term care plan?

A: For employees, premiums are based on their age as of October 1st prior to the date of hire and the amount of coverage (i.e., the Benefit Level) and additional features selected (i.e., Inflation Protection and/or Reduced Paid-Up). For spouses, parents, and parents-in-laws, premiums are based on the age of the insured at the time of enrollment, in addition to amount of coverage and additional features.

Q: Are premiums pre-tax or after-tax?

A: Premiums are after-tax.

Q: What methods of payment are available for long-term care premiums?

A: All active employees eligible to participate in the long-term care option may pay for this coverage through payroll deduction on a monthly basis. Spouses, parents, and/or parents-in-law will be billed directly from Unum. They will have the choice of paying quarterly, semi-annually, or annually. When an eligible family member enrolls in the plan, they must notify Unum of their preferred payment method.

Q: How does one qualify for benefits?

A: You must lose the ability to perform at least three Activities of Daily Living (ADLs) or suffer cognitive impairment after your effective date of coverage as defined in our contract. You will be considered to have lost the ability to perform an activity if you require stand-by assistance in order to perform it safely and completely. Benefits are payable directly to the insured once the insured has been assessed as having a functional or cognitive impairment (as defined by the plan) and has satisfied the waiting period.

Q: What are the Activities of Daily Living?

A: The Activities of Daily Living are: bathing, dressing, transferring, toileting, continence, and eating.

Q: What is a "functional impairment?"

A: The Unum definition of a functional impairment is the inability to perform, without human assistance, three or more of the Activities of Daily Living (ADLs) as follows:

- Bathing
- Dressing
- Transferring
- Toileting
- Continence
- Eating

Q: What is a "cognitive impairment"?

A: A cognitive impairment is an organic brain disorder diagnosed by a physician, where the individual is unable to function without causing danger to himself/herself or others. Alzheimer's disease and senile dementia are examples of cognitive impairments.

Q: What is the "Elimination Period"?

A: The elimination period is ninety (90) consecutive days beginning on the date a physician has determined that you have lost three (3) of six (6) Activities of Daily Living after your coverage effective date. You must satisfy this waiting period before benefits will be paid under this plan.

Q: Who determines if I have actually lost the ability to perform an Activity of Daily Living?

A: The determination is made by a Unum Disability Benefit Specialist, your physician, you, and your family.

Q: How is the date of loss determined?

A: A Unum Disability Benefit Specialist will work with you and your doctor to determine the date the loss began.

Q: How and when should I file a claim?

A: You and your physician are to complete and send in a claim form within 30 days after the loss of three (or more) Activities of Daily Living (ADLs) or Cognitive impairment. Unum recognizes and allows for extenuating circumstances. The loss should be expected to last beyond the Elimination Period of 90 days.

Q: Does my disability have to be permanent to qualify for benefits?

A: No. The definition of loss does not require a loss to be permanent in order to qualify for benefits.

Q: When do benefit payments begin?

A: Benefits begin in the month following the end of the Elimination Period, prorated to the first day after the Elimination Period was satisfied.

Q: To whom are benefit checks sent?

A: Benefits are paid directly to you, and you decide how to spend this money. If you wish, benefit payments may be sent directly to your care provider, or to a facility.

Q: How often are benefits paid?

A: Benefit payments are sent at the end of each month.

Q: Are benefits received through a long-term care plan taxable?

A: This issue varies from state to state. The State of Georgia's long-term care plan is considered a "tax qualified" plan. As such, benefits up to a daily maximum of \$180 are not considered taxable income. Check with your tax accountant or the IRS regarding the possibility of itemizing the premiums that you pay.

Q: Does the long-term care benefit integrate with other benefits?

A: Long-term care benefits do not usually integrate with other benefits you may have.

Q: Does Unum pay benefits even if a relative or friend is the one who takes care of me?

A: Yes. This plan allows payment for informal care.

Q: If my care expenses are lower than the amount of my benefit, will I still receive the full amount?

A: Yes. Your monthly benefit amount is a flat figure, based on the level of coverage you elect and where you receive care, regardless of what you actually spend on care.

Q: What is the follow-up process once I am receiving benefits?

A: Once you are receiving benefits, you will continue to receive benefits for as long as you meet Unum's definition of disability and you have not reached your Lifetime Maximum Benefit amount. As long as you are receiving benefits, Unum will follow-up on your condition by placing a call to you and/or your caregiver, and/or your doctor, if detailed medical information is required. Unum may follow-up monthly in the beginning, and then less frequently - usually every three months. In an extenuating circumstance, a face-to-face assessment may be needed.

Q: If I lose three Activities of Daily Living (ADLs), but am able to work, am I eligible for benefits?

A: Yes. Receipt of benefits is determined solely by meeting benefit eligibility as it is defined in the contract. As long as you have experienced the loss of the ability to perform three or more ADLs or suffer cognitive impairment after your effective date of coverage, you would be eligible for benefits.

Q: What is the Non-Forfeiture, Reduced Paid-Up Option?

A: This option is offered at an additional premium. If you choose this option and the required premiums are paid under this option for at least five (5) consecutive years and then you stop paying premiums, a percentage of your Monthly Benefit Maximum(s) and Lifetime Maximum Amount will automatically continue.

Q: What is Inflation Protection?

A: The Inflation Protection Benefit is an optional feature offered at an additional cost. It automatically increases your overall level of coverage by 5% annually.

Q: Can I continue this long-term care insurance if I leave state employment or retire?

A: Yes. This long-term care insurance plan is portable. You may continue your coverage by applying within 30 days of the termination date. Premiums will be at the same group rates. As long as you continue to pay your premiums directly to the insurance company, your insurance will not be canceled.

Q: Is there a pre-existing conditions clause with the long-term care plan?

A: If you are guaranteed coverage because you are an employee who elected long-term care insurance when first eligible, *a pre-existing condition limitation applies*. A pre-existing condition is a sickness or injury for which the insured received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines in the six months immediately preceding their effective date of coverage. If the insured suffers a cognitive or functional loss within 6 months after their effective date of coverage, and that loss is directly related to a pre-existing condition, then no benefits will be payable until both the six-month period and the waiting period have been fulfilled.

Q: If I have any questions, or if my spouse, parents, and parents-in-law have any questions about this plan, who can we call?

A: Any eligible employee and their eligible family members may call Unum toll-free at 1(888)764-3539 or just remember 1(888)SOG-FLEX.

NOTES:

Vision Insurance

Q: What is the name of the insurance carrier for the vision option?

A: OptumHealth Vision is the carrier for the vision plan.

Q: What is a Vision Plan?

A: The OptumHealth Vision Care program is a full service, freedom of choice program that offers both in-network and out-of-network benefits. In-network providers (or eye care professionals) are available statewide. It provides covered benefits for routine eye exams, glasses, and contacts after you make your co-payment at an In-Network provider. It allows members to access Refractive Eye Surgery at a discounted rate from numerous provider locations.

Q: Do I have a choice of Vision Plan options?

A: Yes, you may elect either the Select Vision plan or the Select Plus Vision plan that covers tints, UV, polycarbonate and basic progressive lenses. See table below for benefits.

Q: Why should I have a regular eye exam?

A: Regular eye examinations are important to your overall health. Regular eye examinations tend to detect early eye disease development, as well as potential health problems. Undiagnosed subtle visual performance problems can also make work and play less fulfilling.

Q: What are network providers?

A: Network providers have an agreement with OptumHealth Vision to provide many “covered in full” benefits, quality service and customer satisfaction. Through a network provider, some services are covered in full after your co-payment. Under the Select Plan, additional services, such as coatings and progressives will be your responsibility but at cost less than normal.

Q: How do I know which vision providers are network providers?

A: Access to your benefits is easy. Simply call OptumHealth Vision’s 24-hour, toll free Provider Locator Service at 1(800) 839-3242 and follow the voice prompts. Following

the voice prompts, simply enter your unique identification number and your work or home ZIP code. The system will respond with a list of the names, addresses, and telephone numbers of conveniently located providers.

Or, you may log on OptumHealth Vision's website at www.myoptumhealthvision.com and click on the Provider Locator option. You will be provided with the names, addresses, telephone numbers, and door-to-door directions to the most convenient providers in your area. Simply call the provider directly to make an appointment

Q: What are out-of-network providers?

