

BUILD YOUR BENEFITS

2018 OPEN ENROLLMENT



Consultants



OPTOMI™



TABLE OF CONTENTS

Welcome.....	4
Eligibility.....	5
Employee Contributions.....	6
Medical & Prescription Drug Benefits.....	7
Dental Benefits.....	8
Vision Benefits.....	9
Voluntary Life & AD&D.....	10
Key Contacts.....	11

Important Notice

Optomi has made every attempt to ensure the accuracy of the information described in this enrollment guide. Any discrepancy between this guide and the insurance contracts or other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to the insurance contracts and legal documents. Optomi reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible employees and Optomi share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with Optomi.

WELCOME

At Optomi, we truly value the dedication that goes into your work every day. We're proud of our talented consultants and understand that our success is because of you. That's why, as an Optomi consultant, you have access to a comprehensive, quality benefits package that offers flexibility and security.

As a newly-eligible employee, this is the perfect time to evaluate the best benefit options for you and your family. Be sure to consider factors like plan costs and what type of services you anticipate needing for the upcoming year.

You must affirmatively enroll if you wish to make elections for yourself or dependents in the medical, dental, vision, or voluntary life & AD&D benefits.

Please note that all elections are considered final and will be in effect until the end of the calendar year. You may not make changes throughout the plan year until the next Open Enrollment period unless you experience a Qualifying Event, such as marriage, divorce, legal separation, birth, adoption, custody, death or involuntary loss of coverage.

Please take the time to read and understand this guide so you can gain a better understanding of your options.



ELIGIBILITY

Full-time employees (working a minimum of 30 hours per week) and their eligible dependents can participate in Optomi benefits. Eligible dependents include:

- Your Legal Spouse
- Children up to age 26
- Children of any age if fully supported by you and incapable of self-support due to a qualifying disability

PROOF OF DEPENDENT ELIGIBILITY

You may be required to provide proof of eligibility for your dependents. If your dependent becomes ineligible for coverage during the year, you must contact Human Resources within 30 days of the Qualifying Event.

ENROLLMENT

Optomi provides a “paperless enrollment.” Enrollment elections are made using EmployDrive’s Self Service Portal. Please contact Human Resources for questions regarding how to access the system.

COMMON BENEFIT TERMS

Before reviewing your benefit choices for this year, here’s a refresher on some key health insurance vocabulary that will help you better understand your options:

Premium	The amount of money that’s paid for your health insurance every month.
Deductible	The amount of money you need to pay out of pocket before your insurance begins contributing money toward your health care costs.
Network	A group of doctors, hospitals, labs, and other providers that your health insurance contracts with so you can make visits at a pre-negotiated, discounted rate. You generally save money by visiting an in-network provider. To find a list of in-network providers, visit the insurance carrier’s website.
Copayment (Copay)	A predetermined dollar amount you pay for visits to the doctor, prescriptions, and other health care (as specified by your plan).
Coinsurance	The percentage you pay for the cost of covered health care services <i>after</i> you’ve met your deductible. For example, if the coinsurance under your plan is 40%, you would pay 40% of the cost of the service and your insurance would pay the remaining 60%.
Out-of-Pocket Maximum	The cap on your out-of-pocket costs for the plan year. Once you’ve reached this amount, your plan will cover 100% of your qualified medical expenses for the plan year.
Maximum Allowable Charge	The contracted fees for which a dental carrier will reimburse the dental provider for services rendered. If your out-of-network dental provider’s fees are more than the plan’s maximum allowed amount, you may be required to pay the difference.
Balance Billing	When a provider bills you for the difference between the provider’s charge and the maximum allowable charge. For example, if the provider’s charge is \$100 and the maximum allowable amount is \$70, the provider may bill you for the remaining \$30. A preferred in-network provider will not balance bill you for covered services.
Social Security Normal Retirement Age (SSNRA)	The age at which a person can receive full Social Security retirement benefits (“primary insurance amount”) upon leaving the workforce. This age varies from age 65 to age 67 based on year of birth.

EMPLOYEE CONTRIBUTIONS

Semi-monthly payroll deduction amounts for each of the benefits being offered are listed below. The deductions for Medical, Dental & Vision are considered pre-tax benefits and will be taken from your paycheck accordingly. All other benefits will be taken on a post-tax basis.

