CGI U.S. Benefits
Open Enrollment

Frequently Asked Questions (FAQ)

(Updated: October 30, 2017)

TOPICS:

ENROLLMENT

Q. What do I need to do before I enroll?
A. Take some time to review the U.S. Benefits Portal, which houses information on all of our benefit programs and provides valuable health care tips, tools and information. This site can be used as a point of reference year round.

www.cgi.com/usbenefits2018

- Login ID: **CGIUS**
- Password: **usbenefits2018**

Q. How and when do I enroll?
A: Once you read the materials and understand your options, use the online Open Enrollment (OE) Election tool between Nov. 6 and Nov. 17, 2017, to enroll in your 2018 benefits. You can access the tool starting Nov. 6 from the U.S. Benefits Portal (see previous question for URL and log in). From there you will be directed to the OE tool where you will need to log in using

your CGI enterprise credentials.

Q. Will the OE tool show my current 2017 elections?
A. Yes, you can print and review it as you make your 2018 elections.

Q: Can I make changes to my elections on the OE tool throughout the open enrollment period or am I committed to my initial election?
A. You can re-enter the OE tool at any time during the Open Enrollment period and modify your elections. Each time you make a change, you will receive an email confirmation. The last email confirmation, or last time you make changes, will be your final election.

Q. What happens if I do nothing during Open Enrollment?
A. If you do nothing, your current health savings account (HSA), medical, dental, and vision plan elections will carry over into the new plan year. However, your current health FSA, limited purpose health FSA, and dependent care FSA will not automatically roll to 2018. You must make new elections for flexible spending accounts.

Q. How can I confirm which plan(s) I am enrolled in during the year?
A. After making your 2018 elections, the OE tool emails an election confirmation statement to your CGI email address, which you should retain for your records. Throughout the year, visit the Human Resources Service Center (log in to CynerGI>My CGI>HR Service Center) to review your benefit elections, as well as your paystub, which contains the amounts paid by you and by CGI.

Q. Is the only method for enrolling in benefits via the online tool?
A. No, if absolutely necessary, a member can use paper forms to enroll. Please open a case on the HR Service Center or call 877-376-3653 to discuss your situation. The completed forms must be returned and processed before the enrollment deadline of Nov. 17.

MEDICAL PLAN OPTIONS AND INFORMATION

Q. Is there an annual or lifetime coverage maximum on the health benefits?
A. No, there are no annual or lifetime dollar maximums on the health benefits. However, limits may apply if the health care services are not legally considered to be “essential health benefits.”

Q. What are “essential health benefits”?
A. Essential health benefits include the following items and services:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services

- Preventive and wellness services, and chronic disease management
- Pediatric services

Q. Does the deductible accumulate toward the out-of-pocket maximum?
A. Yes, the annual deductible counts toward the out-of-pocket maximum for both the Select and Essential plans.

Q. Do out-of-network costs only accumulate toward the out-of-network deductible? If so, are emergency services handled any differently because you may not have the option of picking an in-network hospital in a true emergency?
A. Yes, "credit" toward meeting your deductible and out-of-pocket maximums will accumulate separately depending on whether you use in-network or out-of-network providers. For true emergencies, the claims would be processed at the in-network benefit level and would accumulate toward the in-network deductible and out-of-pocket maximum.

Q. If I don't wear contacts or glasses, does the medical coverage give me one visit per year to check my eyes?
A. Yes, Cigna medical coverage includes coverage for an annual eye exam as part of the preventive care benefit when you use a network provider. There is no coverage for lenses or frames under the preventive benefit. Members who participate in one of CGI's optional vision plans (UHC or VSP) receive one vision examination per plan year with a $10 copay for in-network providers; as well as coverage for contacts or glasses. Participants can be reimbursed up to $50 for exams at out-of-network providers).

Q. Do radiology/lab costs accumulate toward the out-of-pocket?
A. Yes, radiology/lab cumulates toward the out-of-pocket maximum in both the Select and Essential plans.

Q. How much do the MDLIVE and Amwell services cost?
A. MDLIVE and Amwell consultations cost $42 for both the Select and Essential plans until the deductible is met. Once the plan deductible is met, the benefits are paid at the plan coinsurance level (based on a $42 charge). Once the deductible and out-of-pocket maximums are met, the benefit will be covered at 100 percent.

Q. Do telehealth expenses count toward your in-network deductible?
A. Yes, telehealth visits via MDLive and Amwell count toward your deductible and annual out-of-pocket maximum.

Q. Do deductibles accumulate on a family basis for member/spouse/dependent, member/child and member/family tiers or can one individual hit the out-of-pocket maximum and have all of his individual health costs paid by the plan?
A. Members enrolled in member/spouse/dependent, member/child and member/family coverage must meet the ***total*** family deductible before eligible expenses are subject to coinsurance or out-of-pocket maximums. The combined total of eligible expenses of all family members must equal the family deductible before any plan benefits are paid for any one member. For example, an individual member enrolled in the Select plan family coverage must meet the $4,000 deductible before any expenses are subject to co-insurance and out-of-pocket maximum.

Q. What coverage is provided in the Cigna medical plans for acupuncture and chiropractic services?

A. Spinal therapy is covered up to 24 visits per year in both the Select and Essential plans. However, as of the sixth visit (either in or out of network), a medical necessity review and pre-authorization is required by Cigna in order to receive additional visits. Acupuncture is not covered under either of the Cigna plan options.

Q. I have single coverage at the beginning of the year. If I get married or have a baby later in the year what happens when I add my spouse or baby? Will I have to start my plan deductible all over again from $0 in order to meet the family deductible, or do I get credit for the portion I've already met myself?
A. Whatever amount has already been applied toward your annual deductible as a single participant will follow your move to family coverage when it happens within the same plan year. Although your annual deductible will increase from the single amount to the family amount due to the mid-year change, you may also have an opportunity to set aside more money into your HSA as a result.

PREMIUMS

Q. How much did medical premiums increase for 2018?
A. While health care costs are rising on average more than 8 percent across the U.S., CGI took a number of important steps to ease the burden on members and only increase the premium by 2 percent.

Q. Please define annual premium and why we should review this before we choose a health plan?
A. The annual premium is the total amount you pay for premiums for the calendar year. For example member-only coverage for the Select plan has a monthly premium of $90.13 and the annual premium is $1,081.56 ($90.13 x 12); the Essential Plan has premiums that are $54.55 per month and $654.60 for the annual premium. This means the Essential plan costs $426.96 less annually in premiums than the Select plan.

If you would like to know how much will come out of each paycheck for the benefits you select, you can divide the annual amount by the number of pay periods per year (26). For example, the Select medical option will cost $90.13 per month. To do the math for 26 pay periods:

- Divide the annual premium ($1,081.56) by 26 pay periods and you get $41.60 per pay period.

Q. Are there any benefits that are deducted just once per month rather than each pay period?
A. Yes, identity theft insurance and pet insurance benefits offerings will be deducted from the first paycheck every month, so please plan your cash flow accordingly when selecting these benefits.

SURCHARGES

Q. Are the surcharges in addition to the member premium costs? If so, what are they?
A. Yes, there are two surcharges: a $100 per month working spouse surcharge and a $50 per month tobacco/nicotine user surcharges applied to the CGI medical plan options.

Q. Do these surcharges apply to vision or dental coverage?
A. No, there are no surcharges for dental and vision coverage.

Q. Will the surcharges apply to newly hired members?
A. Yes, the surcharges apply to all current members as well as future members hired during the year.

Q. Are the responses to the surcharges (tobacco/nicotine and working spouse) on the honor system?
A. Yes, however if a member submits a false or inaccurate response to the questions, their medical and/or life insurance coverage may be voided and/or they may be liable for retroactive increased premium costs and may be subject to discipline, up to and including termination of employment if they submit false or inaccurate information to these questions.