A: OptumHealth Vision is a freedom of choice program, and as such, a participant can go to any eye care professional and be eligible for covered benefits. An out-of-network provider is an eye care professional that has not contracted with OptumHealth Vision to provide services. If you go to an out-of-network provider, simply save all your receipts for your one-time benefit for the period and submit them (at the same time) to OptumHealth Vision. You will receive reimbursement according to your benefit schedule.

You should submit all receipts for all services at the same time to:

OptumHealth Vision
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

The following information should be included with the itemized receipt submission:

- Covered member's name and address
- Patient's name and date of birth
- Covered member's unique identification number

Q: What are my vision insurance choices?

A: You can enroll in either the Select Vision program or the Select Plus Vision program by marking the appropriate box on the electronic enrollment and selecting Employee, EE plus spouse, EE plus children or EE plus family.

Q: What are my premiums based on?

A: Your premiums for vision insurance are based on a flat group rate, depending on the coverage option (Select or Select Plus) you elect and the level of coverage you select (e.g. employee, EE plus spouse, EE plus children or EE plus family).

Q: Are my premiums for the vision insurance pre-tax?

A: Yes. Premiums for the single and family options are pre-tax, and depending on your tax bracket, could result in a 20%-25% tax savings.

Q: If I enroll in family coverage, who is covered?

A: If you enroll in family coverage, all of your eligible dependents will be covered.

Q: Is there a medical underwriting process required for enrollment?

A: No. There are no medical underwriting requirements.

Q: What if I want to stay with my Departmental/Educational Institution plan?

A: If your Departmental/Educational Institution plan is continuing its plan, you may stay with that plan.

Q: Do vision benefits coordinate with another vision plan I may have?

A: No. OptumHealth Vision does not coordinate benefits so you always obtain the benefit under the OptumHealth Vision plan.

Q: I have vision coverage under my medical plan, should I keep OptumHealth coverage as well?

A: Yes, OptumHealth Vision is a stand-alone voluntary vision care plan. OptumHealth Vision does not coordinate benefits with other vision coverage, so members can access care independently of any other vision coverage they may have. OptumHealth Vision will provide the full level of benefits available under your OptumHealth Vision plan regardless of the other coverage.

Q: Will I receive a vision I.D. card?

A: No. Access to the network's vision care program is easy, fully automated, and does not require the use of an I.D. card or claim form. When you arrange an appointment, identify yourself as a State of Georgia Employee who is enrolled in the OptumHealth Vision program.

Q: What benefits are paid under the vision plan?

A: See table for the Select Plan or the Table for the Select Plus Plan

Select Plan Option

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam <i>Every 12 months</i>	100% after \$10 copay	Reimburses up to \$40
Lenses Standard <i>Every 12 months</i>	100% after \$20 copay	
Single vision, or		Reimburses up to \$40
Lined Bifocal, or		Reimburses up to \$60
Lined Trifocal, or		Reimburses up to \$80
Lenticular		Reimburses up to \$80
Frames <i>Every 24 months after a \$20 materials copay*</i>	Retail locations (Wal-Mart) <ul style="list-style-type: none"> Up to \$130 retail allowance toward any frame package Frames below \$130 provided at no additional cost Private Doctors Office <ul style="list-style-type: none"> \$50 wholesale allowance towards any frame. You pay the difference. Group of select frames at no additional cost 	Reimburses up to \$45 of retail
Contact Lenses <i>Every 12 months in place of eyeglasses</i>		
Medically Necessary	Covered after \$20 materials copay	Reimburses up to \$210
Not Medically Necessary	Covered after \$20 material copay for covered lenses selected from OptumHealth's list. Up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a \$105 allowance that includes fitting, follow-up & materials. Please note to receive the full \$105 credit, you must receive your exam, fitting evaluation and all contact materials at the same	Up to \$105 max that includes fit, follow-up & materials

Flexible Benefits Program

	provider at the same time. (At Wal-Mart \$70 of the \$105 allowance is allocated to materials and \$35 to professional fees).	
Refractive Eye Surgery Access to discounted provider locations throughout the United States. To find a participating laser eye surgeon, visit our web site at www.mvoptumhealthvision.com	<u>Discount only:</u> The in-network benefit is a discount off the full retail price.	No benefits

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

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

Select Plus Plan Option

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam Every 12 months	100% after \$10 copay	Reimburses up to \$40
Lenses Standard <i>Every 12 months</i>	Lens Options covered are: Tints, UV, Polycarbonate and Basic Progressives lenses are covered.	OON Lens options are not covered.
Single vision, or	100% after \$25 copay	Reimburses up to \$40
Lined Bifocal, or	100% after \$25 copay	Reimburses up to \$60
Lined Trifocal, or	100% after \$25 copay	Reimburses up to \$80
Lenticular	100% after \$25 copay	Reimburses up to \$80
Frames <i>Every 24 months after a \$20 materials copay*</i>	Retail locations (Wal-Mart) <ul style="list-style-type: none"> Up to \$130 retail allowance toward any frame package Frames below \$130 provided at no additional cost Private Doctors Office <ul style="list-style-type: none"> \$50 wholesale allowance towards any frame. You pay the difference. Group of select frames at no additional cost 	Reimburses up to \$45 of retail
Contact Lenses <i>Every 12 months in place of eyeglasses</i>		
Medically Necessary	Covered after \$25 materials copay	Reimburses up to \$210
Not Medically Necessary	Covered after \$25 material copay for covered lenses selected from OptumHealth's list. Up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a	Up to \$125 max that includes fit, follow-up & materials

	\$125 allowance that includes fitting, follow-up & materials. Please note to receive the full \$125 credit, you must receive your exam, fitting evaluation and all contact materials at the same provider at the same time. (At Wal-Mart \$70 of the \$125 allowance is allocated to materials and \$55 to professional fees).	
Refractive Eye Surgery Access to discounted provider locations throughout the United States. To find a participating laser eye surgeon, visit our web site at www.myoptumhealthvision.com	<u>Discount only</u> : The in-network benefit is a discount off the full retail price.	No benefits

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

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

Q: What are the vision plan exclusions?

A: The vision care plan includes the following exclusions:

Replacement of lost lenses and/or frames. Lost or stolen lenses or frames furnished under this program are not covered and are the responsibility of the enrollee.

Medical or surgical treatment of eye conditions. Under no circumstances will OptumHealth Vision be responsible for payment for any medical or surgical services. If examination discloses that such treatment is required, notification of this exclusion will be communicated to the enrollee.

Services or materials for which the enrollee may be compensated under any Worker's Compensation Law or other similar employer's liability law, or services which the eligible enrollee, without cost, obtains from any federal, state, county, city, or other governmental organization.

OptumHealth covers standard single vision and standard lined multi-focal lenses for glasses. Under the Select Vision Program, cosmetic lens options such as scratch coating, UV coating, progressive lenses, etc., are not covered but are provided to OptumHealth members at savings. The Select Plus Vision Program offers coverage for Tints, UV, Polycarbonate and Basic Progressive lenses.

Any amounts above the plan's schedule or allowances or benefits received before the appropriate benefits period (12 or 24 months from the last date of service).

Q: Can I continue the vision insurance if I leave state employment or retire?

A: Yes. Any covered employee who terminates employment may temporarily continue vision coverage under the COBRA provision. The after-tax premium for this coverage is 102% of the premium rate paid by active employees.

Q: If I elect to continue coverage under COBRA, does my access to benefits remain as if I was still employed by the State, or does my access to benefits begin anew?

A: Your access remains the same as if you continued employment. Members have access to services per the plan's schedule (See Plan design). The member's access to benefits and benefits coverage remains the same even if they elect coverage under COBRA.

Q: When and how should I file a claim?

A: There are no claims to be filed if you utilize in-network services. You will only be responsible for any required co-payments and any non-covered services or equipment. You simply give the provider the employee's social security number and the patient's date of birth to receive benefits.

If you choose an out-of-network provider, you will be reimbursed based on your pre-determined schedule. Mail your itemized receipts (at the same time), with your Social Security Number and the patient's date of birth to:

*OptumHealth Vision
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130*

Q: What do I do if I have other questions?

A: OptumHealth Vision's customer service representatives are available to answer any questions participants may have regarding their benefits. You may reach OptumHealth

Vision's Customer Service department at 1-800-638-3120. All representatives are trained in the specifics of each plan.