SEMI-MONTHLY CONTRIBUTION SUMMARY

Benefit	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Base Plan - OAP2H 5K/30 6.6 RxH	\$146.83	\$293.66	\$278.98	\$455.18
Buy-Up Plan 1 - OAP5 3K/0	\$213.77	\$427.53	\$406.16	\$662.68
Buy-Up Plan 2 - OAP5 1K/20 3K A	\$236.46	\$472.92	\$449.28	\$733.03
Base Plan - Dental Plan	\$17.50	\$35.16	\$42.49	\$59.94
Buy-Up 1 - Dental Plan	\$21.38	\$42.95	\$51.66	\$73.22
Vision Plan	\$2.84	\$5.73	\$5.44	\$8.55
Voluntary Life & AD&D	See page 10 for rate details			

HOW TO LOCATE A PROVIDER IN THE BCBSGA NETWORK

Your network for residents in the state of Georgia is Blue Open Access POS. For all non-Georgia residents, your network is the National PPO (Blue Card PPO). Using an in-network provider is the most cost effective way to maximize your benefits. Please review the medical carrier website at www.bcbsga.com for more information on doctors in your network.

Listed below are the steps you will use to locate a Provider within your designated Network:

1. Visit <https://www.bcbsga.com/health-insurance/provider-directory/searchcriteria> to get started. If you are not enrolled in a plan you will search as a "Guest" and then choose "Continue" at the bottom of the page.
2. You must answer the questions on next page to continue. Please note, your benefits are offered through your employer.
3. You must enter your state and choose "Medical" as the "Type Of Care" when completing your search options.
4. Please see below for which network to use based upon your location. Choose "Continue" at the bottom of the page.
5. The next page will allow you to drill down further to find a specific Provider or a group of Providers within a certain distance from the zip code you entered.

FOR GEORGIA EMPLOYEES:

Select your state: GA
 Select Plan Type/Network : POS
 Select Plan Name : Blue Open Access POS

FOR NON-GEORGIA EMPLOYEES

Select Your State
 Select Plan Type/Network: PPO
 Select Plan Name: National PPO(Blue Card PPO)

MEDICAL & PRESCRIPTION DRUG BENEFITS

You and your dependents have the choice of three quality and comprehensive medical plans that include prescription drug coverage. When choosing your plan, consider your budget, your preferences, your health and your covered dependents' health. The information below is a summary of coverage only.

MEDICAL BENEFITS – BLUE CROSS BLUE SHIELD OF GEORGIA

Key Features	Base Plan OAP2H 5K/30 7.15K		Buy-Up Plan 1 OAP5 3K/0		Buy-Up Plan 2 OAP5 1K/20 3K A	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Calendar Year Deductible						
Individual	\$5,000	\$15,000	\$3,000	\$9,000	\$1,000	\$3,000
Family	\$10,000	\$30,000	\$6,000	\$18,000	\$2,000	\$6,000
Out-of-Pocket Maximum						
copays, coinsurance and deductibles (medical & pharmacy) apply towards the annual out-of-pocket maximum .						
Individual (includes deductible)	\$7,150	\$21,450	\$4,000	\$12,000	\$3,000	\$9,000
Family (includes deductible)	\$14,300	\$42,900	\$8,000	\$24,000	\$6,000	\$18,000
Coinsurance <u>(Plan Pays)</u>	70%	50%	100%	70%	80%	60%
Coinsurance <u>(You Pay)</u>	30%	50%	0%	30%	20%	40%
Physician Services	**Office visits limited to a combined 3-visit copay max for Primary Care, Specialists and Telemedicine. For all visits after the 3 rd visit, the member pays 30% after deductible.					
Office Visit	**\$35	50%*	\$25	30%*	\$25	40%*
Specialist Visit	**\$35	50%*	\$50	30%*	\$50	40%*
Preventive Care	Plan Pays 100%	50%*	Plan Pays 100%	30%*	Plan Pays 100%	40%*
Telemedicine	\$35	50%*	\$25	30%*	\$25	40%*
Diagnostic Lab and X-Ray Services	30%*	50%*	Plan Pays 100%	30%*	20%	40%*
Maternity Physicians Services <i>Global Care (prenatal, delivery & postpartum)</i>	30%*	50%*	Plan Pays 100%*	30%*	20%*	40%*
Hospital Services						
Inpatient & Physician Services	\$500 + 30%*	50%*	Plan Pays100%*	30%*	20%*	40%*
Outpatient & Physician Services	\$250 + 30%*	50%*	Plan Pays100%*	30%*	20%*	40%*
Emergency Treatment						
Urgent Care Copay	30%*	50%*	\$75	30%*	\$75	40%*
Emergency Room Copay <i>(waived if admitted)</i>	\$250 Co-Pay + 30%*		\$250 Co-Pay		\$250 Co-Pay	
Retail Prescriptions (30-day supply)	*\$750 Individual/\$1,500 Family Deductible <i>(Does not apply to tier 1 or tier 1 mail order)</i>		No Deductible		No Deductible	
Tier 1 - Generic	\$15		\$10		\$10	
Tier 2 - Preferred Brand	*\$50		\$45		\$40	
Tier 3 - Non-preferred Brand	*30% up to \$500 max		\$90		\$70	
Tier 4 - Specialty	Not Available		25% up to \$500 max		25% up to \$500 max	
Mail-Order Prescriptions (90-day supply)						
Generic, Preferred, Non-Preferred	2.5x Retail		2x Retail		2x Retail	