Q. How are the spouse and tobacco/nicotine surcharges handled for CGI married members?
A. The tobacco surcharge is applied only to the member enrolled in medical benefits if he or she has used tobacco in the past six months. The spouse surcharge would apply only if benefits are available through another employer.

Q. Are the surcharges pre or post tax and how does it appear on your pay stub?
A. The surcharges are pre-tax and will appear as separate deductions.

WORKING SPOUSE SURCHARGES

Q. How is the spouse surcharge handled for members whose spouse is on Medicare, Medicaid, or Tricare?

A. The surcharge is not applicable for spouses on Medicare, Medicaid, or Tricare– the surcharge is applicable only for spouses who have benefits available through another employer.

Q. Will additional information be collected such as the spouse's monthly deductible, out-of-pocket maximum deductibles, co-pays for office visits, quality of care and medical coverage and additional surcharges for the working spouse?
A. No, the surcharge is only driven by access to medical coverage through a spouse's employer.

Q. My spouse's employer provides medical insurance, but my spouse waived coverage at open enrollment held earlier this year. How should I respond to the working spouse surcharge question?
A. Because your spouse has access to other coverage, you would have to answer "yes." Commonly, employer plans have provisions allowing enrollment changes for various life events. Typically changes are permitted for employees who have a working spouse whose employer holds open enrollment at a different time during the year. To avoid the CGI surcharge, we encourage your spouse to contact his or her employer to request a change to his or her medical election because CGI is going through the open enrollment process now. Your spouse will likely need to provide a copy of CGI materials validating the dates of the CGI open enrollment period.

Q. Is there any benefit to opting *out* of CGI coverage? For example, military families who receive health care benefits as a military spouse versus the spouse employed at CGI?
A. No, however it is important for you to pick coverage that best meets your needs. CGI is committed to providing competitive and cost-effective benefits.

Q: My spouse works part-time and has access to benefits. Is there a reduced amount for the working spouse surcharge that can be charged given the part-time status?
A: No, because your spouse has access to other coverage and can enroll in company's benefits, the CGI surcharge applies.

Q: If both my spouse and I work for CGI, can we use the family option or do you still have to use the individual option? Which way would prevent penalties?
A: If you and your spouse are both covered under the CGI health plan, you may each be enrolled as a participant or be covered as a dependent of the other person, but not both. The spouse surcharge would not apply because benefits are not available through another employer.

Q. Does the working spouse surcharge go away if the spouse's employer begins offering insurance mid-year?
A. The surcharge is driven by whether or not the spouse has access to medical coverage through the spouse's employer. The surcharge only "goes away" if your spouse used to have access to medical coverage through his or her employer and now no longer has access to medical coverage through his or her employer. If your spouse didn't have any coverage and is now offered coverage through his or her employer mid-year, the surcharge would apply even if you were not paying it before because your spouse now has access to coverage.

SMOKING SURCHARGES

Q: If I quit smoking today, will I get the surcharge dropped off after being tobacco free for six months?
A: The tobacco surcharge will be lifted upon completion of a qualified tobacco cessation program. CGI provides members with resources to become tobacco free. Medical plan participants are eligible for a cessation program that includes coaching and materials. For more information, call the customer service number on the back of your medical ID card or log into myCigna.com.

Q: Will CGI give members an option to enroll in a smoking cessation class or program?
A: Through CGI's medical plan, members can access a tobacco cessation program and materials at no cost.

Q: Do the surcharges go to CGI or Cigna? If CGI, what do you intend to do with the monies collected?
A: CGI's medical plans are self-insured, meaning CGI pays the cost of medical claims from its general assets. CGI also pays fees to the insurance companies that administer the plans. The surcharges are used to fund medical benefits costs.

Q: Can I get the surcharge removed if I enroll in and complete a tobacco cessation program?
A: Yes, members can take advantage of the tobacco cessation program offered through CGI's medical plan, and in doing so, take an important step toward better physical and financial health. Although the tobacco surcharge is applied only to the member's premium, covered spouses and adult children are also eligible to participate. The program includes telephonic coaching and nicotine replacement materials such as patches or gum. The surcharge will be lifted upon successful completion of the program.

Cigna's online tobacco cessation program lasts approximately six months. Through Cigna's telephonic program, participant and coach will have a completion program call to determine if

the participant has met their tobacco cessation goals and if the participant has a high level of confidence in their ability to remain tobacco free.

The minimum requirement for a successful program completion is typically a minimum of 30 days enrolled in the program (the initial assessment date is considered the enrollment date) and tobacco free for a minimum of 30 days.

PHARMACY

Q. How does the mandatory generic substitution program work?
A. In most cases when you take your prescription for a brand name medication to the pharmacy, your prescription will be filled with the generic equivalent. Generic medications contain the same strength and active ingredients as brand name medications but often cost much less. When you get to the pharmacy if you specify you want the brand name drug you will pay more -- and the cost difference between the brand and the generic drug **will not apply to your annual deductible or out of pocket maximum.**

Q. How is the cost of prescription drugs calculated?
A. Although prescription drugs are often priced based on whether they fall under generic, preferred brand, or non-preferred brand "tiers," the cost of drugs under an HSA-compatible plan falls under the deductible just like the medical costs. Instead of paying varying co-pays based on tiers, you pay the full cost of the drug until you meet your annual deductible (and coinsurance, if applicable) up to your annual out-of-pocket maximum.

In the Select Plan option, you will pay Cigna's negotiated discount rate for prescription drugs until you have met your annual deductible. Then, you and the Select plan pay on a "cost share" or co-insurance basis (you pay 10 percent, the plan pays 90 percent) until you have reached your annual out-of-pocket maximum. Once you have reached your annual out-of-pocket maximum, the Select plan will pay 100 percent of your covered costs for both medical and prescription drugs for the rest of the calendar year.

In the Essential Plan, you will pay Cigna's negotiated discount rate until you have met your annual deductible. Because the Essential Plan's annual deductible is the same thing as your annual out-of-pocket maximum, the Essential plan will pay 100 percent of your costs for both medical and prescription drugs for the rest of the calendar year.

Although the drug "tiers" may not seem obvious with this "first dollar" method of payment, it still pays to buy generic and to use mail order because you will frequently get better prices this way. However, that is not always true so the best thing to do is go shop! Check the Cigna website at www.mycigna.com or call Cigna at 855.411.9713 to see how much the drug costs. Then, call the retail pharmacies and see what the best price is for the drugs you need. Many commonly used drugs are available at Walmart for only $4 a script, so be sure to check there, too when you are finding the best price.

Q. What are the mail-order prescription benefits for the Cigna Plans?
A. Mail order dispenses a 90-day supply of your medication delivered to your home. You can download the order form from mycigna.com.

Q. Must I use mail order to get a 90-day supply?
A. No. For added convenience, you can purchase a 90-day supply of most maintenance medications at a participating Cigna network retail pharmacy. Not all retail pharmacies

participate in the 90-day program. To find a participating retail pharmacy, go to **Cigna.com/Rx90network.** The 90-retail supply may not apply to all your drugs. Certain drugs or categories of drugs will continue to require step therapy, have quantity limits and/or require prior authorization. Some specialty drugs are always limited to a 30-day supply and certain specialty drugs must be purchased through Cigna's designated specialty pharmacy. If you do not receive your specialty medication in the approved manner you will be responsible for the full cost and it will not apply to your annual deductible or out of pocket maximum.