Bilingual customer service representatives are available for non-English speaking employees.

Specified Critical Illness

Q: What is the name of the insurance company for the specified critical illness insurance option?

A: Continental American Insurance Company (CAIC) replacing the prior carrier, American General.

Q: How does the change in insurer affect me?

A: If you are currently covered your rate will decrease by 5%; you will receive a new certificate of coverage, and your benefits have been expanded at no additional cost. If you are not currently covered; you have access to an expanded benefit program for lower rates. (see additional questions below for benefit details).

Q: What is specified critical illness?

A: Insurance which provides a lump sum payout to you upon diagnosis of covered illness or certain conditions, meeting certain criteria.

Q: Who can participate?

A: Employees ages 18 – 69 are eligible to participate. When an employee reaches the age of 70, the coverage is reduced in half. Spouses are also eligible to participate, if the employee elects coverage. Eligible children are automatically covered at 10% of the employee's coverage amount.

Q: What are the certain conditions or illnesses?

A: The conditions are: Cancer, Renal Failure, Heart Attack, Stroke, Major Organ Transplant, Coma, Paralysis, Burns, Loss of Sight, Loss of Hearing, and Loss of Speech at 100% of maximum benefit. Carcinoma in Situ and Coronary Artery By-Pass Surgery are covered at 25% of maximum benefit.

Q: What are my coverage options?

A: You may choose a coverage amount (maximum benefit) of \$0, \$5,000, \$10,000, \$20,000, \$30,000, \$40,000, or \$50,000 for employee and \$5,000 or \$10,000 for the spouse (if the employee elects coverage). Eligible children are guaranteed coverage at 25% of the employee's coverage amount.

Q: What is the medical underwriting on this plan?

A: Current or newly eligible employees can select up to \$20,000 of coverage without medical underwriting for this Open Enrollment **ONLY**. Medical underwriting is required for employees selecting a coverage level greater than \$20,000. Be sure and complete the three additional questions for amounts from \$30,000 to \$50,000.

If an employee selects Specified Illness, you may choose a coverage amount of \$5,000 or \$10,000 for your spouse without medical underwriting for this Open Enrollment **ONLY**.

Eligible children are guaranteed coverage at 25% of the employee's coverage amount with no medical underwriting. Eligible children are covered regardless if you select coverage for your spouse. Coverage is to age 19, or 25 if currently enrolled in school.

Q: What are my premiums based on?

A: Your premiums for specified illness insurance are based on your age and the level of coverage chosen. The premium remains the same, as long as coverage is maintained. Coverage increases, if eligible, will be rated on the employees original issue age.

The premium for Spouse coverage is based on the employee's age. No premium will be required for eligible children.

Q: Are premiums pre-tax or after-tax?

A: Specified Illness premiums are after-tax.

Q: Are the benefits from the Specified Illness insurance taxed?

A: No. Benefits received from the specified illness insurance option are generally not taxed.

Q: What is a first occurrence benefit?

A: Lump sum benefit is payable upon initial diagnosis of a covered illness or condition after an insured is hospital confined for the specific critical illness and charged for room and board.

Q: What is an additional occurrence benefit?

A: If an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered illnesses, CAIC will pay the full benefit amount for any additional illness. The occurrences, however, must be separated by at least 6 months.

Q: What is a re-occurrence benefit?

A: If an insured receives full benefit for a covered condition and is later diagnosed with the same condition, carrier will pay the full benefit again. The two dates of diagnosis, however, must be separated by at least 12 months, or a minimum of 12 months treatment free for cancer.

Q: What is a Health Screening benefit?

A: An insured (employee/spouse) may receive a maximum of \$100 for any one covered health screening test per calendar year. This will be paid regardless of the results of the test. Covered health screening tests include: Mammography, Colonoscopy, Pap smear, Breast ultrasound, Chest x-ray, PSA, Stress test, Bone marrow testing, CA 15-3, CA 125, CEA, Flexible sigmoidoscopy, Hemocult analysis, Serum protein test, Thermography, and Fasting blood glucose, triglycerides, or serum cholesterol test.

Q: When can I make changes to my coverage?

A: Only during Open Enrollment, unless you have a Qualifying Event.

Q: Can a new hire get coverage when they become eligible during the year?

A: Yes, for amounts up to \$20,000 for the employee and \$10,000 for the spouse, no Medical Underwriting is required. For amounts in excess of \$20,000 for the employee, you will need to complete the online Medical Underwriting Evidence of Insurability Form within 30 days of your hire date.

Q: Is my coverage portable?

A: Yes, you may “port” coverage if the insured leaves SPA for any reason, if they had been continuously employed and covered for the prior 6 months. You must call CAIC at 1-800-308-6457, complete the appropriate paperwork, and set up direct payment.

Q: What do I do if I have other questions?

A: You may contact Continental American Insurance Company customer service toll free at 1(866) 849-2958 for additional information.

Health Savings Account

PLEASE NOTE: Effective January 1, 2010, the Health Savings Account is no longer an

Flexible Benefits Program

available option under the Flexible Benefits Plan.

Q: If I am currently enrolled in a Health Savings Account for 2009, can I maintain the account?

A: Yes. HSA accounts for 2009 may be maintained directly with the administrator, JP Morgan Chase. Individuals may contact toll free 1 800 893-0763 to receive more information.

Flexible Spending Accounts (FSA) – General Questions

Q: How will an FSA benefit me?

A: There are a number of advantages you can gain by enrolling in an FSA.

The Tax Advantage

An FSA offers you a way to pay for out-of-pocket expenses with money you set aside before any taxes are taken out. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after federal taxes are taken out.

Built-in budgeting

Another advantage of an FSA is built-in budgeting. By participating in the Health Care Spending Account and/or the Dependent (Child) Care Spending Account, you can ensure that funds are put away to be used for their intended purpose. In other words, you will know that you have money available specifically to pay for eligible medical and dependent care expenses.

Advance Reimbursement

For the Health Care Spending Account, you have access to the full amount you elect even before all of the contributions from your paycheck have been made. This means that at the beginning of the plan year, you have access to the total amount you elected for eligible health care expenses as soon as the expenses are incurred.

Q: How do I know how much to contribute to the spending accounts?

A: Worksheets are available on the internet at www.spendingaccount.shps.com to help you determine how much to contribute to your spending account(s).

Q: Who is covered?

A: Expenses for yourself and eligible dependents are covered by the spending accounts. Eligible dependents for the Health Care Spending Account include your spouse, children, and any other person who is a qualified IRS dependent. In essence, anyone you claim on your income tax form is an eligible dependent. Eligible dependents under your Dependent (Child) Care Spending Account include your children under age 13, your spouse if mentally or physically disabled, and any other person who is a qualified IRS dependent, regardless of age, who is mentally or physically incapable of caring for him or

herself.

Q: What kinds of expenses can I have reimbursed through the spending accounts?

A: Health Care Spending Account

Generally, any health care expenses that are *not* paid by any insurance plan are allowed. That includes such things as deductibles, co-payments, vision and hearing care, certain over-the-counter items, prescription eyeglasses, contacts, dental expenses, and other health care expenses allowed as tax deductions by the Internal Revenue Service (IRS).

The Health Care Spending Account works much like insurance. You can submit a claim for eligible expenses incurred during the Plan Year while your “coverage” is in effect. IRS considers expenses to be incurred when the medical treatment or service is provided, and *not when the employee is formally billed or pays for the medical care.*

IRS Publication 502 provides a detailed listing of tax-deductible items that may be eligible for a Health Care Spending Account. A copy of Publication 502 is available from your personnel/payroll office, your local public library, IRS office, or online at http://www.irs.gov/prod/forms_pubs/pubs.html

Dependent (Child) Care Account

Generally, expenses that are for the care and protection of dependents while you are working or looking for work are allowed. Many kinds of dependent care services are covered, including care in your home or in care facilities. Expenses are reimbursable for the care of children (under age 13) and for other IRS-eligible dependents incapable of self-care, such as an elderly parent who you claim as a dependent on your income tax.

If you are married, your spouse must be working, looking for work, or attending school (full-time) in order for dependent care expenses to be reimbursed. Expenses must be for care received during the Plan Year in which you are enrolled.