* Indicates what you will pay for those services after the Medical Deductible has been met.

DENTAL BENEFITS

You and your dependents may enroll in either the base or the buy-up dental. Both plans feature a network of dental care providers whose services you can access at a discounted rate. When you visit a participating in-network provider, you'll save money. If you choose to see a non-participating dentist, be aware that they are able to balance bill you for the difference between the total amount that the insurance carrier allows to be paid for the service (the "maximum allowable charge") and the amount the non-participating provider usually charges for the service.

DENTAL BENEFITS – BLUE CROSS BLUE SHIELD OF GEORGIA

Key Features	BASE PLAN		BUY-UP	
	Dental Complete In-Network Participating Providers	Dental Complete Out-of-Network Non-Participating Providers	Dental Complete In-Network Participating Providers	Dental Complete Out-of-Network Non-Participating Providers
Annual Maximum Benefit	\$1,000	\$1,000	\$1,500	\$1,500
Annual Deductible (<i>Restorative & Major Services Only</i>)				
Individual	\$50	\$50	\$50	\$50
Family	\$150	\$150	\$150	\$150
Dental Plan Benefits (<i>You Pay</i>)				
Diagnostic & Preventive <i>Exams, Cleanings, X-Rays, Fluoride & Sealants</i>	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Restorative (Basic)** <i>Filling, Extractions, Endodontics, Periodontics</i>	20%	20%	20%	20%
Major** <i>Crowns, Bridges</i>	50%	50%	50%	50%
Orthodontics (Children up to Age 19) Lifetime Maximum: \$1,000	Not Covered		50%	50%

****There is a 12-month benefit waiting period for Major Restorative and Prosthodontic Services. This also includes a 24-month waiting period for the replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.**

Participating Providers are dentists who have contracted with Blue Cross Blue Shield of Georgia to provide dental care to members at a negotiated rate. Participating dentists have agreed to accept a negotiated rate as payment in full for covered services. The negotiated rate is usually lower than the participating dentist's normal charge. By choosing a participating dentist, you will be responsible for any applicable deductible and coinsurance amounts, but you will not be responsible for amounts in excess of the negotiated rate for covered services.

Non-Participating Providers are dentists who have not contracted with Blue Cross Blue Shield of Georgia and therefore may charge their usual fee for services they provide to you. When you receive services from a non-participating provider, you will be responsible for any applicable deductible and coinsurance amounts, plus any charges in excess of the allowable charge. This means that if the non-participating dentist charges more than the allowable charge, the non-participating dentist may bill you for the difference.

VISION BENEFITS

You and your dependents have access to vision coverage through Blue Cross Blue Shield of Georgia. Blue Cross Blue Shield of Georgia has a large network of local providers, as well as major national providers, such as LensCrafters, Pearle Vision, Target Optical, JC Penny, and Sears Optical. In addition to the benefits detailed below, this plan offers discounts on LASIK surgery.

VISION BENEFITS – BLUE CROSS BLUE SHIELD OF GEORGIA

Key Features	In-Network	Out-of-Network
Examination & Co-Pays		
Exam Co-Pay	\$10 Copay	\$30 Allowance
Materials Co-Pay (Lenses)	\$10 Copay	
Frames		
Any frame available at provider location	\$130 Allowance + 20% off balance	\$40 Allowance
Lenses (Standard uncoated plastic)		
Single Vision	100% After Copay	\$25 Allowance
Bifocal	100% After Copay	\$40 Allowance
Trifocal	100% After Copay	\$55 Allowance
<i>Additional savings are available to members who want to add additional lens options such as transitional lenses, tinting, UV Coating, progressive lenses and Anti-Reflective Coating. See the Benefit Summary for detailed pricing.</i>		
Contact Lenses (In lieu of eyeglasses)		
Elective Disposable Lenses	\$130 Allowance	\$105 Allowance
Elective Conventional Lenses	\$130 allowance 15% off remaining balance	\$105 Allowance
Medically Necessary	100%	\$210 Allowance
Frequency		
Examinations	Once every 12 Months	
Frames	Once every 24 months	
Lenses	Once every 12 Months	
Contact Lenses	Once every 12 Months	



VOLUNTARY LIFE & AD&D - GREATER GEORGIA LIFE

You can purchase additional Voluntary Life and AD&D coverage for yourself and your dependents.