Q. Are Oral Contraceptives covered under the Cigna Plans?
A. Yes, generally generic contraceptives are covered at no cost to you. You will pay Cigna's negotiated rate for non-generic contraceptive drugs until your annual plan deductible is reached, after which coinsurance applies in the case of the Select option. With the Essential plan once your deductible is met, the plan pays 100 percent for the remainder of the year.

Q. What drugs require Step Therapy or Prior Authorization?
A: Cigna requires you use certain drugs due to cost and medical efficacy unless you obtain approval through a coverage review. To check if your prescription needs prior authorization, visit www.mycigna.com or call Cigna's Customer Service at 855-411-9713.

Examples of drugs requiring step therapy:

- High blood pressure – Atacand, Atacand HRT, Avapro, Availed, etc.
- Sleep aids – Ambien CR, Edluar, Lunesta, Rozerem
- Stomach conditions – Aciphex, Dexilant, Prevacid, Prilosec, etc.

Q. What prescription drugs will continue to be subject to prior authorization by Cigna?
A. Examples of prescription drugs in this category include: Anti-Narcoleptic Agents, Cancer Therapies, Dermatologicals, Erythroid Stimulants, Interferons, Multiple Sclerosis Therapy, Myeloid Stimulants and Hemostatics.

Q. What drugs are currently subject to quantity and dose duration determinations?
A. Examples of prescription drugs in this category include: Anti-Emetics, Anti-Narcoleptic Agents and RA Agents.

Q. How will I know what drugs require prior authorization or quantity/dose and duration determinations?
A. Before filling a prescription the pharmacist will receive an alert and notify you when a drug requires authorization. Those who have a particular concern should call Cigna's Customer Service at 855-411-9713 to talk about the medications they are taking.

Q. Do prescription drug costs count toward the medical plan annual deductible?
A. Yes, prescription drug costs count toward the deductible for both the Select and Essential plans.

Q. Do prescription drug costs count toward the out-of-pocket max?
A. Yes, prescription drug costs count toward the out-of-pocket maximum for both the Select and Essential plans.

Q. When the out-of-pocket maximum is reached, are the prescription costs still the full amount, or does the plan pick up some of the cost?
A. The Select plan option begins paying its co-insurance share (90 percent) once the annual

deductible is reached and then pays at 100 percent once the out-of-pocket maximum is reached. The Essential plan begins paying at 100 percent as soon as the deductible is reached. There is no co-insurance with the Essential option, so the deductible itself is your out-of-pocket maximum.

OTHER HEALTH AND WELLNESS PROGRAMS

Q. Is the Health Risk Assessment, or HRA, kept private?
A. Yes, your responses to the questions are kept 100 percent private from any CGI member. CGI receives aggregate data reporting of the overall health status of the entire company. The only identifying information requested from you is your Member ID and this is to confirm that you have completed the Health Risk Assessment in order to be paid the wellness incentive.

Q. Is the information you fill out on the Health Risk Assessment stored somewhere?
A. The vendor compiles all information in a secure, encrypted location and only aggregate health data of the entire population will be reported to CGI.

Q. How do I earn CGI wellness incentives?
A. Details will be provided ahead of the incentive period to inform you about how and when you can earn wellness incentives.

Q. If you call MDLIVE or Amwell and they can't help you resolve your medical issue (i.e., no prescription written or referred to a specialist), are you charged the consult fee?
A. Yes, you will be charged the $42 fee for the telephonic consultation. It is similar to a doctor's office visit – you don't always get a prescription or an immediate resolution. MDLIVE and Amwell materials outline when it makes the most sense to call or when you should go see your regular physician.

Q. Will I need to enroll in MDLIVE or Amwell during open enrollment?
A. No, any member participating in a Cigna medical plan is eligible to use MDLIVE or Amwell. When you become enrolled in a Cigna medical option, you can pre-register for MDLIVE or Amwell so when you need a consult your medical history is available.

Q. How does a telehealth doctor prescribe a medication?
A. The physician phones in the prescription directly to your preferred pharmacy.

Q. How do I pay telehealth providers?
A. MDLIVE and Amwell accept debit cards, HSA, FSA as well as Visa, MasterCard, American Express, Discover, and PayPal.

Q. When is it considered a good reason to call, given that members will be charged no matter what the outcome is?
A. Telehealth is available 24/7/365 and a member can call if they're considering using the emergency room or urgent care center for a non-emergency issue, on vacation, on a business trip, away from home and for short-term prescription refills. Telehealth is typically used for cold and flu symptoms, bronchitis, respiratory infection, sinus problems, allergies, urinary tract infection, pink eye, and ear infection.

Q. What if I'm not sure I need to call MDLIVE or Amwell; I don't want to pay the fee if I can avoid it.
A. Cigna has a free 24-hour nurse line. Whether it is guidance on medical treatment, or

assistance with a health question, you can always call and get live support 24 hours a day, seven days a week. To access the nurse information line, dial the toll-free number on your Cigna ID card to be connected to a specialist trained as a nurse who is ready to help answer your health questions.

HEALTH SAVINGS ACCOUNTS (HSAs)

HSA ELIGIBILITY AND CONTRIBUTIONS

Q. Am I eligible to contribute to an HSA Account?
A. You are eligible to contribute to an HSA as long as:

- You are a participant in an eligible High Deductible Health Plan, or HDHP
- You are not covered by any other health insurance plan that is not an HDHP
- You yourself are not covered by Medicare
- You yourself were not covered by Veteran's medical or Rx services during the last three months
- You are not active-duty military with Tricare coverage
- You are not claimed as a dependent on another person's tax return
- You or your spouse are not participating in a full Flexible Spending Account (Limited Flexible Spending Accounts are allowed)

If you contributed to an HSA in previous years and are enrolling in a medical plan in 2018 that is not an eligible HDHP, you still can take tax-free distributions from your HSA to pay for your medical claims. You just cannot **add** any **new** money in 2018 because you will no longer be enrolled in an HSA eligible HDHP.

Q. How do I open my HSA account for the first time?
A. Members participating in the Select or Essential plan option should navigate to this website and use the Group ID # 3311716.

Q. Can I have other kinds of insurance with an HSA?
A. Insurance **allowed** with an HSA:

- Accident
- Disability benefits, including VA disability benefits
- Dental care
- Vision care
- Long-term care
- Specified disease or illness
- Insurance that pays a fixed amount per day of hospitalization
- Limited-purpose FSA
- Limited-purpose Health Reimbursement Account

Insurance or accounts **not allowed** with an HSA:

- Health care FSA or full Health Reimbursement Account
- Medical coverage that is not HSA-compliant
- Any VA medical or Rx benefits used within previous three months

- Medicare Part A, B, D or a Medicare Advantage plan

Q. What is the maximum annual contribution limit for 2018?
A. The maximum is determined each year by the IRS. For 2017, the maximum is $3,450 for single coverage and $6,900 for family coverage. And, for those who turn age 55 or older in 2018 and are not eligible for Medicare, the IRS will permit an additional $1,000 in "catch-up" contributions. CGI's contribution counts toward the annual maximum, so make sure you include this amount ($500 per member or $1,000 per family) when you are trying to fund the annual maximum.

2018 IRS Limits

	Single Plan	Family Plan
Maximum Contribution Limit	$3,450	$6,900
Catch-up Contribution (55+)	$1,000	$1,000

Q. Can I make lump-sum contributions to my HSA?
A. Yes, you can make lump-sum post-tax contributions up to the annual maximum.

Q. Can I contribute to an HSA without enrolling in health insurance?
A. No, you must be enrolled in a HSA-compatible medical plan in order to open and fund an HSA bank account. In addition, to take advantage of CGI pre-tax payroll deductions and receive any CGI contributions to Optum Bank, you must be enrolled in either CGI's Select or Essential medical plan.