IRS Publication 503 provides information that may be eligible for a Dependent (Child) Care Spending Account. A copy of Publication 503 is available from your personnel/payroll office, your local public library, IRS office, or online at http://www.irs.gov/prod/forms_pubs/pubs.html.

Q: Why does SHPS show an annual elected amount that is less than what I elected to have in my FSA?

A. Administrative fees to participate in the account are deducted upfront from your reimbursement account. The monthly administration fees to participate in a Flexible Spending Account is \$3.20 a month. The total remains \$3.20 if participating in both.

That is (\$1.60 max. a pay period) for a total of \$38.40 maximum for the year.

Example:

You elect an annual of \$1200.00, which calculates to \$50.00 per pay period.

SHPS will show an annual elected amount of \$1161.60 (1200.00 – 38.40 fee).

Q: Is there a toll-free number I can call to get information on my account?

A: Yes. AccountLINK is an automated system available Monday through Saturday from 8 a.m. to 2 a.m. Eastern time. You can speak with a SHPS customer service counselor about your account(s) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday at 1-800-893-0763.

Q: How do I get my FSA money?

A: When you incur an eligible expense, complete a claim and submit it to SHPS with the required documentation. The processing area will evaluate and enter your claim for reimbursement. You may pick up a form at your personnel/payroll office or download a form from the SHPS web site at www.spendingaccount.shps.com or you may use the debit card to pay for eligible healthcare expenses.

Q: What is the processing time for claims?

A: Usually, SHPS processes claims in approximately five working days from date of receipt.

Q: How frequently are checks issued?

A: SHPS is routinely scheduled to issue checks on a **daily** basis from the Louisville, Kentucky

location.

Q: Can my reimbursement be direct deposited?

A: Yes. You must complete an Electronic Funds Transfer (EFT) Authorization Agreement and mail it to the address on the form. You may pick up a form at your personnel/payroll office or download a form from the SHPS web site at www.spendingaccount.shps.com.

Q: Is there a deadline for submitting expenses to the spending accounts?

A: Yes. All claims must be postmarked on or by May 31, 2010 or they will not be paid.

Q: Where do I send my claim forms?

A: You may fax your claims to 1(866)643-2219 or mail your claims to:

SHPS
FSA Processing Center
P. O. Box 34700
Louisville, KY 40232-4700

Q: What about online submission of claims?

A: Online submission is currently not available; however, you may scan your claim form and documentation and e-mail them to feedback@shps.com. While convenient, you should be aware that e-mailing your information is not a secure method of submission.

Q: Can I use my childcare account to pay for health care expenses?

A: No. The Dependent Care Spending Account is a separate account. You cannot transfer money between accounts, or submit claims that are not consistent with the expense eligibility requirements.

Q: Am I refunded the amount left in my FSA accounts at the end of the year?

A: No. The IRS has determined that an element of risk must be involved in any kind of benefit protection that provides a substantial tax savings. Therefore, the IRS has imposed the "use it

or lose it" regulation. Fortunately, due to the grace period adopted by the State of Georgia, you have 14 ½ months (until March 15 of the following Plan Year) to incur eligible expenses for your Health Care Spending Account. This grace period **does not** apply to Dependent Care Spending Accounts. In addition, you can avoid any loss of funds by carefully determining how much to set aside and by filing claims promptly.

Q: Where does the forfeited money go?

A: The IRS has imposed strict regulations for the use of forfeited money. The funds are used to defray the cost of administering the Plan.

Q: How will I know during the year how much I have left in my accounts?

A: You may call AccountLINK at 1(800)893-0763 or go to www.spendingaccount.shps.com to find out your account balance and when your last claim was paid. The account balance is also displayed on the Explanation of Benefits (EOB) which is issued each time a claim is processed. In addition, you will receive bi-monthly statements during the plan year. Statements show reimbursements paid to date, your account balance, and any debit card swipes that require paper substantiation.

Q: Do the spending accounts actually pay the provider of service?

A: No. Payment is made to the participant only.

Q: Will spending accounts earn interest?

A: No. Paying interest on FSA accounts is illegal. Depending on your tax bracket, the tax savings could represent a much higher savings rate than you could get in a regular interest bearing account.

Q: The process seems so complicated. Are the dollars I save really worth all this trouble?

A: Yes, in most cases. But really, the process is not very complex. The best explanation is an example of the savings. Assume that your annual pay is \$16,000, that you put \$1,000 into a health care account, and that you have \$1,000 in reimbursable expenses during the year. If

you pay those expenses without any tax advantage, as you are doing now, you will need to earn a salary of \$1,000 and the taxes on that amount.

To understand the tax advantage on this example, assume that you are married and file a joint return. You will need to earn \$1,240. That's \$1,000 for the expenses and another \$240 for federal and state income taxes and social security taxes.

Instead, if you take advantage of the spending account, you only need the \$1,000 deposited in your account from pre-tax dollars and don't need to earn the taxes. This would save you \$240 compared to paying these bills with after-tax dollars.

Q: I understand the advantages of the spending account. Can you give me information about the pitfalls?

A: Sure. If you don't use the money for eligible expenses, the money left over will be retained by the Plan to reduce expenses. In other words, you forfeit any unused money. Only under limited situations may you change your deposit amounts during the Plan Year for the spending accounts. If you have a qualified change in status, which affects your spending account, you may be able to change the deposit amount.

Q: Where can I get additional information on the tax treatment of FSAs, especially the advantages of the spending accounts versus the tax credit allowance?

A: Your tax advisor, a tax attorney, a certified public accountant, or another tax expert can help. Also, your tax instructions for filing income tax Form 1040 and the IRS Publications 502, 503, and 504 should help.

Dependent (Child) Care Spending Account (DC FSA)

Q: What is the maximum and minimum amount for the Dependent (Child) Care Spending Account?

A: You may put in a maximum of \$4,992 annually in your account if filing a joint return and \$2,500 annually if married and filing a separate return for the reimbursement of covered Dependent (Child) Care expenses. However, this amount may not exceed the lesser of

the amount of earned income claimed by you or your spouse. You may put in a minimum of \$120 annually (\$10 a month).

Q: Can both my spouse and I contribute the maximum to the Dependent (Child) Care Account if we both work for the State?

A: No. IRS regulations provide that the total of both of your contributions may not exceed \$5,000. Since the State of Georgia Flexible Benefits Program allows a \$416 per month maximum per participant, it is important that you and your spouse be careful to not have combined annual contributions, which exceed the IRS maximums.

Q: What are some of the other IRS requirements that affect the Dependent (Child) Care Spending Account?

A: Federal legislation requires the following:

Use of both the Dependent (Child) Care Spending Account AND the Federal income tax credit at the same time is limited. The amount allowed through a tax credit is directly offset by amounts reimbursed through the Dependent (Child) Care Spending Account.

Employees must include the care provider's name, address and tax I. D. number on their income tax return.

Employers are required to report the salary amount contributed to a Dependent (Child) Care account on the employee's W-2 form. These expenses cannot be duplicated as a tax credit and offset the amount allowed as a tax credit.

Q: What kind of Dependent (Child) Care is covered?

A: Care that is employment related. In other words, care necessary to allow the able adults in the household to work, look for work, or in some cases, to attend school. Eligible expenses include direct supervision of the dependent. For specific information, consult IRS Publication 503, "Child and Dependent Care Expenses."

Q: Will I be reimbursed for the full amount that I request on a Dependent (Child) Care

claim form?

A: Yes. As long as your claim is valid (containing the required documentation) and doesn't exceed the amount you have in your account, you will be reimbursed for the amount of your request (up to your total contribution for the year minus any amounts already reimbursed to you). Claims exceeding your account balance will be paid as your payroll reductions are received from your department and the outstanding amount is for at least \$25. Claims can only be reimbursed for dates of service that have occurred at the time the claim is submitted

Q: Who can provide dependent care?

A: Several types of providers:

A dependent care center: If the facility provides care for more than six (6) individuals, the center must comply with applicable laws and regulations required for licensing.

An individual: You may arrange to have a neighbor or other individual provide care in your home or the neighbor's home. The individual providing the care cannot be your child, unless he or she is age 19 or older. Also, in no circumstance can the individual be a tax dependent claimed by you or your spouse. This individual must sign the claim form or be willing to give you a signed receipt for each payment.