If you choose to increase your existing coverage amounts for you and/or your dependents, or if it has been more than 31 days since first becoming eligible for coverage, evidence of insurability is required and must be submitted to Greater Georgia Life for review prior to the approval of your coverage election. Evidence of insurability is a confidential health questionnaire required for coverage approval. These forms are available from your Human Resources department.

GUARANTEED ISSUE:

During your initial enrollment period you may elect amounts up to the guarantee issue amount listed in the chart below for you and/or your dependents without having to submit evidence of insurability. For all amounts elected above the guarantee issue, evidence of insurability must be submitted to and approved by Greater Georgia Life.

CALCULATING YOUR PREMIUMS:

To calculate your monthly premiums, multiply the number of units of \$1,000 of coverage elected by the rate for your age. Age-banded rates are detailed in the table below. Spouse rates are based on the employee's age, not the spouse's age.

Example: A 35-year-old employee chooses to elect \$100,000 in coverage (which is 100 units of \$1,000 in coverage). At 35-years-old, his rate is \$0.126 per \$1,000 in coverage. His monthly premium will be 100 x \$0.126, which equals \$12.60.

Voluntary Life & AD&D Monthly Rates per \$1,000 in Coverage	
Age Band	Employee & Spouse Spouse rates based on EE age
Under 25	\$0.100
25-29	\$0.091
30-34	\$0.100
35-39	\$0.126
40-44	\$0.192
45-49	\$0.282
50-54	\$0.433
55-59	\$0.682
60-64	\$0.977
65-69	\$1.663
70-74	\$7.903
Child Life Rates per \$1,000	
\$0.228	

Employee (Available in \$10,000 increments)	
Maximum Benefit	5x annual salary up to \$500K
Guarantee Issue	\$100,000
Portability Option	Included
Age Reduction Schedule	35% at age 65; 50% at age 70
Spouse (Available in \$5,000 increments)	
Maximum Benefit	50% of employee amount up to \$250K
Guarantee Issue	\$25,000
Portability Option	Included
Age Reduction Schedule	In accordance with employee age schedule
Child (Available in \$5,000 increments)	
Maximum Benefit	Up to \$10,000
Guarantee Issue	\$10,000
Eligibility	Coverage available up to age 26
Plan Features	
Conversion Option	Included
Portability Option	Included. This feature allows employees to keep group term life insurance for themselves and their families in force under a group trust after leaving Optomi, until they turn age 70. Rates for coverage for employees who elect to port their coverage are based on coverage for all individuals covered by the group trust.
Age Reduction	Benefit reduces by 35% at age 65, 50% at age 70. All coverage terminates at retirement.

KEY CONTACTS

Benefit	Carrier	Contact
<ul style="list-style-type: none"> • Medical • Retail Pharmacy 	Blue Cross Blue Shield of Georgia	<p>Network: Open Access POS www.bcbsga.com Ph. 1-855-397-9269</p> <p>Mail Order Rx Express Scripts www.bcbsga.com Ph. 1-866-281-4654</p>
<ul style="list-style-type: none"> • Dental 	Blue Cross Blue Shield of Georgia	<p>Network: Dental Complete www.bcbsga.com Ph. 1-877-604-2158</p>
<ul style="list-style-type: none"> • Vision 	Blue Cross Blue Shield of Georgia	<p>Network: Blue View Vision www.bcbsga.com Ph. 1-866-723-0515</p>
<ul style="list-style-type: none"> • Voluntary Life & AD&D 	<p>Greater Georgia Life a division of Blue Cross Blue Shield of Georgia</p>	<p>www.ggl.com Ph. 1-800-851-8544</p>

For further clarification regarding an insurance matter, or additional help regarding a claim or invoice, please reach out to your dedicated EPIC Benefits Support Team for assistance.

When calling an insurance company or the Benefits Support Team, please be prepared to provide the following information to expedite the resolution:

- Member ID or Social Security Number
- Home address and Date of Birth
- If calling regarding a claim, the date of service, the doctor's name, and the provider group information, if applicable.

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