Q. My spouse has a flexible spending account, known as an FSA, or health reimbursement account, known as an HRA, through his employer; can I have an HSA?
A. You cannot contribute to an HSA if your spouse's health care FSA or HRA can pay for any of **your** medical expenses before your HSA-compliant health plan deductible is met. Usually, a health care FSA covers the expenses of the participant as well as the participant's spouse and any tax-qualified dependents in the household. If your spouse has a traditional health care FSA, your qualified medical expenses can be covered by your spouse's FSA. This means that your spouse's health care FSA will make you **ineligible** to make contributions to your own HSA.

There are exceptions to this rule because there are health care FSAs that meet the definition of "limited purpose" health care FSAs. Limited purpose FSAs only pay for dental and vision expenses. CGI offers a limited purpose FSA. You may want to check with your spouse's employer to find out if a limited purpose FSA is available for your spouse. As long as neither you nor your spouse has access to a traditional health care FSA, you can contribute to an HSA up to the annual maximum based on your HSA-compatible health plan enrollment ($3,450 per year for individual coverage and $6,900 for family coverage).

Q. What if I stop working for CGI in the middle of the year? Can I still contribute to an HSA?
A. If you end employment with CGI, you can continue contributing to your HSA only if you continue participating in an HSA-compatible health plan for the rest of the year. You can do this by enrolling in one of CGI's HSA-compatible health plan options through COBRA, or you can enroll in an HSA-compatible health plan option through a new employer, if one is offered. You can even purchase an HSA-compatible HDHP on the individual market or through one of the public health care marketplaces. If you take any of these options, you can continue to fund an HSA for the 2018 plan year.

If you leave CGI during the year and you do **not** enroll in another HSA-compatible plan, the annual contribution maximum will have to be prorated based on the number of months in which you were enrolled in the HSA-compatible plan. For example, if you were in an HSA-compatible plan for five months, you could only fund your HSA for five out of 12 months. To figure out the math, take the annual contribution limit allowed and divide the number by 5/12 to determine the total amount. In the example above where you are covered for five out of 12 months and you are trying to fund your HSA to the individual annual maximum of $3,450, you would divide the total annual amount allowed by 12 and then multiply by the number of months you were eligible to fund an HSA.

If you pre-funded your account to the annual max up front and you do not enroll in another HSA-compatible health plan for the remainder of the year, you will need to withdraw excess contribution dollars prior to the end of the tax year and treat these funds as taxable income.

Q. What if I sign up for one of CGI's health plan options in the middle of the year because of a qualifying event, like getting married or having a baby? Can I max out my HSA contributions for the whole year or do I only count the months I was enrolled in an HSA eligible health plan option?
A. If your HSA-compatible coverage begins in July, for example, you can contribute the maximum amount for the year provided you maintain coverage in an HSA-compatible health plan until Dec. 31 of the following year. If you switch back to non HSA-compatible coverage in the following year, you will have to prorate your contribution by dividing the annual maximum by the number of months you were covered under an HSA eligible plan. For example, if you were in an HSA-compatible plan for five months, you could only fund your HSA for five out of 12 months just like in the previous question. If it is determined that you over-funded your account, you will need to withdraw excess contribution dollars prior to the end of the tax year and treat these funds as taxable income.

Q. Can I use my HSA to pay for medical expenses I had before I set up my account?
A. No, you cannot reimburse qualified medical expenses that were incurred before your account was established.

Q: What if my spouse has an HSA, too?
A: If your spouse has an HSA and either of you is covered under the other's plan, your combined HSA contributions are limited to the annual contribution maximum for family coverage. You can fund one HSA to the family maximum limit or you can each open up your own HSA and fund each separate HSA to the individual HSA limit. Please note that there is no such thing as a "joint HSA." Like IRAs, HSAs belong to a single account owner. It is up to the spouses to determine whether to fund one HSA to the family limit or two HSAs to the individual limit, or any other arrangement they prefer as long as the total household amount stays under the annual family maximum at tax time.

Q. Can couples open separate HSA accounts if enrolled in the same HSA-compatible health plan?
A. If both husband and wife are eligible to contribute to an HSA, they are both eligible to establish separate HSAs. In fact, if both spouses want to make "catch-up" contributions when they are age 55+, they **must** establish separate accounts.

Q. If my spouse and I are both age 55 or older, can we both make "catch-up" contributions?
A. Yes, if you are both HSA eligible individuals and you both have established separate HSAs

in your own names. If only one of you has an HSA, only that spouse can make a "catch-up" contribution.

Q. I'm enrolled in Medicare or Tricare, can I have an HSA?
A. If you had an HSA before you enrolled in Medicare or Tricare you can keep your HSA and take out tax-free money. However, you cannot continue to contribute to an HSA once you are enrolled in Medicare or Tricare. While neither members nor CGI will be able to fund an HSA on your behalf, if you are already covered by Medicare, Tricare or other government programs, you can still fund a traditional health care flexible spending account, or FSA, to set aside pre-tax money for out of pocket costs you incur while participating in these plans.

To the extent possible you can choose not to enroll in these government programs or even to disenroll if the ability to fund an HSA is more important to you. We encourage you to weigh the benefits of enrollment in a government program alongside the ability to fund an HSA carefully and do what is best for you. Because each individual is different and each government program has its own complex rules, we recommend our members speak to a tax advisor about the pros and cons of each option.

Q. My spouse is on Medicare or Tricare, can I have an HSA?
A. Yes, you are eligible to fund an HSA for yourself as long as **you, yourself** are not enrolled in Medicare, Tricare, or any other comprehensive health insurance coverage. Even if your spouse is enrolled in Medicare or Tricare, you may contribute to your own HSA account up to the maximum amount allowed based on your HSA-compatible health plan enrollment tier (single versus family coverage). You may even pay for your spouse's non-reimbursable medical expenses out of your HSA.

Q. I am a veteran, can I have an HSA?
A. If you have received any **health** benefits from the Veterans Administration or one of their facilities, including prescription drugs, in the last three months, you are not eligible to fund an HSA. However, you may be able to contribute for the months when you do not use Veterans Services. If you currently receive Veterans Affairs **disability** benefits, you are still eligible to open an HSA.

As a veteran, you are eligible to open and fund a Health Savings Account provided you are enrolled in an HSA-compatible health plan. However, use of your VA benefits can have an effect on what you are allowed to contribute to your HSA each year. VA benefits can be used for dental care, vision care and preventative care (including well-baby visits and immunizations), without affecting what you can contribute to your HSA.

Use of VA benefits for any other medical or prescription drug expense will reduce the amount you can contribute to your HSA for the year. In order to make and/or receive contributions into your HSA, you cannot have used your VA benefits at any time during the previous three months (except for the three areas listed above).

For example, you open your HSA on Jan. 1 and did not use any VA benefits in the previous three months. On June 10 you use VA benefits for a medical expense that was not preventive, dental or vision care related. You do not use your VA benefits for the rest of the year (except for preventive care in September).

You can make deposits into your HSA for the months of January through May and September through December (a total of nine months).

Q. As a service disabled veteran, am I able to enroll my family in the HDHP and take advantage of the HSA for their medical expenses?
A. VA disability payments do not make you ineligible to fund an HSA. Only medical and Rx services from a VA facility make you ineligible to fund an HSA. Even if you are using VA medical and Rx services and are unable to fund an HSA for yourself, one of your family members, such as a spouse, may be able to open up an HSA.