An educational institution/school: You may use the portion of the total expense that is for before school and after school care since educational/tuition fees are not eligible. If your child is below the first grade and the cost of schooling cannot be separated from the cost of care, the employee will be responsible for making the allocation between the cost of schooling and the cost of care.

Q: May I use a Dependent (Child) Care account to pay for private school tuition?

A: You may *not* use your Dependent (Child) Care account to pay for school (public or private) tuition. However, you may use the account for any care services provided before or after school during your working hours. Physically or mentally handicapped children may be an exception. Check IRS Publication 503 "Child and Dependent Care Expenses."

Q: May I use my Dependent (Child) Care account to pay for sending my child to camp?

A: Day camp is fine, as long as the primary purpose is not education. The cost of sending a child to overnight camp is not an eligible expense.

Q: What if my spouse is a full-time student or is unable to care for him or herself?

A: Under IRS rules, the maximum amount you may contribute to the Dependent (Child) Care account is the least of your or your spouse's income or \$5,000. If your spouse is a full-time student or incapable of self-care, your spouse is assumed to have earned income of \$2,400 per year if you have one (1) eligible dependent for care and \$4,800 per year if you have two (2) or more eligible dependents.

Q: How is "incapable of self-care" defined?

A: An individual is physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for the individual's hygiene or nutritional needs, or requires full-time attention of another person for the individual's own safety or the safety of others. The inability of an individual to engage in any substantial gainful activity or to perform the normal household functions of a homemaker or care for minor children by reason of a physical or mental condition does not of itself establish that the individual is physically or mentally incapable of self-care.

Q: How is full-time student defined?

A: For the purposes of the Dependent (Child) Care Spending Account, the IRS considers an individual a full-time student if he or she attends an accredited educational institution for at least five (5) months in a calendar year. A full load of courses must be taken.

Q: I am divorced but do not claim my child as a tax exemption. Can I establish a Dependent Care Spending Account?

A: For children of divorced or separated parents, only the custodial parent can claim a tax credit or establish a dependent care FSA, even if the other parent may claim a tax

exemption. The rule applies to a child who is a qualifying individual and who (i) receives over one-half of his support from one or both parents who are divorced or legally separated; and (ii) is in the custody of one or both parents for more than one-half of the calendar year.¹ Under this rule, the custodial parent may claim the tax credit (or establish a dependent care FSA) even if the other parent may claim a tax exemption for the child. A child can be the qualifying individual of only one parent in one taxable year.

Q: What happens to the balances in my Dependent (Child) Care Spending Account if I leave State employment?

A: If you leave the State during the year, you can continue to submit eligible Dependent (Child) Care expenses for the Plan Year in which you leave until the money in your account is used up. At the end of the year, you will also have through May 31 to submit any Dependent (Child) Care expenses incurred in the previous Plan Year. The same provisions apply if you are away from work on a leave of absence.

Health Care Spending Account (HCSA)

Q: How does the 2 ½ month grace period affect my Health Care Spending Account?

A: For the HCSA you now have an extra 2 ½ months at the end of the year to incur eligible expenses before you must forfeit unspent funds. This means that you may be reimbursed for services incurred through March 15, 2010. This greatly increases your opportunities to spend your entire allotment within the 14 ½ month period.

Q: What is the maximum and minimum amount for a Health Care Spending Account?

A: You may put in a maximum of \$5,040 annually (\$420 a month). The minimum is \$120

annually (\$10 a month).

Q: Does a Health Care Spending Account replace my medical plan?

A: No. The Health Care Spending Accounts offer you a means to pay for eligible out-of-pocket health care expenses with pre-tax money. You (or your provider) should first submit your claims to your health plan so that they can pay according to the plan limits. Then, the remaining out-of-pocket eligible expenses can be submitted to your Health Care Spending Account Plan.

Q: Will I be reimbursed for the full amount I request on a Health Care Claim Form?

A: You can access the full amount you elect for the Health Care Spending Account at the beginning of the Plan Year. This means that you have access to the "elected coverage amount" for eligible health care expenses just as soon as the date of service is incurred.

- Your "*Elected Coverage Amount*" is the number of months for which you are expected to continue during the remainder of the Plan Year. That number will be twelve (12) for most people; for new employees, it will be less than twelve (12).
- As an example, let's assume that during the fall Open Enrollment period, a current employee decides to contribute \$20 a month to the Health Care Spending Account. The number of months the employee is expected to contribute will be twelve (12) months (January through December); those 12 months multiplied by \$20 comes to \$240. The *Elected Coverage Amount* of \$240 is the maximum amount for which the employee may receive reimbursement for eligible health care expenses incurred during the Plan Year and while the employee is covered under the Plan.

Q: What does the IRS consider to be "medical care?"

A: Medical care expenses include amounts paid for the diagnosis, cure, treatment, or prevention of disease, and for treatments affecting any part or function of the body. *The expenses must be to alleviate or prevent a physical defect or illness. Expenses for solely cosmetic reasons generally are not expenses for medical care.*

Q: What does the IRS consider to be a cosmetic procedure?

A: Generally, cosmetic surgery is considered to be any procedure that is performed to improve the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. Procedures such as face lifts, hair transplants, hair removal (electrolysis), teeth whitening, bonding, and liposuction are not considered to be eligible expenses through the Health Care Spending Account. However, you can include in medical expenses the amount you pay for cosmetic surgery if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. If you have a specific question regarding cosmetic surgery, call the Spending Account Program directly.

Q: My spouse is employed and is covered by group medical insurance. Can I submit his/her coinsurance payment or deductible from another health plan to my spending account for payment?

A: Yes. For the HCSA, you may submit expenses for your spouse just as you would submit expenses for yourself. However, it is illegal to submit expenses that have been paid by another insurance plan as well as those reimbursed by another spending account.

Q: My children are covered under my spouse's group medical coverage as well as my own. Do I need to file expenses incurred on behalf of my children with both insurance carriers?

A: Yes. Explanation of Benefits from both insurance carriers is required. This also applies when there is an ex-spouse who also has coverage for your children.

Q: What about dental/vision/hearing expenses that are not reimbursed by insurance benefits?

A: For the HCSA, vision care expenses for things such as routine eye exams, prescription contact lenses, or prescription eyeglasses are eligible for reimbursement from your account as are hearing expenses and most dental and orthodontic expenses not reimbursed by any plan.

Dental and vision procedures that are done strictly for cosmetic purposes are not eligible for

reimbursement.

Q: What about certain over-the-counter (OTC) items?

A: OTC items are eligible to submit through your Health Care Spending Account if they are used for a medical reason. Some examples include antacids, allergy medications, pain relievers, and cold medicines, none of which require a physician's prescription. When submitting your claims for OTC expenses, you must provide an itemized receipt including the date of service you made the purchase, the name of the over the counter item(s), and the name and address of the provider.

Q: How will our dental plan coordinate with the spending accounts?

A: Any expenses not paid by any dental plan (co-payments, deductibles, adult orthodontia, etc.) can be paid from the HCSA, as long as the expenses are not considered cosmetic in nature.

Q: Will I be reimbursed for orthodontic expenses on a monthly basis or in one lump sum?

A: Orthodontic expenses are reimbursed from your HCSA as the expenses are *incurred and paid*.

Typically, the orthodontist will provide a “contract” of expected expenses and requires approximately one-third payment in advance. The remaining fees are coordinated with monthly visits and adjustments for the employee. In this situation, the expenses are incurred and paid on a monthly basis and reimbursed from the spending account on a monthly basis.

If a dental insurance plan is covering a portion of the expenses, the orthodontist typically files with the dental insurance for payment on a monthly (or quarterly) basis. In this situation, the expenses are incurred and paid on a monthly (or quarterly) basis and reimbursed from the spending account on a monthly (or quarterly) basis.

- Sometimes, if there is no dental insurance involved, an employee will elect to pay the expense in full at the time the bands are placed. In this situation, the expenses are incurred and paid at the same time and reimbursed from the spending account in one

lump sum.

In any of the situations listed, if you have incurred and paid orthodontic expenses on a monthly basis or in one lump sum, the Spending Account Program will reimburse you provided that you attach the appropriate documentation.

Q: Do my dependents have to be covered under my medical plan for me to request reimbursement for their non-covered expenses?

A: No. Any health expenses allowed by the IRS that are not paid by any other plan may be submitted to the Health Care Spending Account.