Q. Is there an alternative savings account for members enrolled in Medicare, Tricare or another government plan?
A. While neither CGI nor our members are able to fund an HSA, if you are already covered by Medicare, Tricare or other government programs, including members who regularly use VA benefits, members can still fund a regular health care flexible spending account, or FSA, to set aside pre-tax money for out-of-pocket costs incurred while participating in these plans. Alternatively, you can choose not to enroll in these government programs or even to dis-enroll in the programs if the ability to fund an HSA is more important to you. We encourage you to weigh the benefits of enrollment in a government program alongside the ability to fund an HSA and do what is best for you. Because each individual is different and each government program has its own complex rules, we recommend our members speak to a tax advisor about the pros and cons of each option.

Q: Can I have an HSA if I am also covered under my spouse's insurance?
A: It depends. You cannot be enrolled simultaneously in your spouse's comprehensive, "traditional co-pay" health insurance plan and one of CGI's consumer-driven health plans at the same time and fund an HSA in the same year due to federal law. However, if your spouse's plan is also an HSA-compatible plan, you can dual enroll and both still be eligible to fund an HSA.

If your spouse does **not** have an HSA-compatible health plan, you can still pay claims out of an HSA as long as it was funded in a previous year when you were eligible to contribute due to being enrolled in an HSA-compatible health plan at that time, but you cannot contribute to an HSA in any **current** year when you are double-covered in a plan that offers "comprehensive coverage" due to federal law.

Q. Can I have coverage through CGI as my primary insurance, and have coverage under my spouse's plan as secondary insurance?
A. In a year when you are "dual enrolled" in both CGI's HSA-compatible coverage and your spouse's comprehensive medical coverage, you cannot contribute any new money into your HSA, nor have CGI contribute into an HSA on your behalf as long as you are enrolled in your spouse's comprehensive medical plan. This includes having access to your spouse's traditional health care FSA, unless it is a limited purpose FSA.

Q. Will I still be able to keep my current HSA account balance if I enroll in my spouse's plan?
A. Yes, the HSA account is yours to keep–you own it. You may continue to take distributions from your HSA in future years, even if your spouse's plan is not HSA-compatible. However, you will not be able to continue funding your HSA account in future years as long as your spouse's plan is not an HSA-compatible health plan. You can continue funding your HSA account in future years if your spouse's plan **is** an HSA-compatible health plan.

Q. My domestic partner is covered by one of CGI's health plan options. Can I use my HSA for my domestic partner's medical expenses?
A. If your domestic partner meets all the IRS qualifications as a tax dependent, you can legally use your HSA for his or her qualified medical expenses.

Q. Can an employee use HSA or limited purpose FSA funds to pay for medical care of a dependent who is not claimed on the employee's tax return?
A**.** No, the dependent must meet all the IRS qualifications as a tax dependent.

Q. What are the consequences if I fund an HSA bank account when I'm not eligible or use my HSA for expenses that are not eligible? How does the IRS find out I have an HSA?
A. Optum Bank is required to report the funding of HSAs to the IRS annually. Additionally, your CGI W-2 is required to report the value of pre-tax benefits to the IRS each year. In the event you are audited by the IRS, you will need to demonstrate your eligibility to participate in an HSA and provide proof that reimbursements from your account were for eligible expenses. Taxes and penalties are assessed for ineligible use of an HSA.

Q. What is the Form 8889 filing requirement?
A. Participants making contributions to an HSA are required to attach Form 8889 to their 1040 tax return.

HEALTH SAVINGS ACCOUNTS - DISTRIBUTIONS

Q. May I use the funds in my HSA only for my own expenses or may I also use it for other family members?
A. You may use the funds in your HSA for any person treated as a qualified dependent on your federal tax return, even if this person is not covered under an HSA-compatible health plan. While it is possible to do this, it may reduce the dollars you will have in your HSA to offset your own out-of-pocket responsibility because you will only be able to fund your HSA to the contribution level that matches your enrollment coverage tier.

Q. If I am still carrying health coverage for my 24-year-old, can I use my HSA to help pay for his qualified medical expenses?
A. It depends. An adult child must still be a **tax dependent** for his or her medical expenses to qualify for payment or reimbursement from a parent's HSA. If the adult child is not a tax dependent, but is covered by a parent's HSA-eligible health plan, he or she may be able to open his or her own HSA. In these circumstances, it is best to consult with a tax advisor.

Q. What is a tax dependent child versus a non-tax dependent child?
A. If an adult child is not a tax dependent of the member (parent/primary account holder) then the adult child may have to establish his or her own HSA.

- When the child is still a tax-dependent (up to age 19 or, if full-time student, age 24), then the child's out-of-pocket medical expenses can be paid with the primary account holder's HSA. In other words, the parent can use their own HSA to pay for the child's medical expenses.
- When the child is no longer a tax-dependent but is still enrolled in the parent's HSA-compatible health plan (through age 26), then the child's out-of-pocket medical expenses cannot be paid with the primary account holder's HSA. In other words, the adult child would have to set up his or her own HSA to pay for his or her own medical expenses.

Q. What happens to the money in my HSA when I die?

A. If you die, ownership of any money in your account will be given to your spouse if he/she has been designated as your beneficiary and it will be treated as your spouse's HSA after your death. If you designate your spouse as the beneficiary, your spouse essentially becomes the owner of your HSA when you die. If your estate or a non-spouse entity is the beneficiary, the money in your HSA account will be considered taxable income to you on your final tax return.

Q. Can I use money in my HSA to pay or reimburse myself for medical expenses I incurred in the past?
A. Yes, the only "rule" is that expenses for which HSA funds can be used must have been incurred on or after the date your health savings account was established.

Q. Can I use my HSA debit card to get money out at an ATM?
A. Bank rules may differ, but with Optum Bank you can get money from an ATM. ATM fees for both Optum Bank and the ATM bank used would apply so consider this option carefully. The withdrawn HSA cash can be used to pay a provider or to reimburse yourself for expenses you may have paid with other financial means. As with other payment methods, you should always save your receipts to validate the withdrawal against a qualified medical expense to avoid potential tax and IRS penalties.

Q. What happens if I go to use the HSA card and there's not enough money in my account to cover the bill I'm trying to pay?
A. The card will be rejected and you will need to find another way to pay the bill. When your account is built back up with enough money to pay the bill, you can file for reimbursement. You can even reimburse yourself.

Q. Can I use the HSA card to make a partial payment of a bill?
A. You can do this provided the merchant will allow you to use two forms of payment. However, the amount for which you use the HSA debit card cannot exceed the amount in your account at the time. If you are facing a claim payment that is larger than the balance in your HSA, you may want to pay the claim with other financial means first and then reimburse yourself later when you have enough money in your account to cover the charge.

Q. What happens to money left in the account at the end of the year?
A. Money left in the account at the end of a calendar year will be rolled over to the next year.

Q. Can you use your HSA for uninsured dental expenses?
A. Yes, however you may want to consider a limited purpose FSA for dental and vision expenses so that your HSA account can continue to grow for future medial and prescription drug expenses.

Q. Are travel expenses considered an eligible health care expense under the HSA program?
A. Publication 502 from the IRS provides a list of eligible health care expenses. Visit: www.irs.gov to download a copy of the publication.

Q. When you decide how much to contribute to the HSA, is that amount available for you to use on Jan. 1 like it is with the health care FSA account?
A. No, you cannot use amounts that are not yet deposited into your account, as you can with a health care FSA. On Jan. 1, you have access to only the funds that are already deposited in your HSA account, if any. The HSA works more like a bank account where you can only debit the amount of money that has already been deposited and is available to you. If you decide to enroll in a limited purpose FSA for dental and vision expenses, you will have an ADP debit card for your LPFSA and an Optum Debit card for your HSA.

Q. Can a member pay for a dependent's or spouse's expenses with his or her HSA funds?
A. Yes, a member can also pay for the expenses of a spouse enrolled in another employer's plan. However, if the spouse is enrolled in a plan that is not an HSA-compatible health plan, the lower annual contribution limit for a single person will apply to the HSA account funding.