Q: Do I have to file my expenses with my insurance plan first even if I have not met the deductible?

A: Yes. You must file with any insurance company through which you have coverage and obtain the appropriate Explanation of Benefits (EOB) before filing with the HCSA program.

Q. What do I provide as documentation if my health insurance does not provide an Explanation of Benefits for prescription drugs?

A: You should provide an itemized receipt which includes the actual date of service (including the year), the type of service received, the total amount charged, the name of the patient, and the complete name, address, and telephone number of the service provider.

Q: If I do not have any insurance coverage, how can I be reimbursed?

A: For items not covered under any insurance plan, you should submit an itemized receipt which includes the actual date of service (including the year), the type of service received, the total amount charged, the name of the patient, and the complete name, address and telephone number of the service provider.

Q: Are the expenses I submit to the spending account deductible on my income tax return at year-end?

A: No, because you have already received reimbursement with tax-free dollars. Only expenses not reimbursed through an insurance plan or spending account may be claimed on your income tax return.

Q: If I terminate, can I continue to file claims?

A: Yes. Your actual coverage will end at the end of the calendar month following your last regular monthly contribution. For example, if you terminate employment on October 31, your last contribution to your Health Care Spending Account would be taken from your October 31 paycheck. Your coverage would end November. Therefore, if you submit a claim for expenses incurred on or after December 1, your claim would not be paid. You can continue to file claims for eligible expenses that were incurred during your "coverage period" until September 30th following the end of the Plan.

You may update your "coverage period" after you terminate state employment for a limited period of time under the rules of the federal law called COBRA. For more information on updating your coverage through COBRA, contact the Flexible Benefits Program at 404-656-2730 (inside metro Atlanta) or 1(888)968-0490 (outside metro Atlanta).

SHPS Debit Visa Card

Q: What can I use the Spending Account Visa Card for?

A: You may use the card to pay for eligible Health Care expenses.

Q: When can I start using my Spending Account Visa Card?

A: You may begin using the card at the beginning of the plan year once funds have been made available and after you have activated and signed the card.

Q: Is there a fee for using the Spending Account Visa Card?

A: There is no fee to use the Spending Account Visa card.

Q: Will I get a new card each year?

A: No, but you will receive a new card before your current card expires. Your card expires on the date listed on the front of the card or when you are no longer a member of the

Flexible Benefit Spending Account program.

Q: How many cards are issued for each family?

A: When you enroll Health Care Spending Account, you will receive a VISA Savings and/or Spending Account Card for purchases of eligible health-care expenses. You may request up to 4 additional cards with your spouse or dependent's name on it, for a fee of \$5.00 per card.

Q: Where can I obtain a complete list of eligible expenses?

A: Visit www.spendingaccount.shps.com to obtain a list of eligible spending account qualified expenses.

Q: Can I use the SHPS Spending Account Card for over-the-counter (OTC) medicine purchases?

A: You can use your card to purchase OTC items. Please remember to only purchase health-related items that are eligible under your Plan. Please see your benefit plan documents or visit www.spendingaccount.shps.com for a listing of eligible items.

Q: What should I do if I receive services from a person or facility that doesn't accept the card?

A: Pay for the expense by other means, and then file a claim for reimbursement. Access a claim form at www.spendingaccount.shps.com or by calling Customer Service at the phone number listed on the back of your card. You should receive reimbursement within five to seven business days after filing your claim with SHPS.

Q: My card did not work when I tried to use it. What could be the problem?

A: There are a few possibilities:

- The merchant is not classified as a qualified spending account service provider (e.g., convenience store).
- Your purchase is not eligible or covered by your company's plan. Examples include magazines, cosmetics, or vitamins.
- You do not have sufficient funds in your account to cover the entire amount of your purchase.

- Your card has been suspended temporarily due to problems validating certain expenses you've paid with the card previously.
- The card system is temporarily shut down.
- You selected "debit" when you swiped the card. Even though the card says "debit card" you must select "credit" when using it to make purchases because you do not have a personal identification number (PIN).

If you're unable to use the card for your purchase, you may pay for the expense with another form of payment and then file a claim for reimbursement.

Q: What should I do if I don't want to use the SHPS Spending Account Card to pay for any eligible expenses?

A: For the Health Care Spending Account, you may pay from your personal bank account and submit your eligible expenses to SHPS for reimbursement.

Q: What if the amount of my expense is greater than my account balance?

A: For the HCSA, your account balance is credited for the full year of monthly contributions.

Q: Can I use the SHPS Spending Account Visa Card to purchase items, such as prescription drugs and contacts, by mail order or online?

A: Yes. Simply enter your card number for items such as prescription drugs or, contacts, as you would when purchasing online with a credit card.

Q: What if my card is lost or stolen?

A: To report a lost or stolen card, call Customer Service at 1(888)835-3060. SHPS will mail a replacement card to you. A card replacement fee of \$15.00 will apply.

Q: How can I access my account information?

A: You can go online to www.spendingaccount.shps.com to check your account status, or you may call SHPS AccountLINK toll free at 1(800)893-0763 to speak to a customer service agent regarding your current account balance and status of your last claim. .

Q: How do you automatically substantiate my transactions?

A: SHPS has the ability to obtain general information from various plans, retailers, and vision centers that can be used to auto-substantiate your expenses. If SHPS is unable to auto-substantiate your transaction, additional information will be requested for you.

Q: When will I have to submit receipts or EOBs?

A: You will be notified by SHPS, if receipts or additional EOB information is required to properly substantiate your transactions. Receipts will be requested either monthly or bi-monthly.

Q: Are OTC items able to be auto-substantiated?

A: Some OTC items can be auto-substantiated without the need to submit receipt information. If you purchase your OTC items at your local retailer, then most likely you will be required to submit additional receipt information or prove it was an eligible OTC item. Go to www.spendingaccount.shps.com to find out more.

Q: Why didn't it auto-substantiate?

A: There are multiple reasons that could impact why your transaction wasn't automatically substantiated. Some of the common reasons are as follows:

- Timing of claims when they are received from the Pharmacy Benefit Managers, Health & Dental plans, Rx Retailers, and Vision Centers.
- Tax information wasn't automatically forwarded to us to use in our substantiation routine.
- You don't belong to a health, dental, or vision plan that we have partnered with to receive the general claim information that is used to auto-substantiate.

The Enrollment Process

Q: How do I enroll?

A: To enroll in the Flexible Benefits Program, make your online selections during Electronic Enrollment and print your confirmation screen. Also, you may have to complete some other forms by the required deadlines:

- **SHBP Dependent and Miscellaneous Update Form** if you are signing up for family health coverage during Open Enrollment; after Open Enrollment, use this form only to add or delete dependents or for other miscellaneous updates on your health coverage;
- **Enrollment Supplement for HMOs Form** if you are signing up for an HMO for the first time, are changing to family coverage, or are changing HMOs;
- **HMO Residence Requirement Waiver Form**, if you are signing up for an HMO and you work in but do not live in the HMO service area.
- **Discontinuation of Health Benefit Coverage Form** if you discontinue your

coverage during Open Enrollment;

- **Declination of Health Benefit Coverage Form** if you decline your coverage as a new employee;
- **State Health Benefit Plan Membership Form** if you are enrolling for the first time, transferring, or completing another allowable change after the Open Enrollment period;
- **Minnesota Life Beneficiary Election Form** if you choose life and/or accidental death insurance for the first time or want to change your beneficiary;
- **CAIC American General Medical Underwriting Form – Online Evidence of Insurability** for Specified Illness; if required.
- **Minnesota Life Medical Underwriting Form – Online Evidence of Insurability** for life, spouse life, and child life; if required.
- **The Standard Disability Medical Underwriting Form – Online Evidence of Insurability** for long-term disability, if required.
- **Unum Long Term Care Insurance Application** if enrolling for the first time as a current employee or if choosing to increase a coverage level and/or add an optional feature.
- **Dentist Selection Form** if enrolling in the Prepaid Dental option. Call Cigna at 1(800)642-5810 for the form.

Q: What if the information on the Electronic Enrollment webpage is wrong?