Q. If I enroll in either of CGI's health care plan options and I open an HSA before Jan. 1, can I make a deposit into the HSA prior to Jan. 1?
A. No, contributions for 2018 can only begin with pay dates occurring on, or after Jan. 1, 2018. However, you can open an HSA bank account with Optum Bank right now and wait to contribute to it until Jan. 1, 2018.

Q. Am I required to open an HSA bank account?
A. No, you can enroll in either one of CGI's health plan options without establishing a pre-tax health saving account. There is no requirement to do so. However, if you want to receive CGI's bi-weekly contribution ($19.24 for single/$38.47 family), **you must have an open and established Optum Bank HSA account.**

Please keep in mind that CGI will not retroactively deposit amounts for any pay period that your Optum bank account was not open and fully established, including any money offered to you in your first paycheck of the year.

Q. Is the CGI contribution to my HSA account included in the IRS annual maximum amount?
A. Yes, the IRS considers contributions from both the employer and the employee when determining the annual maximum amount. If you wish to maximize your HSA account funding, make sure you exclude the $500 per member and $1,000 per family that CGI contributes to your HSA account. Be sure to also consider any money your spouse or your spouse's employer is putting into his or her HSA or the amount of any wellness incentives offered by CGI or your spouse's employer because the maximum is a household maximum as defined by the IRS and counts all sources of contribution. If you participate in CGI's wellness program, you are eligible for up to an additional $175. Please plan your contributions accordingly.

For example, in 2018 when you enroll in one of CGI's health plans with "member only" coverage CGI will contribute up to $500 to your HSA account so you will need to fund your HSA with only $2,950 of your own money in order to reach the $3,450 annual max ($2,950 + $500 = $3,450). Further, if you participate in any or all three of CGI's wellness incentives throughout the year, you can receive up to an additional $175 of CGI contributions, so you'd need to reduce your own payroll deductions accordingly to avoid the penalties for exceeding the IRS maximum.

Q: Does the company's contribution for the HSA get deposited monthly or bi-weekly?
A: CGI will contribute tax-free dollars ($19.24 for member-only and $38.47 for family) each pay period (bi-weekly) provided your health savings account is open with Optum Bank.

Q. Can a member elect to contribute a larger sum of money, for instance $500 per pay period, in order to build the account quicker? If so, would I need to take action in order to change/stop contribution when the account reached their desired amount?
A. Yes, you can. There's an HSA enrollment/change form to complete which can be requested through the HR Service Center (CynerGI > MyCGI > HR Service Center). You can change the dollar amount any time, though be careful not to exceed the IRS annual maximum ($3,450 per member and $6,900 per family in 2018, including both employer and member contributions

combined).

Q. Is Optum Bank my only option for the HSA?
A. Other banks offer HSAs, but only Optum Bank accepts CGI payroll deductions and CGI contributions.

Q. How do I open up a bank account with Optum?
A. There are brochures on the Open Enrollment site that provide details on how to open up a bank account with Optum, including links embedded in the brochures that are pre-populated with the correct group number for your coverage.

What you'll need

- Your social security number
- Your primary email address
- An identification number from another form of ID, such as your driver's license, state-issued identification or passport
- Visit the online custom enrollment link and use CGI's Group Number: 3311716

Be on the lookout

When enrolling, you can choose to receive your welcome kit electronically or by mail. You will also receive an HSA Debit MasterCard® and a personal identification number, or PIN, by mail in two separate unmarked envelopes for your safety and security.

If you need extra debit cards

If you have family coverage, you can order extra debit cards for your spouse and dependents on your plan when enrolling in your account. You'll need each cardholder's name, social security number and date of birth.

Q. Does Optum Bank invest the HSA funds in securities or do they keep it safe?
A. Optum Bank, Member FDIC, insures deposits up to $250,000. Thus, the account holder's money is kept safe. Once your account reaches a certain balance, Optum has non-bank account investment options you can consider.

Q. Where is Optum Bank located? Do all the transactions need to be online or is there an actual bank where people can visit?
A. Optum Bank started operating on July 21, 2003, in Salt Lake City, Utah, as a Utah state-chartered industrial loan corporation. Originally named Exante Bank, it changed its name to OptumHealth Bank in 2008 and to Optum Bank in 2012. There are no branches or retail banks.

Q. Can an employee make changes to their HSA contribution during the year or how often can it be changed? What is the process to change it?
A. Yes, you can front load it, start contributions or stop contributions at any time. However, if you are trying to coordinate your contributions through payroll it may take up to two pay periods for the change to go through. To make changes to your payroll deductions, open a case on the HR Service Center (CynerGI > MyCGI > HR Service Center),

Q. Do co-pays fall under your deductible with an HSA account?
A. There are no co-pays with HSA-compatible health plan options. Your co-insurance (the percent you pay) for qualified medical services and prescriptions counts toward your deductible

and out-of-pocket maximum and can be paid from your HSA account.

Q. If a member already has an HSA account at Optum Bank linked to a CGI plan, does the user need to take any further action in order to continue receive CGI contributions next year?
A. No, so long as you continue to be enrolled in either the CGI Select or Essential health plan option, you do not need to take any action during open enrollment.

Q. If my spouse has an HSA plan for his/her use only through their employer, can I still open an HSA for myself and my children?
A: Yes, when you enroll yourself and children in an HDHP, you can open your own HSA and fund it within the IRS annual contribution limits.

Q. If we have the HSA and the limited purpose FSA which account, how are the funds taken to pay expenses?
A. You reimburse yourself or pay your provider directly through your Optum HSA. Or, when using FSA funds, submit receipts for reimbursement through the WageWorks spending account website myspendingaccount.wageworks.com. Please keep in mind that the HSA account is for **any** tax qualified expense (medical, prescription drugs, dental or vision) and the Limited Purpose FSA (LPFSA) is for **dental and vision claims** only.

You cannot submit a medical or prescription claim to the LPFSA, which is why it is called a "limited purpose" FSA–it is limited to dental and vision only. The reason you may want to fund both an HSA and an LPFSA is that it allows you to save more money in your HSA for both current and future medical and prescription drug costs which tend to have higher and more unpredictable costs than dental and vision claims. In addition, the HSA balance rolls over from year to year which can help you pay for future medical claims while the LPFSA has the same "use it or lose it" rules and lower annual contribution limits as a traditional health care FSA.

Q. Do you have to submit claims to get reimbursed through your Optum HSA?
A. No, you can pay your provider directly from your HSA account or you can even reimburse yourself. HSA claims are not submitted or reviewed by a third party like FSA claims are with ADP. The HSA money is yours and how you use it is entirely up to you. However, you should keep your receipts because you will need to support your HSA distributions because they are subject to an IRS audit. If your receipts are less than your distribution amounts, any amount withdrawn in excess of receipts will be taxable income to you and will also be subject to additional 20 percent IRS penalty taxes.

Q. What happens to the money in my health savings account after I turn age 65?
A. You can continue to use your account tax-free for out-of-pocket health expenses. When you enroll in Medicare, you can use your account to pay Medicare premiums, deductibles, copays and coinsurance under any part of Medicare. If you have retiree health benefits through a former employer, you can also use your account to pay for your share of retiree medical insurance premiums. The one expense you cannot use your account for is to purchase a Medicare supplemental insurance or "Medigap" policy.

Once you turn age 65, you can also use your account to pay for things other than medical expenses. If used for other expenses, the amount withdrawn will be taxable as income but will not be subject to any other penalties. Individuals less than age 65 who use their accounts for non-medical expenses must pay income tax and a 20 percent penalty on the non-qualified withdrawal.

HSAs AND FLEXIBLE SPENDING ACCOUNTS – HOW THEY WORK TOGETHER

Q. With an HSA, can I also contribute to a health care FSA?
A. If you enroll in a health savings account, or HSA, you cannot also enroll in a regular health care FSA. However, you can participate in a limited purpose FSA, or LPFSA, to pay dental and vision expenses that are not covered, or only partially covered, by dental or vision insurance plans.

Q. What is a limited purpose FSA (LPFSA)?
A. A limited purpose FSA, or LPFSA, allows you to set aside pre-tax deferrals to pay for non-covered dental, preventive and vision expenses. Like a traditional FSA, the LPFSA contributions are exempt from federal income tax, social security taxes (FICA) and, in most cases, state income tax. The LPFSA is designed for participants in an HSA plan who want preserve their pre-tax HSA funds for medical expenses.

Q. What type of claims can I submit to an LPFSA?
A. The LPFSA works just like the health care FSA but covers **only** your out-of-pocket vision and dental costs.

Q. What is the most I can contribute to the LPFSA?
A. Just like with the traditional FSA, you can contribute from $120 to $2,650 per year. The IRS determines which expenses are eligible for reimbursement.

Q. Does the LPFSA work like the health FSA or the HSA? Is it "use it or lose it" like the FSA or does it roll over like the HSA?
A. The LPFSA works exactly the same way as the health FSA in that has "use it or lose it" rules.

Q. Does a member need to enroll again every year in an FSA?
A. Yes, it's an active annual enrollment event. It does not automatically roll over from year to year. This rule applies to traditional health care FSAs, limited purpose (dental and vision only) FSAs and dependent care FSAs.

Q. What is the federal annual limit for the health care FSA?
A. The federal limit is $2,650 for either a traditional health care FSA or a limited purpose FSA.

Q. Are the limits changing in 2018 for the dependent care flexible spending account?
A. No, the limit remains at $5,000.

Q. If I do not enroll in a CGI medical plan, can I enroll in just the dependent care FSA?
A. Yes.

DENTAL

Q. Did dental premiums change for 2018?
A. No, dental premiums remain the same as last year.

Q. Is Orthodontia covered for adults and children?
A. Orthodontic coverage for both adults and children is provided **only** in the Select Dental Plan option.

Q. Is Invisalign covered under the orthodontic benefits?
A. Yes, Invisalign is included under orthodontic services, which are covered only in the Select Dental plan option.

Q. What is the difference between the Delta Dental Preferred Provider Organization network, or PPO, and Premier network?
A. The negotiated fees for services from dentists who participate in the Delta Dental PPO network are discounted deeper. The amount you would owe a Delta Dental Premier dentist who is not a Delta Dental PPO dentist may be higher than the amount you would owe a Delta Dental PPO dentist for the same covered services.

Q. Are white fillings covered out-of-network?
A. Yes, the same services are covered in- and out-of-network. However, the co-insurance is lower out-of-network, so you will pay more for out-of-network services.

Q. Do preventative dental care services count toward the annual maximum?
A. Yes.

Q. If I want to keep dental coverage, do I have to enroll in the highest plan option (Select)?
A. No, each year, you may select the appropriate coverage for the upcoming year.

Q. Can I increase my annual dental maximum by having my cleaning and preventive care visits?
A. Yes, the MaxOver feature allows members to roll-over unused annual maximum dollars to the next plan year, provided they have had at least one exam and cleaning during the year. Claims in the Select plan for orthodontics do not apply, but claims paid for all other covered services do apply (including preventive services). In summary:

- The maximum amount that can be rolled over in the Select Plan is $375 each year, provided Delta Dental has paid $750 or less in claims throughout the plan year.
- The maximum amount that can be rolled over in the Essential Plan is $250 each year, provided Delta Dental has paid $500 or less in claims throughout the plan year.

The roll-over continues until the annual maximum cap has been reached. The annual maximum cap is $3,000 in the Select Plan and $2,000 in the Essential Plan. This is tracked for individual members and each of their covered dependents. Each April, Delta Dental will mail members a statement which indicates the MaxOver amount or total annual maximum that the member and their dependents have received for that year.

Q. From year to year can I switch between the dental Select option and Essential option?
A. Each year at open enrollment, you may select either plan for the upcoming year. You cannot switch between the two plans during the year.

Q. Do both dental plans offer two free in-network preventive care visits per calendar year?
A. Yes, both dental options allow for two preventive visits per calendar year. To obtain the MaxOver benefit of $250 in the Essential plan and $375 in the Select plan, you must have one dental cleaning and one preventive exam during the calendar year.

Q. Will 2018 dental coverage cover orthodontic treatments already in progress?
A. If you currently have orthodontic treatment in progress and you enroll in the Select plan, which provides orthodontic coverage, Delta Dental will prorate the remaining months in active

(with the bands on the teeth/teeth moving) treatment.

Q. If I switch dental plans, what happens to my MaxOver benefit? Does it go away or does it come with me to the new plan?
A. For the MaxOver benefit, it is helpful to think of it in the terms of two buckets of money:

1. Bucket #1 is the annual maximum amount:
   - Essential Plan Annual Maximum: $1,000
   - Select Plan Annual Maximum: $1,500
2. Bucket #2 MaxOver amounts (amounts that have rolled over each year)

When you (and your covered dependents) switch from one plan option to another, your MaxOver amounts automatically carry over to your new plan option.

VISION

Q. Did vision premiums change?
A. No, the cost for the three vision plan options, (UHC Select, UHC Essential and VSP Choice vision plans) remain the same in 2018.

Q. Are vision exams covered every year?
A. Vision exams are covered once every 12 months under all of CGI's vision plans (VSP and UnitedHeathcare).

QUALIFYING EVENTS

Q. My spouse had a chance to enroll in their employer's plan earlier this year and didn't. I want to avoid the CGI working spouse surcharge; can he ask his employer to allow him to enroll now as a qualifying event?
A. Yes, it would most likely be considered a qualifying event by your spouse's employer. He should immediately follow up with his employer. The majority of Flex plans will allow participants to change their elections when another employer's open enrollment is held at a different time of year. Your spouse will likely need to provide his/her employer some type of documentation that CGI's Open Enrollment is going on now.

Q. I am getting married next year. Will I have an opportunity to enroll my spouse at that time?
A. Yes, a marriage is a qualifying event and you will have 31 days from the date of the event to enroll your spouse or change your benefits elections.

Q. If I have a baby and enroll the baby within 31 days, when does the coverage actually start for the baby?
A. The date of birth is the date the coverage actually starts. Coverage is on day one and is retroactive to that date.

Q. My spouse was not eligible for his employer's benefits at the time of CGI's open enrollment, but he will become eligible in 2018. What is the mechanism for reporting the change in status?
A. The member should notify HR of the change request/life event within 31 days and complete an enrollment change form.

DOMESTIC PARTNER COVERAGE

Q. What documentation is required to continue enrollment or add a domestic partner to my medical, dental, vision or supplemental life coverage?
A. An updated domestic partner affidavit and tax certification form is required annually for all domestic partners in order to enroll or continue enrollment in CGI's medical, dental, vision and/or supplemental life benefits.

Q. What happens if I enroll a domestic partner and do not complete the required affidavit?
A. CGI employs a third party to conduct a dependent verification process to ensure that all dependents (child, spouse, domestic partner) enrolled in coverage are actually eligible for coverage. This process helps manage health care costs for all CGI members by ensuring that only eligible dependents are enrolled. Doing so allows CGI to continue to provide a comprehensive benefits program that is both competitive and cost- effective for its members and the organization. In addition, CGI must adhere to Defense Contract Audit Agency, or DCAA, regulations and ensure claims paid under the Plan are only for those dependents defined as eligible by the Plan.