A: There are four elements on your Electronic Enrollment information that are critical to calculating options available, coverage levels, and the monthly premiums. If your county of residence, date of birth, disability retirement eligibility status, or salary as of October 1 or as of your date of hire (if you are hired during the Plan Year after October 1) is incorrect, contact your personnel/payroll office *immediately*. If you have proof that you are eligible for disability retirement through your retirement system, submit that proof to your personnel/ payroll office.

Q: Can I continue participating in my Departmental/Educational Institution plans, too?

Flexible Benefits Program

A: You may continue participating in any Departmental/Educational Institution plans for life or disability that are similar to programs offered under this Program. You may have dental coverage in the Flexible Benefits Program and dental coverage through a Departmental/Educational Institution plan. Your department plan will be considered the primary insurer; the Flexible Benefits dental plan will coordinate benefits and be considered the secondary insurer.

Q: Can I drop these coverages at any time?

A: No. When you enroll in the Flexible Benefits Program and confirm your choices online, you are making your benefit choices for the entire Plan Year. If you leave active State employment and then return during the same Plan Year, your previous choices will remain in effect. Under very limited circumstances, you may change some of your choices during the Plan Year; see the Terms and Conditions on the Electronic Enrollment page for details and your “*You Decide!*” booklet.

Q: How long do my choices last?

A: The Plan Year for the Flexible Benefits Program begins on January 1 and continues through December 31 of the same year. Assuming you have met all of the administrative and contractual requirements and continue to pay premiums each month, your coverage will continue throughout the Plan Year. Every Open Enrollment (October-November), you'll be able to choose to continue or change your benefit options.

Q: When can I change my choices?

A: You can change your choices once a year, during Open Enrollment, for the upcoming January through December. If you have a qualified family status change or involuntarily lose other coverage, you may be eligible to change some of your coverages if you notify your agency and request the change within a specified time frame. All requests resulting in a change in coverage must be filed within thirty (30) days of the event. For additional details, refer to Internal Revenue Service Regulations, the rules for the Flexible Benefits Program, FLEX User's Guide Procedure Number 88-U140, "Changes In Coverage Due to Changes in Family Status," and the rules of the State Health Benefit Plan.

Q: What's the enrollment deadline?

A: Open Enrollment ends on **Tuesday, November 10, 2009**. Some departments require an earlier deadline. The deadline for our department is _____. However, it would be to your benefit to enroll as quickly as possible. That way, you may receive confirmation of your options more quickly.

Q: Whom do I contact if I have questions?

A: For general questions about the Program, contact your personnel/payroll office. Benefit telephone numbers are listed on the back cover of the *"You Decide!"* enrollment booklet.

For specific questions about the State Health Benefit Plan, call (404)651-6142 or 1(800)483-6983. If you have questions about an HMO, contact that HMO.

Contact the Flexible Benefits Program at (404)656-2730, if in the Atlanta area, or call toll-free at 1(888)968-0490, for specific questions about life, spouse life, child life, AD&D, short-term disability, long-term disability, dental, vision, specified illness, spending accounts, and health savings account.

Contact the GE Signature Legalcare at 1(800)848-2012 for specific details about the legal option. Contact Unum at toll-free 1(888)SOG-FLEX or 1(888)764-3539 for information about the long-term care option.

Q: How will I know if my choices were recorded properly?

A: After you have made your choices during Open Enrollment through the Team Georgia website, it will be updated into the FLEX system. Your department will receive two (2) copies of a personalized Confirmation Statement listing your choices. Your department is responsible for forwarding a copy of this statement to you before your choices go into effect. If you do not receive a copy, ask your personnel/payroll office for one.

Q: What should I do with my Confirmation Statement?

A: When you receive your Confirmation Statement, review it carefully. Compare the

choices on this statement with those showing on your Electronic Enrollment confirmation page. Be sure to review the messages on the back of the Confirmation Statement for reminders about medical underwriting requirements and coverages limitations, if applicable.

If the choices do not agree, contact your personnel/payroll office *immediately*. It is your responsibility to notify your agency of errors in your payroll deductions for Flexible Benefits; if you fail to contact your agency regarding errors, you may be required to maintain the option for the duration of the Plan Year.

Q: What happens if I don't do Electronic Enrollment?

A: You are encouraged to go online and to choose the benefit coverage that is right for you. If you don't make your online selections by the deadline, you will continue to be covered under the same benefits in which you participate now--with updated premiums. By not making any online selections, you are agreeing to keep the same options that you already have.

Q: How do I decline coverage in some areas?

A: Under each option area, there is a "no coverage" box. If you do not wish to be covered by that option, check that box. Before you decline or discontinue coverage, refer to your "*You Decide!*" enrollment booklet. If you discontinue health coverage, you must complete a Discontinuation of Health Benefit Coverage Form along with marking "no coverage" on Electronic Enrollment. If you decline health coverage, you must complete a Declination of Health Benefit Coverage Form.

Q: How do I change the tax status of my life insurance coverage?

A: Click on the box shown on the Electronic Enrollment's life page indicating that you either want to elect after-tax premiums for life insurance or discontinue your after-tax premiums. Be sure to verify that the tax status of your life insurance is correctly reflected on your Confirmation Statement.

Options When Leaving State Employment

Q: Can I continue my insurance coverages when I leave State employment?

A: Not all insurance coverages may be continued after leaving State employment. However, some coverages may be continued on a temporary basis, while others may be continued as long as you pay the premiums. Depending on the reason an employee is leaving State employment (i.e., retirement or resignation), some insurance coverages may be continued through the retirement systems, some may be continued through COBRA, some may be converted or ported, and some may be direct-billed through the insurance carrier.

Q: What coverages are eligible to be taken out of my retirement check?

A: If an employee is eligible to retire and immediately draw a retirement check from an eligible retirement system, health insurance and dental insurance can be continued, provided the employee was already enrolled as an active employee.

Q: Can I pick up coverage under health insurance after I retire?

A: No. An employee must be enrolled as an active employee and continue the coverage into retirement.

Q: Can I pick up coverage under dental insurance after I retire?

A: No. An employee must be enrolled as an active employee and continue the coverage into retirement.

Q: What if I resign from State employment without being eligible to retire? Can I continue my health insurance?

A: Yes, through COBRA you can continue your health insurance on a temporary basis. Also, if you are a state employee and have eight or more years of service, you can continue coverage on a permanent basis, provided annual premiums are kept current. Teachers and other school-system employees may continue coverage if they have 20 or more years of service.

Q: What is COBRA?

A: COBRA is a federal law named the Consolidated Omnibus Budget Reconciliation Act. This law allows "Temporary Extended Coverage" of health and medical related insurances under certain conditions of loss of coverage to "extended beneficiaries." Personal premium payments are required in order to continue the coverage. Under COBRA, health, dental, vision, and the Health Care Spending Account (HCSA) are available.

Q: Who is an "extended beneficiary"?

A: An "extended beneficiary" is an individual who was covered as an active or retired employee, employee on approved leave of absence without pay or a person who was covered as a spouse or eligible dependent of an active or retired employee or employee on approved leave of absence without pay on the date of the loss of coverage under the health, dental, or HCSA.

Q: How do I enroll in COBRA?

A: Eligible employees will be provided a COBRA enrollment form and instructions, including the premium amount within 45 days of the coverage termination date. The State Health Benefit Plan (SHBP) is responsible for mailing the COBRA notice for the health insurance option; Flexible Benefits is responsible for mailing the COBRA notice for dental, vision, and the HCSA.

If an employee is covered under health, dental, vision, and/or HCSA, the employee will receive two (2) separate COBRA enrollment forms -- one for the health insurance and one for the dental, vision, and/or HCSA. Each COBRA enrollment form must be completed and returned to the address noted on the instructions (with the premium) in order to continue coverage.

Contact the SHBP Eligibility Section at (404)651-6142 or toll-free 1(800)483-6983 for details on the health insurance, and the Flexible Benefits Program at (404)656-2730, if a local call, or call toll-free 1(888)968-0490 for details on the dental, vision, and HCSA plans.

Q: What are the premium payments under COBRA?

A: The premiums for COBRA continuation are 102% of the total premium.

Q: How long can I continue coverage under COBRA?

A: Eligible employees can continue Dental or Vision coverage for a maximum period of 18 months under COBRA. The HCSA can be continued for the remainder of the Plan Year. An additional 11 months of coverage may be provided to an extended beneficiary that meets the definition of disability under Title XVI of the Social Security Act. This special extension applies to the disabled beneficiary and any other eligible family members. Eligibility for the additional 11 months is based on the beneficiary notifying the Administrator (SHBP and/or Flexible Benefits) no later than 60 days following the date of Social Security determination. And, notice of the Social Security Disability approval must be given within the initial 18-month continuation period.