If you portray a person as an eligible spouse, child or domestic partner and their status cannot be verified, you will be unable to enroll them.

CGI reserves the right to request reverification of dependent status at any time and will pursue any fraudulent activity, which may result in disciplinary action including repayment of claims paid on ineligible dependents dating back to original enrollment. Additionally, premiums paid by the member on behalf of the ineligible dependent will not be reimbursed.

OTHER

Q. Where can members find the enrollment forms and information about Lifestyle Benefits benefits such as Pet Insurance, 529 College Savings Account, and Member Assistance program?
A. Enrollment in any of the Lifestyle Benefits is available any time throughout the year. More information can be found on the CGI U.S. Benefits website (Login ID: **CGIUS;** Password: **usbenefits2018)**.

Q. The 529 plan is asking me for information I do not have. In the 'Name of employer' field, should it be 'CGI' or 'CGI Federal'? I also need the Employer Identification Number for the application.
A. For employee benefits purposes, all CGI companies in the U.S. roll up under "CGI Technologies & Solutions Inc." The EIN is 54-0856778.

Q. Does one lose the company sponsor's long term disability benefit when one reaches retirement age? What is the retirement age?
A. "Normal Retirement Age" is defined by Social Security and depends in part on what year you were born in relation to the effective date of the policy. In addition, the benefits are reduced depending on the age at which your disability begins. For members age 69 and over , the long

term disability benefit may be paid for up to 12 months. For members who elect early social security retirement, the long term disability benefit will be reduced by that amount until the claim is closed. The table below depicts how normal retirement age and maximum benefit periods are currently defined in the long term disability certificate:

Maximum Benefit Period (For Injury or Sickness)

The later of your SSNRA* or the Maximum Benefit Period listed below

Age When Disability Begins	Maximum Benefit Period
Age 62 or less	Your 65th birthday or the date the 42nd monthly benefit is payable, if later
Age 63	The date the 36th monthly benefit is payable
Age 64	The date the 30th monthly benefit is payable
Age 65	The date the 24th monthly benefit is payable
Age 66	The date the 21th monthly benefit is payable
Age 67	The date the 18th monthly benefit is payable
Age 68	The date the 15th monthly benefit is payable
Age 69 or older	The date the 12th monthly benefit is payable

*SSNRA means the Social Security Normal Retirement Age is effect under the Social Security Act on the Policy Effective Date.

Q. After retirement, does the long-term disability benefit then come from Social Security? Is the long-term disability benefit from SSA in addition to the regular SSA retirement check?
A. The goal of long-term disability benefits is to pay a portion of lost income until you are able to retire and collect social security benefits. Once you have reached normal retirement age as defined by the Social Security Administration, you will no longer receive long-term disability payments as you will instead receive social security retirement income payments.

Q. When does the Open Enrollment site actually close?
A. While the Open Enrollment Tool will close at midnight Pacific Time on Friday, Nov. 17, the CGI U.S. Benefits website will remain available to members throughout the year.

Q. What is the URL and phone number for the 401(k)?
A. T. Rowe Price Retirement Plan Services participant website is: rps.troweprice.com The phone number is 800-922-9945.

Q. Who should we contact if we have additional questions as we are going through benefits materials?
A. Please open a case in the HR Service Center (CynerGI > MyCGI > HR Service Center).

ABOUT CONSUMER-DRIVEN HEALTH PLANS

Q. Why are consumer-driven health plans with health savings accounts popular?
A. There are many reasons why consumer-driven health plans, or CDHPs, with HSAs have gained popularity the past few years. CDHPs typically costs less than traditional co-pay plans, and encourage you to take more control over how your health care dollars are spent, which can save you money.

In addition, CDHPs let you open and build a health savings account with three tax advantages: no tax on the money when it goes in, the money invested grows tax-free over the years and there is no tax when you take the money out of the account—as long as you use it for medical expenses. HSAs are yours to keep, so you can take the money in your account with you if you leave CGI for any reason, including retirement.

After age 65, an HSA behaves like an IRA, so if you withdraw the funds and use them for something other than a medical expense, you will only have to pay income taxes on the distribution, as the 20 percent IRS penalty tax will no longer apply.

Q. Is everyone eligible to participate in High Deductible Health Plans?
A. No, if you yourself are currently enrolled in Medicare, Tricare or other government programs, you will not be able to open and contribute to an HSA. However, there are alternatives to HSAs that can assist you with paying your current year claims on a pre-tax basis, such as a traditional Health Care FSA. Please note that if your spouse is on Medicare, Tricare or another government program, this should not affect your eligibility to fund an HSA for yourself. As long as you yourself only have access to HSA-compatible health coverage (and you do not have access to a traditional Health Care FSA through your spouse) you should be able to fund an HSA.

Q. Will my physician be familiar with a High Deductible Health Plan?
A. Yes, these plans have become the norm. If you or your doctor's office has questions about your coverage, you can always call the Customer Service telephone number on your medical ID card.

Q. How are preventive care services covered?
A. Preventive care services received from an in-network primary care physician are covered at 100 percent (you do not have to meet a deductible), and you will pay coinsurance if you go to a provider out-of-network for preventive care. The following are preventive services that may be covered:

- Annual physicals/Well-child visits
- Flu vaccines (if given in the office or pharmacy of a Cigna network provider)
- Immunizations
- Age-appropriate screenings such as colonoscopies, PSA tests, mammograms, PAP tests, etc.

Only services coded by your doctor as preventive are generally paid at 100 percent in-network with no deductible. If the same tests are done to diagnose an illness or treat a known condition, they are not considered preventive care. It's a good idea to ask your doctor how a service will be coded to avoid surprises.

Q. What about medical services other than preventive care? How will my cost for these services be determined?
A. You will pay the cost of the in-network medical services (at discounted prices) up to the point where you meet your deductible. Then, you pay a percentage of all services until you reach the out-of-pocket maximum for the Select plan option. For the Essential plan option, there is no coinsurance after the deductible is met, so your annual deductible is your annual out of pocket maximum. Once you have reached your annual out of pocket maximum in either health plan option, all eligible medical expenses will be paid in full by the plan for the rest of the calendar year. Your costs will be subject to the in-network or out-of-network provisions of the plan.

Out of network care will cost you more. There is a limit to the amount your plan will pay for

covered out of network services, called the maximum reimbursable charge (MRC). An out of network provider can bill you directly for any amount above the maximum reimbursable charge. And the amount does NOT apply to your deductible or out of pocket maximum.

Q. What about the costs of prescription drugs? How are those costs handled?

A. By law, most prescription drug costs must be part of the overall coverage in a high deductible health plan. Prescriptions are subject to the deductible (and coinsurance, if applicable). Except for certain preventive medications, you must pay the full cost of prescription drugs until you meet your annual deductible (then coinsurance, if applicable). Once you have hit your out of pocket maximum, the plan will pay 100 percent of the costs of the drugs for the rest of the year.

Q. How do I pay for services?

A. Because you need to meet the annual deductible before the plan cost share kicks in (except for preventive care which is paid at 100 percent), you should ask your provider to file your claim **before** you make any payments. In-network providers should file the claim for you. Then, when you receive your Explanation of Benefits, or EOB, from your health carrier, you will know the exact amount owed and can make your payment to your provider using funds in your HSA or by paying out-of-pocket.

When filling a prescription you can use your HSA debit card to make the payment, provided there are sufficient funds in your HSA. The pharmacist will calculate the amount you owe. If there are not enough funds in your account to pay the bill, you can pay for the prescriptions out of your own pocket and later reimburse yourself when there are sufficient funds in your account. Optum Bank representatives can help you with this.