If the employee does not elect to continue coverage under COBRA, an eligible dependent of the employee may elect coverage. If the employee has family coverage and does not make an election to continue, a qualifying dependent for the employee may be eligible to continue coverage for a maximum period of 36 months.

Q: Will the same coverage be provided under COBRA?

A: Yes. Employees interested in the HCSA should note that contributions through COBRA will be paid on an after-tax basis. Therefore, an employee may not benefit from continuing the HCSA under COBRA, unless he/she has not already incurred eligible expenses within the coverage period. As the HCSA has features similar to an insurance product in that coverage is provided on a month to month basis, if an employee leaves State employment during the 2008 Plan Year, coverage for the spending account may not be available for the entire Plan Year. Employees have a deadline of May 15, 2009 to submit claims for eligible expenses incurred during the coverage period. For more information regarding the HCSA, please contact the Flexible Benefits Program at (404) 656-2730, if calling locally, or call toll-free 1(888)968-0490.

Q: Can I convert my dental insurance?

A: Only the Prepaid dental option has a conversion provision. However, all the dental

options qualify for COBRA continuation.

Q: Can I continue my life, spouse life, child life, and accidental death and dismemberment (AD&D) options?

A: Yes. A "conversion" option is available for the life, spouse life, child life, and AD&D options. Subject to certain conditions, a "portability" option is also available for the life and dependent life options. Please contact Minnesota Life Branch office at (404)522-1660.

Q: What does the term "conversion" mean?

A: "Conversion" refers to the purchase of an individual policy, following the loss of coverage under a group plan. Conversion is available to employees covered under the life, spouse life, child life, and accidental death and dismemberment (AD&D) options. Under conversion the employee must apply within 30 days of the loss of coverage under the group term life insurance plan to "convert" to an individual whole life policy.

Q: Would medical underwriting be required to convert the life insurance?

A: No. All employees, regardless of medical condition, are eligible to convert their coverage to an individual policy, as long as the filing is completed within the 30 day time limit.

Q: What does "portability" mean?

A: "Portability" refers to the continuation of your group term life insurance on an individual direct billing basis. Portability is available for the life, spouse life, and child life options to employees who are not leaving State employment due to a sickness or injury. Employees must apply within 30 days of the loss of coverage under the group term life insurance plan to "port" to an individual term life policy.

Q: Would medical underwriting be required to port the life insurance?

A: No. As long as the employee is keeping the same or decreasing the amount of coverage. Employees are eligible to port their coverage, as long as the filing is completed within the

30-day time limit. However, to be eligible to use the portability option, employees cannot be leaving State employment due to sickness or injury.

Q: Can I increase my life insurance after leaving State employment?

A: Employees using the portability option can increase their coverage subject to medical underwriting (proof of good health). Only the employee life coverage is eligible to be increased; the amount of spouse life and child life cannot be increased.

Q: What is the difference between a whole life and term life policy?

A: Term life insurance is the type of insurance you have while covered under the group plan. It does not provide cash value and premiums will increase as you age. Whole life insurance is a level premium individual life insurance policy (premiums do not increase with age), and cash value begins to build after the policy has been in force for two years. Because the whole life policy contains the cash value feature, the rates are generally higher.

Q: Can I continue my legal insurance?

A: Yes. You may continue your legal coverage to the end of the Plan Year during which you leave State employment. The employee has the option of being direct-billed for the legal insurance, as long as the employee contacts the insurance carrier within 30 days of the loss of coverage. To ask for direct-billing, contact the legal insurance plan for more information at 1(800)848-2012.

Q: Can I continue my long-term care insurance?

A: Yes. Long-term care coverage is an individual product, and the employee has the option of being direct-billed for the long-term care insurance. The employee must contact the insurance carrier within 31 days of the loss of coverage. To ask for direct-billing, contact UNUM at 1(800)227-4165 for more information.

Q: Can either or both of the disability plans be continued after leaving State employment?

A: The short-term disability insurance cannot be continued as an individual policy after the end of state employment. The long-term disability insurance can be continued as an individual policy after the end of state employment, except in the case of retirement.

Q: What if I have a disability that begins prior to leaving State employment?

A: The policy does specify that an employee whose total disability began while the policy was in force (prior to the coverage termination under the group plan) is eligible to file for disability benefits, subject to the terms and conditions of the group policy. Refer to the Disability Summary Plan Document for details.

Also, an employee who is considered "totally and permanently disabled", as defined in the Minnesota Life Summary Plan Document, may apply to continue coverage under the "Total Disability - Annual Proof (Waiver of Premium)" provision.

Q: What happens to the Dependent Care Spending Account (DCSA)?

A: The DCSA may not be continued after leaving State employment. Any eligible expenses incurred during the time you are covered may be submitted for payment during the remainder of the Plan Year (January 1, 2009 through December 31, 2009) and during the grace period ending May 15, 2010. For more information regarding the DCSA after leaving State employment, please refer to the Spending Account information section or contact the Flexible Benefits Spending Accounts Section at (404) 656-2730, if calling locally, or call toll-free 1(888)968-0490.

Q: Can I continue my specified illness insurance?

A: Yes. Specified illness can be kept as an individual policy, and the employee will be direct-billed for the specified illness insurance. The employee must contact the insurance carrier within 30 days of the loss of coverage. To ask for direct-billing, contact CAIC American General at 1(866)849-2958 for more information.

Handling Questions on Enrollment

Your job is to give the employee the information needed to make whatever decisions are best for that individual--not to "sell" the employee on any particular decisions.

With this in mind, it's important to observe these rules:

DON'T.....

- Venture opinions on future tax laws, savings needs, and advantages and disadvantages of the plan. Confine your discussion to the use of materials provided and factual information.
- Say anything that can be taken as advice on taxes or enrollment decisions, which the employee has to make. Emphasize that employees are responsible for making their own choice and no one is being forced to participate in any option.

DO

- Review the Plan's provisions with the employee, explaining what it will and won't do.
- Help the employee understand the mechanics of making their choices during Electronic Enrollment and completing the online forms.
- Feel free to use any of the factual information you've been given.
- Encourage the employee to see a professional tax expert--particularly those employees making decisions about the child care spending account vs. the dependent care tax credit.

Questions to Aid Flexible Benefits Enrollment

When an employee asks you for assistance in considering options, you may find it helpful to ask some or all of these questions:

1. Are you married?
2. Does your spouse work?
3. Does your spouse have benefit coverage where he/she works? If so, what coverage is available at what cost?

Medical?
Dental?
HMO?
Life insurance?
Spouse life insurance?
Child life insurance?
Accident or AD&D insurance?
Long-term Disability?
Short-term Disability?
Legal insurance?
Long-term Care?
Vision?
Specified Illness insurance?

4. Do you have private insurance coverage of any kind? If so, what coverage is available at what cost?

Medical?
Dental?
HMO?
Life insurance?
Spouse life insurance?
Child life insurance?
Accident or AD&D insurance?
Long-term Disability?
Short-term Disability?
Legal insurance?
Long-term Care?

Vision?
Specified Illness insurance?
Retirement plans?

5. Do you have children?
 - How old?
 - How many?
 - Do they live with you?

6. What is your age?

7. Do you know about any significant life changes this year?
 - Birth or adoption of child?
 - Divorce or separation?
 - Spouse changing jobs?

8. How much money can your family comfortably budget for medical expenses this year?
For all benefit coverages?

9. Do you have any hobbies or activities where you might be accidentally injured?

10. Are you currently using an income tax credit for dependent care?

Employee Question Response Form

If you don't know the answers to some questions and can't find the right information in this guide, be candid and say so. Write down the question and the name of the employee who asked it. Tell the employee you will get back with the answer as soon as possible. These boxes are for the meeting leader's use in noting questions for later response:

<p>Question:</p> <p>Name:</p> <p>Location/Phone:</p>
<p>Question:</p> <p>Name:</p> <p>Location/Phone:</p>

Question:

Name:

Location/Phone:

Question:

Name:

Location/Phone:

Question:

Name:

Location/Phone: